☐ Data Entered ☐ Brief Local ☐ Brief NSO ☐ Appoint Rep 21-22

☐ Intent File 21-0966 ☐ Military Rec SF-180 ☐ Release Info 3288 ☐ Unemploy 21-8940

☐ PTSD 21-8940 ☐ Health Ben 10-10EZ ☐ Claim 21-526EZ ☐ Info Request 20-10206

☐ Priority 20-10207 ☐ Evidence 20-10208 ☐ Witness 21-10210 ☐ Ch 31 Assist 28-10212

RESET

PRINT

MUST open with Adobe, not browser. ©John Stephen Davis

Today's Date (mm/dd/yyyy): _____

First Name: _____ Middle Name: _____ Last Name: _____

Primary Phone (no spaces): _____ Secondary Phone (no spaces): _____

Email: _____

Number/Street: _____ Apt/Unit: _____ City: _____

State/Province: _____ Country: _____ Zip: _____ Zip Extra: _____

SSN (9 digits only): _____ Service Number (no spaces): _____

Date of Birth (mm/dd/yyyy): _____ Place of Birth: _____

Branch (Choose only 1): ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast G

☐ Other: _____

Component (check all that apply): ☐ Active ☐ Reserves ☐ National Guard ☐ Retired From Military?

Gender: ☐ Male ☐ Female

First Claim? ☐ Yes ☐ No If not 1st Claim, Previous Claim No: | | | | | | | | | |

☐ Compensation ☐ Pension ☐ Survivor Benefit

## SF-180, REQUEST PERTAINING TO MILITARY RECORDS

Veteran Deceased? ☐ Yes ☐ No If deceased, Date Deceased (mm/dd/yyyy): _____

**Active Service #1**

Branch: _____ Service Number (no spaces): _____ Officer? ☐ Yes ☐ No

Date Entered (mm/dd/yyyy): _____ Date Released (mm/dd/yyyy): _____

**Active Service #2**

Branch: _____ Service Number (no spaces): _____ Officer? ☐ Yes ☐ No

Date Entered (mm/dd/yyyy): _____ Date Released (mm/dd/yyyy): _____

**ReserveService#1**

Branch: _____ Service Number (no spaces): _____ Officer? ☐ Yes ☐ No

Date Entered (mm/dd/yyyy): _____ Date Released (mm/dd/yyyy): _____

**ReserveService#2**

Branch: _____ Service Number (no spaces): _____ Officer? ☐ Yes ☐ No

Date Entered (mm/dd/yyyy): _____ Date Released (mm/dd/yyyy): _____

**GuardService#1**

Branch: _____ Service Number (no spaces): _____ Officer? ☐ Yes ☐ No

Date Entered (mm/dd/yyyy): _____ Date Released (mm/dd/yyyy): _____

**GuardService#2**

Branch: _____ Service Number (no spaces): _____ Officer? ☐ Yes ☐ No

Date Entered (mm/dd/yyyy): _____ Date Released (mm/dd/yyyy): _____

- - - - - - - - - - - - - - - - - - End of Veteran Data (Service Officer Fills in Remainder) - - - - - - - - - - - - - - - - - -

# Contact Brief - Local

Date (mm/dd/yyyy): _____

CSO: _____

Client: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Action Requested:

Action Taken:

**Forms:**

☐ 21-22 Appoint Rep ☐ 21-526ez Claim ☐ 21-4138 Statement ☐ 21-686c Dependents ☐ 28-1900 Voc Rehab ☐ 26-1880 Certif Elig ☐ 10-10ez Health Ben

Following sent direct, not sent to NSO

☐ 21-0966 Intent ☐ 21-8940 Unemploy ☐ 21-4192 Unemploy2 ☐ 21-0781 PTSD ☐ SF-180 Military Recs ☐ 10-5345 VA MedRecs ☐ 3288 C-File

FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

# Contact Brief

National Headquarters
3725 Alexandria Pike
Cold Spring, KY 41076
859-441-7300
Toll Free 877-426-2838

National Service and
Legislative Headquarters
807 Maine Avenue SW
Washington, DC 20024
202-554-3501

Select one:

☑ Department/Chapter Service Office ☐ Hospital Service Coordinator ☐ Job Fair
☐ National Service Office ☐ Transition Service Office ☐ Information Seminar

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ ZIP: _____ Email: _____

SS#: _____ Date of Birth: _____ VA Claim #: ☐☐☐☐☐☐☐☐☐

DAV Member: ☐ Yes ☐ No If Yes, Membership #: _____ % of Disability (s): _____

Branch of Service: _____ EAD: _____ RAD: _____

Action Desired: _____

Action Taken: _____

_____

Which National Service Office received information/forms: _____

How were they sent? ☐ Email ☐ Fax ☐ Mail ☐ CMS ☐ Other: _____

How did you receive confirmation that the NSO office recieved all documents/requests? _____

VA Forms:

☐ 21-22 ☐ 21-0966 ☐ 21-526ez ☐ 20-0995 ☐ 20-0996 ☐ 21-4138 ☐ 21-686c ☐ 28-1900

Other Forms: _____

Prepared & Submitted By:

_____
Name and Title

Received & Reviewed By:

_____
Name and Title

Instructions: Send the original with any necessary documentation to the DAV National Service Office located at the VA office where the veteran's records are maintained. This form should be completed in all cases where a service inquiry is taken and referred to the DAV National Service Office.

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

**IMPORTANT**: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

**NOTE:** If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative.* See Page 4 for information on how to submit the completed form, either by mail, in person at a VA regional office or electronically. VA forms are available at www.va.gov/vaforms.

## SECTION I: VETERAN'S INFORMATION

**NOTE**: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. &
Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

## SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. &
Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

## SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

Disabled American Veterans

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

## SECTION IV: AUTHORIZATION INFORMATION

**19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C**. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

**20. LIMITATION OF CONSENT**- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

**21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS** - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

## SECTION V: SIGNATURES

**NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC**

| 22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)* | 22B. DATE SIGNED *(MM/DD/YYYY)* |
|---|---|
| 23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)* | 23B. DATE SIGNED *(MM/DD/YYYY)* |

**NOTE**: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

| **VA USE ONLY** | COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE | DATE SENT | ACKNOWLEDGED *(Date)* | REVOKED *(Reason and date)* |
|---|---|---|---|---|

**PENALTY**: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

# Department of Veterans Affairs

**VA DATE STAMP**
**(DO NOT WRITE IN THIS SPACE)**

## INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

**(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)**

**NOTE**: Please read the Privacy Act and Respondent Burden below before completing the form.

## SECTION I: CLAIMANT/VETERAN IDENTIFICATION

**NOTE**: You can ***either*** complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*

| 2. CLAIMANT'S SOCIAL SECURITY NUMBER | 3. VA FILE NUMBER *(If applicable)* | 4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY) |
|---|---|---|
| | | |

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***

| 6. VETERAN'S SOCIAL SECURITY NUMBER | 7. VETERAN'S SEX | 8. VETERAN'S SERVICE NUMBER *(If applicable)* |
|---|---|---|
| | ☐ MALE ☐ FEMALE | |

9. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

| 10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? | 11.TELEPHONE NUMBER *(Include Area Code)* | 12. EMAIL ADDRESS *(If applicable)* |
|---|---|---|
| ☐ YES ☐ NO | | |

