OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 11/30/2017

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

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

2. VETERAN'S SOCIAL SECURITY NUMBER

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

4. VA FILE NUMBER

5. DATE OF BIRTH (MM,DD,YYYY)
Month Day Year

6. SEX
☐ MALE ☐ FEMALE

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

8A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?
☐ YES ☐ NO *(If "Yes," complete Items 8B & 8C)*

8B. POINT OF CONTACT *(Name of person that VA can contact in order to get in touch with you)*

8C. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*

9A. SERVICE *(Check all that apply)*
☐ ARMY ☐ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ COAST GUARD

9B. COMPONENT *(Check all that apply)*
☐ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

10A. 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

10B. FORWARDING ADDRESS AND EFFECTIVE DATE *(Provide the date you will be living at this address)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

EFFECTIVE DATE:
Month Day Year

11. PREFERRED TELEPHONE NUMBER

12A. PREFERRED E-MAIL ADDRESS *(If applicable)*

12B. ALTERNATE E-MAIL ADDRESS *(If applicable)*

VETERANS SOCIAL SECURITY NO. ___ - __ - ____

13. LIST THE DISABILITY(IES) YOU ARE CLAIMING *(If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151)*.

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

	DISABILITIES
1.	
2.	
3.	
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18.	
19.	
20.	

14. 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) AND PROVIDE TREATMENT DATES:

A. NAME *AND* LOCATION	B. DATE(S) OF TREATMENT

VETERANS SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

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):*
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 and 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 II: SERVICE INFORMATION

15A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," complete Item 15B)* ☐ NO *(If "No," skip to Item 16A)*

15B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER:

16A. MOST RECENT ACTIVE SERVICE ENTRY DATE (MM,DD,YYYY)
Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

16B. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE (MM,DD,YYYY)
Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

16C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☐ NO

16D. PLACE OF LAST OR ANTICIPATED SEPARATION

17A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES ☐ NO *(If "Yes," complete Items 17B thru 17F)* *(If "No," skip to Item 18A)*

17B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

17C. OBLIGATION TERM OF SERVICE
From: Month ☐☐ – Day ☐☐ – Year ☐☐☐☐
To: ☐☐ – ☐☐ – ☐☐☐☐

17D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

17E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*
( )

17F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

18A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES ☐ NO
(If "Yes," complete Items 18B & 18C)

18B. DATE OF ACTIVATION: (MM,DD,YYYY)
Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

18C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)
Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

19A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES ☐ NO
(If "Yes," complete Item 19B)

19B. DATES OF CONFINEMENT (MM,DD,YYYY)
From: Month ☐☐ – Day ☐☐ – Year ☐☐☐☐
To: Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

SECTION III: SERVICE PAY

20A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY?
☐ YES ☐ NO *(If "Yes," complete Items 20B and 20C)*

20B. LIST AMOUNT *(If known)*
$

20C. LIST TYPE *(If known)*

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you ***do not*** want to receive VA compensation in lieu of military retired pay, you should check the box in **Item 21**. Please note that if you check the box in **Item 21**, you ***will not*** receive VA compensation, if granted.

☐ **21. I want military retired pay instead of VA compensation**

IMPORTANT: You may elect to keep the training pay for inactive duty training days 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 22**, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

☐ **22. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.**

VETERANS SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in **Items 23, 24 and 25** to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

23. ACCOUNT NUMBER *(Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA)*

☐ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: _____ Account No.: _____

24. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	25. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

SECTION V: CLAIM 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, and I waive any privilege which makes the information confidential.

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 26**, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify 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 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.

26. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan on submitting further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

27A. VETERAN/SERVICE MEMBER/ALTERNATE SIGNER SIGNATURE (**REQUIRED**)	27B. DATE SIGNED

SECTION VI: WITNESSES TO SIGNATURE

28A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	28B. PRINTED NAME AND ADDRESS OF WITNESS
29A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	29B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

I certify that the claimant has authorized the undersigned representative to file this supplemental 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.

30A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	30B. DATE SIGNED

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.

OMB Control No. 2900-0743
Respondent Burden: 15 minutes
Expiration Date: 06/30/2019

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

PRE-DISCHARGE COMPENSATION CLAIM
(For use only with Benefits Delivery at Discharge (BDD) or Quick Start Claims)

IMPORTANT: Please read the Privacy Act and Respondent Burden on the back before completing the form.

THIS FORM WILL BE USED FOR *(CHECK ONLY ONE)*

☐ **Benefits Delivery at Discharge (BDD) CLAIMS** ☐ **Quick Start Claims**

SECTION I: TO BE COMPLETED BY SERVICE MEMBER

1. SERVICE MEMBER NAME *(Last, first, middle)*

2. PLACE OF SEPARATION

3. SOCIAL SECURITY NUMBER

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

5. SEX ☐ MALE ☐ FEMALE

6A. CURRENT ADDRESS

Street address, rural route, or P.O. Box Apt. number

City State ZIP Code Country

6B. TELEPHONE NUMBERS *(Include Area Code)*

Daytime

Evening

Cell phone

7A. WORK E-MAIL ADDRESS *(If applicable)*

7B. PERSONAL E-MAIL ADDRESS *(If applicable)*

8A. FORWARDING ADDRESS

8B. TELEPHONE NUMBER

9A. NAME AND RELATIONSHIP OF NEXT OF KIN

9B. ADDRESS OF NEXT OF KIN

9C. TELEPHONE NUMBER OF NEXT OF KIN

10A. HAVE YOU EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO *(If "Yes," provide your file number in Item 10B)*

