# Examination for Housebound Status or Permanent Need for Regular Aid and Attendance

**1. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT**

**2. VA FILE NUMBER**

**3. HOME ADDRESS**

**4. PLACE OF EXAMINATION**

**5. DATE OF EXAMINATION**

**6. WERE CLAIMANT ACCOMPANIED TO PLACE OF EXAMINATION?**

- ☐ YES
- ☐ NO

*(If "YES," complete Items 7 and 8)*

**7. NAME OF NURSE OR ATTENDANT**

**8. MODE OF TRAVEL**

**9. IS CLAIMANT HOSPITALIZED?**

- ☐ YES
- ☐ NO

*(If "YES," complete Items 10 and 11)*

**10. DATE ADMITTED**

**11. NAME AND ADDRESS OF HOSPITAL**

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**NOTE:** VA MEDICAL EXAMINER PLEASE READ CAREFULLY.

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound or in need of the regular aid and attendance of another person.

Findings should be recorded to show whether the claimant is blind or bedridden.

The report should be in sufficient detail for the regional office rating board to determine whether there is disease or injury producing physical or mental impairment, loss of coordination or. enfeeblement affecting ability to dress and undress, for self feeding, to attend to the wants of nature and keep him/herself ordinarily clean and presentable.

In addition, it is necessary to state findings indicating whether the claimant is "housebound", that is whether he/she is confined to the home or immediate premises.

In either instance, whether the claimant is claiming housebound aid and attendance benefits, the report should reflect how well the individual ambulates, where the individual goes, and what he/she is able to do during a typical day.

**12. INDIVIDUAL'S COMPLAINT**

**13A. AGE**

**13B. SEX**

**14. WEIGHT**

- ACTUAL: __ lbs.
- ESTIMATED: __ lbs.

**15. HEIGHT**

- FT: __
- INCHES: __

**16. NUTRITION**

**17. GAIT**

**18. BLOOD PRESSURE**

**19. PULSE RATE**

**20. RESPIRATORY RATE**

**21. NUMBER OF HOURS IN BED FROM 9 PM TO 9 AM:**

**22. POSTURE AND GENERAL APPEARANCE**

**23. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY FOR SELF FEEDING, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE**

**24. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO EXTENT OF LIMITATION OF MOTION, ATROPHY, CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.**
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>2a. Certification of Need for Higher Level Aid and Attendance (38 U.S.C. 314 (c)(2))</td>
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<td>2b. Additional Remarks</td>
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<td>3a. Are AIDS such as cancer, brain, or organ failure a condition that requires?</td>
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<td>3b. Describe how often per day or week and during what circumstances the individual is able to leave the home or maintain personal hygiene.</td>
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<td>5a. Is the claimant able to walk without the assistance of another person?</td>
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