## SECTION II: GENERAL BENEFIT ELECTION

***IMPORTANT***: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

**13. I intend to file for the general benefit(s) checked below:** ***(Choose all that apply)***

☐ **COMPENSATION** ☐ **PENSION**

**NOTE: Only check the box below if you are a surviving dependent of the veteran.**

☐ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

**IMPORTANT**: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at **www.va.gov.** If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

## SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

| 14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE | 14B. DATE SIGNED *(MM,DD,YYYY)* |
|---|---|
| | |

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*

(**NOTE**: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

**RESPONDENT BURDEN**: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2024

# REQUEST PERTAINING TO MILITARY RECORDS

**Requests can be submitted online using eVetRecs at http://www.archives.gov/veterans/military-service-records/**
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

## SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

| 1. NAME USED DURING SERVICE (last, first, full middle) | 2. SOCIAL SECURITY # | 3. DATE OF BIRTH | 4. PLACE OF BIRTH |
|---|---|---|---|
| | | | |

**5. SERVICE, PAST AND PRESENT** *(For an effective records search, it is important that ALL service be shown below.)*

| | BRANCH OF SERVICE | DATE ENTERED | DATE RELEASED | OFFICER | ENLISTED | SERVICE NUMBER (If unknown, write "unknown") |
|---|---|---|---|---|---|---|
| **a. ACTIVE** | | | | ☐ | ☐ | |
| **b. RESERVE** | | | | ☐ | ☐ | |
| **c. NATIONAL GUARD** | | | | ☐ | ☐ | |

**6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN:** 1. _____ 2. _____ 3. _____ 4. _____

**7. IS THIS PERSON DECEASED?** ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

**8. DID THIS PERSON RETIRE FROM MILITARY SERVICE?** ☐ NO ☐ YES

## SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

**1. CHECK THE ITEM(S) YOU ARE REQUESTING:**

☒ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation):_____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
***An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box:*** ☐ I want a **DELETED** copy.

☒ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☒ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.

☐ I request inpatient/hospitalization records from _____(facility), last treated in _____(year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☒ **Other (Please Specify):** All awards, decorations, badges

**2. PURPOSE:** (Providing information about the purpose of the request is **voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

## SECTION III - RETURN ADDRESS AND SIGNATURE

**1. REQUESTER NAME:** _____

**2. RELATIONSHIP TO VETERAN:** Self

**3.** ☒ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.
☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)
☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)
☐ OTHER (Specify): _____

**4. SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 4 on accompanying instructions.)

Name _____

Street Address _____ Apt. # _____

City _____ State _____ ZIP Code _____

Daytime Phone _____ Fax Number _____

Email Address _____

**5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information.** *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

_____ _____
**Signature Required** – Do not print **Date**

* This form is available at http://www.archives.gov/veterans-military-service-records/standard-form-180.pdf on the National Archives and Records Administration (NARA) web site. *

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

# REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

**PRIVACY ACT STATEMENT:** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

**RESPONDENT BURDEN:** VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send** this form or requests for benefits to this address.

| TO | **Department of Veterans Affairs**<br>Department of Veterans Affairs<br>P.O. Box 4444<br>Janesville, WI 53547-4444 | NAME OF INDIVIDUAL *(Type or print)* | |
|---|---|---|---|
| | | VA FILE NO. *(Include prefix)* | SOCIAL SECURITY NUMBER |

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Veteran Name _____ SSN _____

Street Address _____ Apt.# _____ VA File Number _____

City _____ State _____ Zip Code _____

Primary phone _____ Secondary phone _____

Email address _____

**VETERAN'S REQUEST**

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶ NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

***NOTE:*** *Additional information may be listed on the reverse side of this form.*

| SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)* | DATE |
|---|---|
| | |

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

OMB Approved No. 2900-0404
Respondent Burden: 45 minutes
Expiration Date:10/31/2020

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

**IMPORTANT**: This is a claim for compensation benefits based on unemployability. When you complete this form you are claiming total disability because of a service-connected disability(ies) which has/have prevented you from securing or following any substantially gainful occupation. Answer all questions fully and accurately. See mail information on page 4 of this form.

**Social Security Benefits**: Individuals who have a disability and meet medical criteria may qualify for Social Security of Supplemental Security Income disability benefits. If you would like more information about Social Security benefits, contact your nearest Social Security Administration (SSA) office. You can locate the address of the nearest SSA office in your telephone book blue pages under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TDD line 1-800-325-0778). You may also contact SSA by Internet at http://www.ssa.gov/.

## SECTION I - VETERAN IDENTIFICATION INFORMATION

**NOTE**: You can ***either*** complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly to expedite processing the form.

1. NAME OF VETERAN *(FIRST, MIDDLE INITIAL, LAST)*

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. DATE OF BIRTH

5. MAILING ADDRESS OF VETERAN *(No. and street or rural route, city or P.O., State, ZIP Code and Country)*

No. &
Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

6. EMAIL ADDRESS *(If applicable)*

◉ I agree to receive electronic correspondence from VA in regards to my claim.

7. TELEPHONE NUMBER *(Include Area Code)*

Enter International Phone Number *(If applicable)*

## SECTION II - DISABILITY AND MEDICAL TREATMENT

8. WHAT SERVICE-CONNECTED DISABILITY PREVENTS YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?

9. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?

◯ YES ◯ NO

10. DATE(S) OF TREATMENT BY DOCTOR(S)
(Go to Item 26 - Remarks - for additional dates)

FROM – –

TO – –

11. NAME AND ADDRESS OF DOCTOR(S)

12. NAME AND ADDRESS OF HOSPITAL

13. DATE(S) OF HOSPITALIZATION
(Go to Item 26 - Remarks - for additional dates)

FROM – –

TO – –

## SECTION III - EMPLOYMENT STATEMENT

14. DATE YOUR DISABILITY AFFECTED FULL-TIME EMPLOYMENT
Month – Day – Year

15. DATE YOU LAST WORKED FULL-TIME
Month – Day – Year

16. DATE YOU BECAME TOO DISABLED TO WORK
Month – Day – Year

17A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR?

$ ,

17B. WHAT YEAR?

17C. OCCUPATION DURING THAT YEAR?

VETERAN'S SOCIAL SECURITY NUMBER

## SECTION III - EMPLOYMENT STATEMENT *(Continued)*

**18. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED**
**(Include any military duty including inactive duty for training)**

| A. NAME AND ADDRESS OF EMPLOYER (OR UNIT) | B. TYPE OF WORK | C. HOURS PER WEEK |
|---|---|---|
| | | |

| D. DATES OF EMPLOYMENT FROM | D. DATES OF EMPLOYMENT TO | E. TIME LOST FROM ILLNESS | F. HIGHEST GROSS EARNINGS PER MONTH |
|---|---|---|---|
| – – | – – | | $ , |

| G. NAME AND ADDRESS OF EMPLOYER (OR UNIT) | H. TYPE OF WORK | I. HOURS PER WEEK |
|---|---|---|
| | | |

| J. DATES OF EMPLOYMENT FROM | J. DATES OF EMPLOYMENT TO | K. TIME LOST FROM ILLNESS | L. HIGHEST GROSS EARNINGS PER MONTH |
|---|---|---|---|
| – – | – – | | $ , |

| M. NAME AND ADDRESS OF EMPLOYER (OR UNIT) | N. TYPE OF WORK | O. HOURS PER WEEK |
|---|---|---|
| | | |

| P. DATES OF EMPLOYMENT FROM | P. DATES OF EMPLOYMENT TO | Q. TIME LOST FROM ILLNESS | R. HIGHEST GROSS EARNINGS PER MONTH |
|---|---|---|---|
| – – | – – | | $ , |

| S. NAME AND ADDRESS OF EMPLOYER (OR UNIT) | T. TYPE OF WORK | U. HOURS PER WEEK |
|---|---|---|
| | | |

| V. DATES OF EMPLOYMENT FROM | V. DATES OF EMPLOYMENT TO | W. TIME LOST FROM ILLNESS | X. HIGHEST GROSS EARNINGS PER MONTH |
|---|---|---|---|
| – – | – – | | $ , |

19. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NATIONAL GUARD, DOES YOUR SERVICE CONNECTED DISABILITY PREVENT YOU FROM PERFORMING YOUR MILITARY DUTIES?

◯ YES ◯ NO

| 20A. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS | 20B. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME |
|---|---|
| $ , | $ , |

| 21A. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY? | 21B. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS? | 21C. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS? |
|---|---|---|
| ◯ YES ◯ NO *(If "Yes," give the facts in Item 26, "Remarks")* | ◯ YES ◯ NO | ◯ YES ◯ NO |

22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BECAME TOO DISABLED TO WORK?

◯ YES ◯ NO *(If "Yes," complete Items 22A, 22B, and 22C)*

| 22A. NAME AND ADDRESS OF EMPLOYER | 22B. TYPE OF WORK | 22C. DATE APPLIED |
|---|---|---|
| | | – – |
| NAME AND ADDRESS OF EMPLOYER | TYPE OF WORK | DATE APPLIED |
| | | – – |
| NAME AND ADDRESS OF EMPLOYER | TYPE OF WORK | DATE APPLIED |
| | | – – |

## SECTION IV - SCHOOLING AND OTHER TRAINING

23. EDUCATION *(Check highest year completed)*

GRADE SCHOOL ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 HIGH SCHOOL ◯ 9 ◯ 10 ◯ 11 ◯ 12 COLLEGE ◯ Fresh ◯ Soph ◯ Jr ◯ Sr

24A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?

◯ YES ◯ NO (If "Yes," complete Items 24B and 24C)

| 24B. TYPE OF EDUCATION OR TRAINING | 24C. DATES OF TRAINING | |
|---|---|---|
| | BEGINNING | COMPLETION |
| | – – | – – |

25A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?

◯ YES ◯ NO (If "Yes," complete Items 25B and 25C)

| 25B. TYPE OF EDUCATION OR TRAINING | 25C. DATES OF TRAINING | |
|---|---|---|
| | BEGINNING | COMPLETION |
| | – – | – – |

26. REMARKS (If any)

26. REMARKS (If any) (Continued)

## SECTION IV - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

**AUTHORIZATION FOR RELEASE OF INFORMATION**: I authorize the person or entity, including but not limited to any organization, service provider, employer, or Government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

**CERTIFICATION OF STATEMENTS: I CERTIFY THAT** as a result of my service-connected disabilities, I am unable to secure or follow *any* substantially gainful occupation and that the statements in this application are true and complete to the best of my knowledge and belief. I understand that these statements will be considered in determining my eligibility for VA benefits based on unemployability because of service-connected disability.

I UNDERSTAND THAT IF I AM GRANTED SERVICE-CONNECTED TOTAL DISABILITY BENEFITS BASED ON MY UNEMPLOYABILITY, I MUST IMMEDIATELY INFORM VA IF I RETURN TO WORK. I ALSO UNDERSTAND THAT TOTAL DISABILITY BENEFITS PAID TO ME AFTER I BEGIN WORK MAY BE CONSIDERED AN OVERPAYMENT REQUIRING REPAYMENT TO VA.

| 27. SIGNATURE OF CLAIMANT *(Required)* | 28. DATE SIGNED |
|---|---|
| | |

WITNESSES NEEDED IF "X" MARK IS MADE (Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known and the signature and address of such witnesses must be shown in Items 29A & 29B and 30A & 30B.

| 29A. SIGNATURE OF WITNESS *(Sign in ink)* | 29B. ADDRESS OF WITNESS |
|---|---|
| | |
| 30A. SIGNATURE OF WITNESS *(Sign in ink)* | 30B. ADDRESS OF WITNESS |
| | |

**PENALTY**: The law provides severe penalties which include fine or imprisonment or both for the willful submission of any statement or evidence of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

## SECTION V - WHERE TO SEND CORRESPONDENCE

### MAIL TO:

**Department of Veterans Affairs**
**Evidence Intake Center**
**PO Box 4444**
**Janesville, WI 53547-4444**

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5101(c)(1). VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN**: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0659
Respondent Burden: 1 hour 10 minutes
Expiration Date: 07/31/2020

**Department of Veterans Affairs**

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

# STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

**IMPORTANT:** If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1, or visit **https://www.veteranscrisisline.net/** to chat online, or send a text message to **838255** to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for **deaf and hard of hearing** individuals is available.

**INSTRUCTIONS:** List the stressful incident or incidents that occurred in service that you feel contributed to your current condition. For each incident, provide a description of what happened, the date, the geographic location, your unit assignment and dates of assignment, and the full names and unit assignments of you know of who were killed or injured during the incident. Please provide dates within at least a 60-day range and do not use nicknames. It is important that you complete the form in detail and be as specific as possible so that research of military records can be thoroughly conducted. If more space is needed, attach a separate sheet, indicating the item number to which the answers apply.

## SECTION I: VETERAN'S IDENTIFICATION INFORMATION

**NOTE:** You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)*

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)*

7. E-MAIL ADDRESS *(Optional)*

## SECTION II: STRESSFUL INCIDENTS

8A. DATE ***FIRST*** INCIDENT OCCURRED *(MM/DD/YYYY)*
Month Day Year

8B. DATES OF UNIT ASSIGNMENT *(MM/DD/YYYY)*
**FROM:** Month Day Year **TO:** Month Day Year

8C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*

8D. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

8E. DESCRIPTION OF THE INCIDENT

8F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT

## SECTION II: STRESSFUL INCIDENTS *(Continued)*

**NOTE:** Information about persons who were killed or injured during the first incident *(attach a separate sheet if more space is needed.)*

9A. NAME OF PERSON *(First, Middle Initial, Last)*

| 9B. RANK *(If applicable)* | 9C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* | 9D. PLEASE CHECK ONE |
|---|---|---|
| | Month Day Year | ◯ KILLED IN ACTION ◯ WOUNDED IN ACTION ◯ OTHER |
| | | ◯ KILLED NON-BATTLE ◯ INJURED NON-BATTLE |

9E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

10A. NAME OF PERSON *(First, Middle Initial, Last)*

| 10B. RANK *(If applicable)* | 10C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* | 10D. PLEASE CHECK ONE |
|---|---|---|
| | Month Day Year | ◯ KILLED IN ACTION ◯ WOUNDED IN ACTION ◯ OTHER |
| | | ◯ KILLED NON-BATTLE ◯ INJURED NON-BATTLE |

10E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

| 11A. DATE ***SECOND*** INCIDENT OCCURRED *(MM,DD,YYYY)* | 11B. DATES OF UNIT ASSIGNMENT *(MM/DD/YYYY)* | |
|---|---|---|
| Month Day Year | **FROM:** Month Day Year | **TO:** Month Day Year |

11C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*

11D. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

11E. DESCRIPTION OF THE INCIDENT

11F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT

## SECTION II: STRESSFUL INCIDENTS *(Continued)*

**NOTE:** Information about persons who were killed or injured during the second incident *(attach a separate sheet if more space is needed.)*

12A. NAME OF PERSON *(First, Middle Initial, Last)*

12B. RANK *(If applicable)*

12C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*
Month Day Year
– –

12D. PLEASE CHECK ONE
◯ KILLED IN ACTION ◯ WOUNDED IN ACTION ◯ OTHER
◯ KILLED NON-BATTLE ◯ INJURED NON-BATTLE

12E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

13A. NAME OF PERSON *(First, Middle Initial, Last)*

13B. RANK *(If applicable)*

13C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*
Month Day Year
– –

13D. PLEASE CHECK ONE
◯ KILLED IN ACTION ◯ WOUNDED IN ACTION ◯ OTHER
◯ KILLED NON-BATTLE ◯ INJURED NON-BATTLE

13E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

14. REMARKS

## SECTION III: VETERAN SIGNATURE

**I HEREBY CERTIFY THAT** the information I have given on this form is true and correct to the best of my knowledge and belief.

15. SIGNATURE

16. DATE SIGNED *(MM/DD/YYYY)*

**PRIVACY ACT NOTICE:** The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is necessary to obtain supporting evidence of stressful incidents in service. If the information is not furnished completely or accurately, VA will not be able to thoroughly research your military records for supporting evidence. The responses you submit are considered confidential (38 U.S.C. 5701).

**RESPONDENT BURDEN:** We need this information in order to assist you in supporting your claim for post-traumatic stress disorder (38 U.S.C. 5107 (a)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

**PENALTY** - The law provides severe penalties which include fine or imprisonment or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date 12/31/2020

Department of Veterans Affairs

# APPLICATION FOR HEALTH BENEFITS

## SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

| 1A. VETERAN'S NAME *(Last, First, Middle Name)* | 1B. PREFERRED NAME | 2. MOTHER'S MAIDEN NAME |
|---|---|---|
| | | |

| 3A. BIRTH SEX | 3B. SELF-IDENTIFIED GENDER IDENTITY | 4. ARE YOU SPANISH, HISPANIC,OR LATINO? | 5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)* | 6. SOCIAL SECURITY NO. |
|---|---|---|---|---|
| ☐ MALE<br>☐ FEMALE | ☐ MALE<br>☐ FEMALE | ☐ YES<br>☐ NO | ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE<br>☐ BLACK OR AFRICAN AMERICAN ☐ WHITE<br>☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER | |

| 7. VA CLAIM NUMBER | 8A. DATE OF BIRTH *(mm/dd/yyyy)* | 8B. PLACE OF BIRTH *(City and State)* | 9. RELIGION |
|---|---|---|---|
| | | | |

| 10A. PERMANENT ADDRESS *(Street)* | 10B. CITY | 10C. STATE | 10D. ZIP CODE | 10E.COUNTY |
|---|---|---|---|---|
| | | | | |

| 10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)* | 10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)* | 10H. E-MAIL ADDRESS *(optional)* |
|---|---|---|
| | | |

| 11A. RESIDENTIAL ADDRESS *(Street)* | 11B. CITY | 11C. STATE | 11D. ZIP CODE | 11E.COUNTY |
|---|---|---|---|---|
| | | | | |

| 12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)* | 13. CURRENT MARTIAL STATUS |
|---|---|
| ☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL | ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED |

| 14A. NEXT OF KIN NAME | 14B. NEXT OF KIN ADDRESS | 14C. NEXT OF KIN RELATIONSHIP |
|---|---|---|
| | | |

| 14D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)* | 14E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)* | 15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*) |
|---|---|---|
| | | |

| 16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT | 17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)* | 18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? |
|---|---|---|
| ☐ YES ☐ NO | | ☐ YES ☐ NO |

## SECTION II - MILITARY SERVICE INFORMATION

| 1A. LAST BRANCH OF SERVICE | 1B. LAST ENTRY DATE | 1C. FUTURE DISCHARGE DATE | 1D. LAST DISCHARGE DATE |
|---|---|---|---|
| | | | |

| 1E. DISCHARGE TYPE | 1F. MILITARY SERVICE NUMBER |
|---|---|
| | |

| 2. MILITARY HISTORY *(Check yes or no)* | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| A. ARE YOU A PURPLE HEART AWARD RECIPIENT? | ☐ | ☐ | G. DO YOU HAVE A VA SERVICE-CONNECTED RATING? | ☐ | ☐ |
| B. ARE YOU A FORMER PRISONER OF WAR? | ☐ | ☐ | IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ % | | |
| C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998? | ☐ | ☐ | H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975? | ☐ | ☐ |
| D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY? | ☐ | ☐ | I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY? | ☐ | ☐ |
| E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION? | ☐ | ☐ | J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY? | ☐ | ☐ |
| F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998? | ☐ | ☐ | K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987? | ☐ | ☐ |

| **APPLICATION FOR HEALTH BENEFITS** *Continued* | VETERAN'S NAME *(Last, First, Middle)* | SOCIAL SECURITY NUMBER |
|---|---|---|

**SECTION III - INSURANCE INFORMATION** ***(Use a separate sheet for additional information)***

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

| 2. NAME OF POLICY HOLDER | 3. POLICY NUMBER | 4. GROUP CODE | 5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO | 6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO<br>6B. EFFECTIVE DATE *(mm/dd/yyyy)* |
|---|---|---|---|---|
| | | | | |

**SECTION IV - DEPENDENT INFORMATION** ***(Use a separate sheet for additional dependents)***

| 1. SPOUSE'S NAME *(Last, First, Middle Name)* | | 2. CHILD'S NAME *(Last, First, Middle Name)* | |
|---|---|---|---|
| 1A. SPOUSE'S SOCIAL SECURITY NUMBER | | 2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)* | 2B. CHILD'S SOCIAL SECURITY NO. |
| 1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* | 1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE | 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)* | |
| 1D. DATE OF MARRIAGE *(mm/dd/yyyy)* | | 2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER | |
| 1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)* | | 2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO<br>2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO | |
| 3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO | | 2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* | |

**SECTION V - EMPLOYMENT INFORMATION**

| 1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED | 1B. DATE OF RETIREMENT | |
|---|---|---|
| 1C. COMPANY NAME. *(Complete if employed or retired)* | 1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP )* | 1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)* |
| | | |

**SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN** ***(Use a separate sheet for additional dependents)***

| | VETERAN | SPOUSE | CHILD 1 |
|---|---|---|---|
| 1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS | $ | $ | $ |
| 2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS | $ | $ | $ |
| 3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE. | $ | $ | $ |

**SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES**

| | |
|---|---|
| 1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.* | $ |
| 2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)* | $ |
| 3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.* | $ |

| APPLICATION FOR HEALTH BENEFITS *Continued* | VETERAN'S NAME *(Last, First, Middle)* | SOCIAL SECURITY NUMBER |
|---|---|---|

## SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

**By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.**

## ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

**ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.**

**SIGNATURE OF APPLICANT**
*(Sign in ink)* _____ **DATE** _____

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 09/30/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

**IMPORTANT**: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS *(Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. (See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)*

◉ FULLY DEVELOPED CLAIM (FDC) PROGRAM ○ STANDARD CLAIM PROCESS

○ IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)

○ BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

## SECTION I: IDENTIFICATION AND CLAIM INFORMATION
## (If claim is not an original claim, only Section I, IV, and a signature are required)

**NOTE**: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*

3. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

4. HAVE YOU EVER FILED A CLAIM WITH VA?
○ YES ○ NO *(If "Yes," provide your file number in Item 5)*

5. VA FILE NUMBER

6. DATE OF BIRTH *(MM-DD-YYYY)*

7. VETERAN'S SERVICE NUMBER *(If applicable)*

8. SEX
○ MALE ○ FEMALE

9. BDD CLAIMS ***ONLY:*** **PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** *(MM-DD-YYYY)*
__ __ – __ __ – __ __ __ __

10. TELEPHONE NUMBER *(Optional) (Include Area Code)*

Enter International Phone Number *(If applicable)*

11. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

12. EMAIL ADDRESS *(Optional)* ○ I agree to receive electronic correspondence from VA in regards to my claim.

○ 13. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX *(Includes Work Study/Internship)? (If you are not a VA employee skip to Section II, if applicable)*

## SECTION II: CHANGE OF ADDRESS

**NOTE**: If you are temporarily or permanently changing your address, complete Items 14A through 14C.

14A. TYPE OF ADDRESS CHANGE *(Complete if applicable) (Check only one box)*

○ TEMPORARY ○ PERMANENT

14B. NEW ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

14C. EFFECTIVE DATE(S) OF NEW ADDRESS *(If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)*

| | Month | Day | Year | | Month | Day | Year |
|---|---|---|---|---|---|---|---|
| **BEGINNING DATE:** | __ | __ | __ __ __ __ | **ENDING DATE:** | __ | __ | __ __ __ __ |

## SECTION III: HOMELESS INFORMATION

**IMPORTANT**: The following questions (Items 15A through 15F) should ***only*** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

15A. ARE YOU CURRENTLY HOMELESS?

- ◯ YES *(If "Yes," complete Item 15B regarding your living situation)*
- ◯ NO

15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ◯ LIVING IN A HOMELESS SHELTER
- ◯ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)
- ◯ STAYING WITH ANOTHER PERSON
- ◯ FLEEING CURRENT RESIDENCE
- ◯ OTHER (Specify)

15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

- ◯ YES *(If "Yes," complete Item 15D regarding your living situation)*
- ◯ NO

15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ◯ HOUSING WILL BE LOST IN 30 DAYS
- ◯ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)
- ◯ OTHER (Specify)

15E. POINT OF CONTACT *(Name of person VA can contact in order to get in touch with you)*

15F. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*

## SECTION IV: CLAIM INFORMATION

**16**. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY *(If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)*

**NOTE:** List your claimed conditions below. **See the following three examples for guidance on how to complete Section IV**.

| EXAMPLES OF DISABILITY(IES) | EXAMPLES OF EXPOSURE TYPE | EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE | EXAMPLES OF DATES |
|---|---|---|---|
| Example 1. HEARING LOSS | NOISE | HEAVY EQUIPMENT OPERATOR IN SERVICE | JULY 1968 |
| Example 2. DIABETES | AGENT ORANGE | SERVICE IN VIETNAM WAR | DECEMBER 1972 |
| Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE | | INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED | 6/11/2008 |

| | CURRENT DISABILITY(IES) | IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation) | EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY | APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT:
**NOTE**: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

| A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY | B. DATE OF TREATMENT (MM-YYYY) | C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT |
|---|---|---|
| | | ◯ Don't have date |
| | | ◯ Don't have date |
| | | ◯ Don't have date |
| | ☐☐ – ☐☐☐☐ | ◯ Don't have date |

**NOTE**: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW. (VA forms are available at www.va.gov/vaforms)

| ***For:*** | ***Required Form(s):*** |
|---|---|
| Supplemental Claims | VA Form 20-0995, *Decision Review Request: Supplemental Claim* |
| Dependents | VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674 |
| Individual Unemployability | VA Form 21-8940 and 21-4192 |
| Post-Traumatic Stress Disorder | VA Form 21-0781 or 21-0781a |
| Specially Adapted Housing or Special Home Adaptation | VA Form 26-4555 |
| Auto Allowance | VA Form 21-4502 |
| Veteran/Spouse Aid and Attendance benefits | VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779 |

## SECTION V: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
◯ YES *(If "Yes," complete Item 18B)* ◯ NO *(If "No," skip to Item 19A)*

18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:

19A. BRANCH OF SERVICE
◯ ARMY ◯ NAVY ◯ MARINE CORPS
◯ AIR FORCE ◯ COAST GUARD ◯ SPACE FORCE

19B. COMPONENT
◯ ACTIVE ◯ RESERVES ◯ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES *(MM,DD,YYYY)*
ENTRY DATE: Month ☐☐ – Day ☐☐ – Year ☐☐☐☐
EXIT DATE: ☐☐ – ☐☐ – ☐☐☐☐

20B. PLACE OF LAST OR ANTICIPATED SEPARATION

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
◯ YES ◯ NO

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate enlistment and discharge date(s), if applicable)*

From:

To:

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
◯ YES *(If "Yes," complete Items 21B thru 21F)*
◯ NO *(If "No," skip to Item 22A)*

21B. COMPONENT
◯ NATIONAL GUARD
◯ RESERVES

21C. OBLIGATION TERM OF SERVICE
Month Day Year
From: ☐☐ – ☐☐ – ☐☐☐☐
To: ☐☐ – ☐☐ – ☐☐☐☐

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
◯ YES ◯ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
◯ YES *(If "Yes," complete Items 22B & 22C)*
◯ NO

22B. DATE OF ACTIVATION:
Month Day Year
☐☐ – ☐☐ – ☐☐☐☐

22C. ANTICIPATED SEPARATION DATE:
Month Day Year
☐☐ – ☐☐ – ☐☐☐☐

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
◯ YES *(If "Yes," complete Item 23B)*
◯ NO

23B. DATES OF CONFINEMENT

| From: Month | Day | Year | To: Month | Day | Year |
|---|---|---|---|---|---|
| ☐☐ – | ☐☐ – | ☐☐☐☐ | ☐☐ – | ☐☐ – | ☐☐☐☐ |
| ☐☐ – | ☐☐ – | ☐☐☐☐ | ☐☐ – | ☐☐ – | ☐☐☐☐ |

## SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?
- ◯ YES *(If "Yes," complete Items 24C and 24D)*
- ◯ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?
- ◯ YES *(If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)*
- ◯ NO

24C. BRANCH OF SERVICE
- ◯ ARMY
- ◯ AIR FORCE
- ◯ NAVY
- ◯ MARINE CORPS
- ◯ COAST GUARD
- ◯ SPACE FORCE

24D. MONTHLY AMOUNT

25. RETIRED STATUS
- ◯ RETIRED
- ◯ PERMANENT DISABILITY RETIRED LIST
- ◯ TEMPORARY DISABILITY RETIRED LIST

**IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):**
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26**.
**Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.**

**IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.**

◯ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

**IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:**
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which ***may*** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?
- ◯ YES *(If "Yes," complete Items 27B through 27D)*
- ◯ NO

27B. DATE PAYMENT RECEIVED *(MM-DD-YYYY)*
☐☐ – ☐☐ – ☐☐☐☐

27C. BRANCH OF SERVICE
- ◯ ARMY
- ◯ NAVY
- ◯ MARINE CORPS
- ◯ AIR FORCE
- ◯ COAST GUARD
- ◯ SPACE FORCE

27D. AMOUNT RECEIVED
*(Provide pre-tax amount)*

**IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:**
You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

**IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.**

◯ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

## SECTION VII: DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

◯ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT *(If you check this box skip to Section VIII)*

30. ACCOUNT NUMBER *(Check only **one** box below and provide the account number)*

Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ◯ CHECKING ◯ SAVINGS

31. NAME OF FINANCIAL INSTITUTION *(Provide the name of the bank where you want your direct deposit)*

32. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

## SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

### VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

| 33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**) | 33B. DATE SIGNED *(MM-DD-YYYY)* |
|---|---|
| | |

## SECTION IX: WITNESSES TO SIGNATURE

| 34A. SIGNATURE OF WITNESS *(Sign in ink)* (***Note**: Only sign if veteran signed in Item 33A using an "X")* | 34B. PRINTED NAME AND ADDRESS OF WITNESS |
|---|---|
| | |
| 35A. SIGNATURE OF WITNESS *(Sign in ink)* (***Note**: Only sign if veteran signed in Item 33A using an "X")* | 35B. PRINTED NAME AND ADDRESS OF WITNESS |
| | |

## SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

| 36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**) | 36B. DATE SIGNED *(MM-DD-YYYY)* |
|---|---|
| | |

## SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE (NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.
**NOTE**: A POA's signature ***will not*** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual As Claimant's Representative,* indicating the appropriate POA is of record with VA.

| 37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE | 37B. DATE SIGNED *(MM-DD-YYYY)* |
|---|---|
| | |

**PRIVACY ACT NOTICE**: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

**RESPONDENT BURDEN**: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Approved No. 2900-0877
Respondent Burden: 5 Minutes
Expiration Date: 10/31/2023

Department of Veterans Affairs

**VA DATE STAMP**
**(DO NOT WRITE IN THIS SPACE)**

# FREEDOM OF INFORMATION ACT (FOIA) OR PRIVACY ACT(PA) REQUEST

**INSTRUCTIONS**: Read the Privacy Act and Respondent Burden information on Page 4 before completing the form. This form must be signed by the requester, authorized organization, or third party who has been authorized by the requester. For additional information on VA FOIA and PA requests visit our website at **https://www.va.gov/FOIA/Requests.asp**. You may also contact the VA at **https://iris.custhelp.va.gov** or call us toll-free at 1-800-827-1000. If you use a Telecommunications device for the deaf (TDD),the Federal Relay number is 711. VA forms are available at **www.va.gov/vaforms.**

## SECTION I: REQUEST FOR INFORMATION ON YOURSELF

**(If you are seeking information on yourself, complete Sections I, III, V and VI. Complete Section IV, if applicable.)**

**NOTE**: You may complete the form on-line or by hand. If completed by hand, print the information requested in ink, neatly and legibly, and completely fill in each applicable circle to help expedite processing of the form.

1. NAME (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER

3. ALIEN REGISTRATION NUMBER (A-number) (If applicable)

4. VA FILE NUMBER (If applicable)

5. DATE OF BIRTH

6. PLACE OF BIRTH (Provide City and State, County and State or City and Country)

7. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

8A. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

8B. FAX NUMBER (If applicable) – –

Enter International FAX Number (If applicable)

9. E-MAIL ADDRESS

I agree to receive electronic correspondence from VA.

## SECTION II: REQUEST FOR INFORMATION ON A PERSON OTHER THAN YOURSELF

**(If you are seeking information on an individual other than yourself, complete Sections II, III, V and VII or VIII. Complete Section IV, if applicable.)**

10. NAME (First, Middle Initial, Last) OR YOUR ORGANIZATION'S NAME

11. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

12A. TELEPHONE NUMBER (Include Area Code) – –

Enter International Phone Number (If applicable)

12B. FAX NUMBER (If applicable) – – –

Enter International FAX Number (If applicable)

SOCIAL SECURITY NUMBER

## SECTION II: REQUEST FOR INFORMATION ON A PERSON OTHER THAN YOURSELF (Continued)

**(If you are seeking information on an individual other than yourself, complete Sections II, III, V and VII or VIII. Complete Section IV, if applicable.)**

**NOTE**: Items 13 through 16 must be completed to inform VA on whom the person is you are requesting the information about.

13. NAME OF THE PERSON YOU ARE REQUESTING INFORMATION ON (First, Middle Initial, Last)

14. SOCIAL SECURITY NUMBER

15. ALIEN REGISTRATION NUMBER (A-number) (If applicable)

16. VA FILE NUMBER (If applicable)

## SECTION III: RECORDS YOU ARE SEEKING

**(This information is required in order to complete the request)**

17. SELECT THE TYPE(S) OF RECORDS YOU ARE REQUESTING, BELOW:

- (●) CLAIMS FILE (C-FILE)
- (●) DD FORM 214
- ( ) HUMAN RESOURCE RECORDS
- ( ) LIFE INSURANCE BENEFIT RECORDS (If applicable, enter policy number in Section IV, Item 18, Remarks)
- (●) SERVICE TREATMENT RECORDS / MILITARY TREATMENT RECORDS
- ( ) LIFE INSURANCE RECORDS
- (●) HOME LOAN BENEFIT RECORDS
- (●) DISABILITY EXAMINATIONS (C & P EXAMS) (If applicable enter date of exam in Section IV, Item 18, Remarks)
- ( ) VOCATIONAL REHABILITATION AND EMPLOYMENT RECORDS
- ( ) FIDUCIARY SERVICES RECORDS
- (●) MILITARY TO CIVILIAN TRANSITION (TAP) DOCUMENTS
- ( ) PENSION BENEFIT DOCUMENTS
- ( ) EDUCATION BENEFIT RECORDS
- ( ) FINANCIAL RECORDS
- ( ) OTHER (Specify)

## SECTION IV: REMARKS

18. REMARKS (If any)

Please provide results in a computer file instead of on paper.

## SECTION V: WILLINGNESS TO PAY FEES

19. **IMPORTANT**: For the purpose of fees only, FOIA divides requesters into three categories: (1) commercial requesters may be charged fees for searching for records, reviewing the records, and photocopying them; (2) educational, non-commercial scientific institutions, and representatives of the news media are charged for photocopying after the first 100 pages; (3) all other requesters (requesters who do not fall into any of the other two categories) are charged for photocopying after the first 100 pages and for time spent searching for records in excess of two hours. VA charges $0.15 per single-sided page for photocopying. Actual costs are charged for a format other than paper copies.

An agency may grant fee waivers if the requester successfully demonstrates that the disclosure of information is in the publics interest because it is likely to contribute significantly to the public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

(●) **I AM WILLING** TO PAY THE APPLICABLE FEES UP TO THE AMOUNT OF $ 1 0 0 .00

( ) IF YOU BELIEVE YOU ARE ENTITLED TO A FEE WAIVER OR EXPEDITED PROCESSING, INDICATE HERE:

## SECTION VI: REQUESTER CERTIFICATION AND SIGNATURE

**I CERTIFY THAT** I have completed this FOIA/PA request and declare it is true and correct to the best of my knowledge and belief.

| 20A. REQUESTER'S SIGNATURE ***(REQUIRED)*** | 20B. DATE SIGNED<br>Month Day Year |
|---|---|
| | |

## SECTION VII: THIRD-PARTY CERTIFICATION AND SIGNATURE
## (Valid only if Section II has been completed and requester has an authorized third party)

**I CERTIFY THAT** the requester has authorized me as the undersigned representative and certifies that the truth and completion of the information contained in this document is to the best of the requesters knowledge and belief.

**NOTE**: A third-party signature ***will not*** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third Party* is of record or completed and attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

| 21A. THIRD-PARTY SIGNATURE | 21B. DATE SIGNED<br>Month Day Year |
|---|---|
| | |

## SECTION VIII: POWER OF ATTORNEY (POA) CERTIFICATION AND SIGNATURE
## (Valid only if Section II has been completed and requester has authorized POA representation)

**I CERTIFY THAT** the requester has authorized me as the undersigned representative and certifies the truth and completion of the information contained in this document to the best of the requesters knowledge and belief.

**NOTE**: A POA's signature ***will not*** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative* or VA Form 21-22a*, Appointment of Individual as Claimant's Representative* is of record or attached to this request.

| 22A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE) | 22B. DATE SIGNED<br>Month Day Year |
|---|---|
| | |

**PENALTY**: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document to which you are not entitled.

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

**RESPONDENT BURDEN**: We need this information to identify and obtain the information you are requesting. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0877
Respondent Burden: 7 Minutes
Expiration Date: 10/31/2023

Department of Veterans Affairs

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

# PRIORITY PROCESSING REQUEST

**INSTRUCTIONS**: Before completing this form, read the Privacy Act and Respondent Burden on page 5. Use this form to request priority processing of a claim due to certain status or circumstances. For more information, contact us at **https://iris.custhelp.va.gov**, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at **www.va.gov/vaforms**.

## SECTION I - VETERAN'S IDENTIFICATION INFORMATION

(This information is required to process your request)

**NOTE**: You can *either* complete the form on-line or by hand. If completed by hand, print the information requested in ink, neatly, and legibly and completely fill in each circle to expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER

3. DATE OF BIRTH (MM-DD-YYYY)

4. VA FILE NUMBER (If applicable)

5. INSURANCE NUMBER (If applicable)

6. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

7. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS ◉ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION

**(If other than Veteran)**

9. CLAIMANTS NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER – –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH (MM-DD-YYYY) – –

13. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

14. TELEPHONE NUMBER (Include Area Code) – –

Enter International Phone Number (If applicable)

15. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION III - REASON(S) FOR REQUEST

**(This information is required in order to complete your request)**

16. HOMELESS INFORMATION (Check all that apply)

16A. ARE YOU CURRENTLY HOMELESS?

◯ YES (If "YES," complete item 16B regarding your living situation)

◯ NO (If "NO," skip to item 16C)

16B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION

◯ LIVING IN A HOMELESS SHELTER

◯ STAYING WITH ANOTHER PERSON

◯ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g. living in a car or tent)

◯ 16A. ARE YOU CURRENTLY HOMELESS? Radio button. YES

◯ OTHER (Specify)

| 16C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS? | 16D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION |
|---|---|
| ◯ YES (If "YES," complete item 16D regarding your living situation) ◯ NO (If "NO," skip to item 17) | ◯ HOUSING WILL BE LOST IN 30 DAYS ◯ LEAVING PUBLICLY FUNDED SYSTEM OF CARE IN 30 DAYS OR LESS (e.g. homeless shelter) ◯ OTHER (Specify) |

## 17. OTHER REASON(S)/CIRCUMSTANCES FOR REQUEST (Check all that apply)

◯ EXPERIENCING EXTREME FINANCIAL HARDSHIP ◯ TERMINALLY ILL ◯ MEDAL OF HONOR/PURPLE HEART RECIPIENT

◯ DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS) ALSO KNOWN AS LOU GEHRIG'S DISEASE ◯ 85 YEARS OF AGE OR OLDER

◯ VERY SERIOUSLY INJURED/ILL OR SERIOUSLY ILL/INJURED (VSI/SI) DURING MILITARY SERVICE

◯ FORMER PRISONER OF WAR (Provide date(s) of confinement) (MM-DD-YYYY)

| | | | |
|---|---|---|---|
| FROM | – – | TO | – – |
| FROM | – – | TO | – – |

## SECTION IV - REPORT OF MEDICAL TREATMENT (If applicable)

18. LIST VA MEDICAL CENTERS (VAMC), DEPARTMENT OF DEFENSE (DoD) MILITARY TREATMENT FACILITIES (MTF), OR PRIVATE MEDICAL FACILITIES WHERE YOU WERE TREATED FOR THE CIRCUMSTANCE YOU IDENTIFIED IN ITEM 17 AND PROVIDE APPROXIMATE BEGINNING DATE OF TREATMENT:

| NAME/LOCATION OF TREATMENT FACILITY | DATE OF TREATMENT (MM-DD-YYYY) |
|---|---|
| City<br>State/Province Country | – – |
| NAME/LOCATION OF TREATMENT FACILITY | DATE OF TREATMENT (MM-DD-YYYY) |
| City<br>State/Province Country | – – |
| NAME/LOCATION OF TREATMENT FACILITY | DATE OF TREATMENT (MM-DD-YYYY) |
| City<br>State/Province Country | – – |
| NAME/LOCATION OF TREATMENT FACILITY | DATE OF TREATMENT (MM-DD-YYYY) |
| City<br>State/Province Country | – – |
| NAME/LOCATION OF TREATMENT FACILITY | DATE OF TREATMENT (MM-DD-YYYY) |
| City<br>State/Province Country | – – |

## SECTION V - CERTIFICATION AND SIGNATURE

**I CERTIFY THAT** I have completed this form and it is true and correct to the best of my knowledge and belief.

| 18A.SIGNATURE OF REQUESTER ***(REQUIRED)*** | 18B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

## SECTION VI - THIRD PARTY SIGNATURE
## (Only required if requester has an authorized third party)

**I CERTIFY THAT** the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

**NOTE**: A third-party signature ***will not*** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, is of record or attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

| 19A. THIRD-PARTY SIGNATURE ***(REQUIRED)*** | 19B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

## SECTION VII - POWER OF ATTORNEY (POA) SIGNATURE
## (Required only if requester has an authorized POA representation)

**I CERTIFY THAT** the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

**NOTE**: A POA's signature ***will not*** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual as Claimant's Representative,* is of record or attached to this request.

| 20A. POWER OF ATTORNEY (POA) SIGNATURE ***(REQUIRED)*** | 20B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

**PENALTY**: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations, 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

**RESPONDENT BURDEN**: This information will let us help you in support of or response to your claim. Title 38, United States Code, allows us to ask for this information. It should take you about 7 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid Office of Management and Budget (OMB) control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0877
Respondent Burden: 5 Minutes
Expiration Date: 10/31/2023

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# DOCUMENT EVIDENCE SUBMISSION

**INSTRUCTIONS**: Read the Privacy Act and Respondent Burden on Page 2 before completing this form. This form is used for the submission of additional documentation or evidence in support of a claim. For more information, contact us at **https://iris.custhelp.va.gov**, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at **www.va.gov/vaforms**.

## SECTION I: VETERAN'S IDENTIFICATION INFORMATION

**NOTE**: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH (MM-DD-YYYY)

5. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

6. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

7. E-MAIL ADDRESS

◯ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION

**(If other than veteran)**

8. CLAIMANTS NAME (First, Middle Initial, Last)

9. SOCIAL SECURITY NUMBER

10. VA FILE NUMBER (If applicable)

11. DATE OF BIRTH (MM-DD-YYYY)

12. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

13. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

14. E-MAIL ADDRESS

◉ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION III: DOCUMENT/EVIDENCE TYPE YOU ARE SUBMITTING

15. IS THIS FORM BEING SUBMITTED IN RESPONSE TO A REQUEST YOU RECEIVED FROM VA?

◯ YES ◯ NO

16. IDENTIFY THE DOCUMENT(S) OR EVIDENCE YOU ARE SUBMITTING TO SUPPORT YOUR ESTABLISHED CLAIM.

**NOTE**: You may select one or more type(s), depending on the type of documentation/evidence being provided with this form.

| | |
|---|---|
| ◯ BIRTH CERTIFICATE | ◯ DEATH CERTIFICATE |
| ◯ DEPENDENCY INFORMATION | ◯ DIVORCE DECREE |
| ◯ FINANCIAL INFORMATION | ◯ MARRIAGE CERTIFICATE |
| ◯ MEDICAL TREATMENT RECORDS | ◯ COURT PAPERS/DOCUMENTS |
| ◯ MILITARY PERSONNEL RECORDS | ◯ SERVICE TREATMENT RECORDS |

◯ LAY STATEMENT (Describe)

◯ OTHER (Describe)

## SECTION IV: CERTIFICATION AND SIGNATURE

**I CERTIFY THAT** I have filled this form out completely and that it is true and correct to the best of my knowledge and belief.

| 17A. VETERAN/CLAIMANT'S SIGNATURE **(REQUIRED)** | 17B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

## SECTION V: THIRD-PARTY SIGNATURE
## (Valid only if requester has an authorized third-party)

**I CERTIFY THAT** the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge. **NOTE**: A third-party signature ***will not*** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, is of record or attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

| 18A.THIRD-PARTY SIGNATURE | 18B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

## SECTION VI: POWER OF ATTORNEY (POA) SIGNATURE
## (Valid only if requester has an authorized POA representation)

**I CERTIFY THAT** the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of veteran/claimant's knowledge.

**NOTE**: A POA's signature ***will not*** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual as Claimant's Representative,* is of record or attached to this request.

| 19A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE | 19B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

**PENALTY**: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document to which you are not entitled.

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

**RESPONDENT BURDEN**: This information will let us help you in support of or response to your claim. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

# LAY/WITNESS STATEMENT

**VA DATE STAMP**
(DO NOT WRITE IN THIS SPACE)

**INSTRUCTIONS**: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at **https://iris.custhelp.va.gov**, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at **www.va.gov/vaforms**. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547-4444.**

## SECTION I: VETERAN'S IDENTIFICATION INFORMATION

**NOTE**: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH

5. VA INSURANCE FILE NUMBER (If applicable)

6. CURRENT MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. &
Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

7. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

8. E-MAIL ADDRESS

○ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
## (Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH

13. VA INSURANCE FILE NUMBER (If applicable)

14. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. &
Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

15. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

16. E-MAIL ADDRESS

○ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION III: STATEMENT

**(Use this section to submit your statement, or a statement from someone else writing on your behalf)**

**NOTE**: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

## SECTION III: STATEMENT (Continued)
**(Use this section to submit your statement, or a statement from someone else writing on your behalf)**

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

## SECTION IV: WITNESS CONTACT INFORMATION
**(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)**

18. WITNESS NAME (First, Middle Initial, Last)

19. RELATIONSHIP TO VETERAN/CLAIMANT (Check all that apply)

SERVED WITH VETERAN/CLAIMANT  FAMILY/FRIEND OF VETERAN/CLAIMANT  COWORKER/SUPERVISOR OF VETERAN/CLAIMANT

OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

21. E-MAIL ADDRESS

## SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

**I CERTIFY THAT** I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

22B. DATE SIGNED

Month Day Year

**PENALTY**: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document to which you are not entitled.

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records-VA, published in the Federal Register. Your obligation to respond is voluntary.

**RESPONDENT BURDEN**: This form is used to submit a statement that supports a claim already pending or already established with VA. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0882
Respondent Burden: 10 minutes
Expiration Date: 02/29/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# CHAPTER 31 REQUEST FOR ASSISTANCE

**INSTRUCTIONS:** Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a request for assistance with your Chapter 31 benefits. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA Forms are available at www.va.gov/vaforms.

## SECTION I: CLAIMANT'S INFORMATION

**NOTE**: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. CLAIMANT'S NAME (First, Middle Initial, Last)

2. VA FILE NUMBER

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

3. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

4. TELEPHONE NUMBER(S) (Include Area Code)

Daytime:

Cell phone:

International Telephone Number (If applicable):

5. E-MAIL ADDRESS (Optional) ◉ I agree to receive electronic correspondence from VA in regards to my claim.

## SECTION II: ASSISTANCE YOU ARE REQUESTING
## (IMPORTANT: Sections II and III must be completed in order to process your request)

6. SELECT THE ASSISTANCE YOU ARE REQUESTING, BELOW:

- ◯ WITHDRAW MY APPLICATION FOR CHAPTER 31 BENEFITS
- ◯ REQUEST FOR A REVOLVING FUND LOAN
- ◯ REQUEST FOR REIMBURSEMENT
- ◯ MITIGATING CIRCUMSTANCES FOR REDUCTION OR COMPLETE WITHDRAWAL FROM TRAINING
- ◯ OTHER (Specify)
- ◯ REQUEST TO DISCONTINUE MY CHAPTER 31 PROGRAM AND CLOSE MY CASE
- ◯ REQUEST FOR SUPPLIES OR EQUIPMENT TO PARTICIPATE IN MY REHABILITATION PROGRAM
- ◯ DISCUSS AN ISSUE/CONCERN REGARDING MY REHABILITATION SERVICES

## SECTION III: ADDITIONAL INFORMATION NEEDED TO PROCESS REQUEST
## (Use this section to describe and explain the reason for the requested assistance)

7. REMARKS

## SECTION IV: CERTIFICATION AND SIGNATURE

**I CERTIFY THAT** I have filled this form out completely and that it is true and correct to the best of my knowledge and belief.

| 8A. SIGNATURE OF CLAIMANT | 8B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | |

**PENALTY**: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your response is voluntary.

**RESPONDENT BURDEN**: This form is used to submit a request for assistance by a Chapter 31 claimant. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.