10B. VA FILE NUMBER

11. WHAT DISABILITIES ARE YOU CLAIMING? SUBMIT ADDITIONAL SUPPORTING STATEMENTS AND INFORMATION CONCERNING YOUR CLAIMED DISABILITIES ON VA FORM 21-4138, STATEMENT IN SUPPORT OF CLAIM, AVAILABLE AT www.va.gov/vaforms

IMPORTANT: If claiming dependents, please attach a completed VA Form 21-686c, Declaration of Status of Dependents, available at www.va.gov/vaforms

SECTION II: SERVICE INFORMATION

12A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," go to Item 12B)*
☐ NO *(If "No," go to Item 13A)*

12B. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER

13A. I ENTERED THIS CURRENT PERIOD OF ACTIVE SERVICE ON *(MM,DD,YYYY)*
mo day yr

13B. BRANCH OF SERVICE

13C. ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY

13D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☐ NO

14A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C.?
☐ YES ☐ NO *(If "Yes," provide date of activation in Item 14B)*

14B. DATE OF ACTIVATION *(MM,DD,YYYY)*
mo day yr

15A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?

15B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)*

16A. DO YOU HAVE ADDITIONAL PERIODS OF ACTIVE SERVICE?
☐ YES *(If "Yes," go to Item 16B)*
☐ NO *(If "No," go to Item 17A)*

16B. I PREVIOUSLY ENTERED ACTIVE SERVICE ON *(MM,DD,YYYY)*
mo day yr

SECTION III: MILITARY RETIRED PAY

17A. WILL YOU RECEIVE RETIRED PAY?	17B. TYPE OF RETIRED PAY?
☐ YES ☐ NO *(If "Yes," complete Item 17B)*	☐ LONGEVITY ☐ DISABILITY ☐ TDRL

18A. WILL YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE PAY?	18B. LIST AMOUNT *(If known)*	18C. LIST TYPE *(If known)*
☐ YES ☐ NO *(If "Yes," complete Items 18B and 18C)*		

IMPORTANT: Unless you check the box in Item 19 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by that amount. VA will notify the Military Retired Pay Center of all benefit changes.

If you receive both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

19. ☐ No, I do not want VA compensation in lieu of military retired pay.

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 20, 21 and 22 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

20. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

☐ CHECKING _____ ☐ SAVINGS _____ ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

21. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	22. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

SECTION V: CERTIFICATIONS 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, and I waive any privilege which makes the information confidential.

23A. YOUR SIGNATURE *(Do NOT print)*	23B. DATE SIGNED

SECTION VI: WITNESSES TO SIGNATURE

24A. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	24B. PRINTED NAME AND ADDRESS OF WITNESS
25A. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	25B. PRINTED NAME AND ADDRESS OF WITNESS

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 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.

OMB Control No. 2900-0001
Respondent Burden: 15 minutes
Expiration Date: 6/30/2017

Department of Veterans Affairs

VETERAN'S SUPPLEMENTAL CLAIM FOR COMPENSATION

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

IMPORTANT: PLEASE READ THE PRIVACY ACT NOTICE AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

PART I - VETERAN'S IDENTIFYING INFORMATION

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

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

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

5. TELEPHONE NUMBER(S)

A. DAYTIME *(Include Area Code)*

B. EVENING *(Include Area Code)*

6. E-MAIL ADDRESS *(If applicable)*

PART II - INFORMATION ABOUT CLAIM

7. I WOULD LIKE TO FILE A CLAIM FOR: *(Check all that apply)*

☐ **INCREASED EVALUATION** OF THE DISABILITY(IES) FOR WHICH I AM ALREADY SERVICE CONNECTED *(Provide the name of the disability(ies))*

☐ **SERVICE CONNECTION** FOR NEW DISABILITY(IES) *(List your new disability(ies))*

☐ **REOPENING** OF PREVIOUSLY DENIED DISABILITY(IES) *(List your previously denied disability(ies))*

☐ **DISABILITY(IES) SECONDARY** TO MY EXISTING SERVICE CONNECTED DISABILITY(IES) *(Provide the name of the disability(ies) and your service connected condition(s))*

8A. NAME AND LOCATION OF VA MEDICAL CENTER THAT HAS MY RELEVANT TREATMENT RECORDS

8B. NAME AND ADDRESS OF MILITARY FACILITY THAT HAS MY RELEVANT TREATMENT RECORDS

8C. DO YOU HAVE PRIVATE TREATMENT RECORDS?

☐ YES ☐ NO *(If "Yes," please attach the treatment records to this form. If you would like to have VA request your private treatment records, please attach a VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs, for each private treatment provider. The form is available at www.va.gov/vaforms.)*

9. I WOULD LIKE TO FILE A CLAIM FOR OTHER VA BENEFITS *(Check appropriate box)*

☐ AID AND ATTENDANCE ☐ OTHER *(Specify benefit)*

☐ AUTOMOBILE ALLOWANCE

IMPORTANT - If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103 (c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

10. I WOULD LIKE TO FILE A CLAIM FOR ADDITIONAL BENEFITS BECAUSE MY SPOUSE IS SERIOUSLY DISABLED *(Please provide spouse's name and social security number in Items 10A & 10B)* ☐

A. SPOUSE'S NAME

B. SPOUSE'S SOCIAL SECURITY NO.

11A. VETERAN'S SIGNATURE *(Do NOT print)*

11B. DATE SIGNED

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 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 USC 5101 (c) (1). The 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 maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). 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.

RESPONDENT BURDEN: We need this information to make an eligibility determination for veterans' filing supplemental compensation claims (38 U.S.C. 5101). 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.

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: 1/31/2015

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, DEATH PENSION, AND/OR ACCRUED BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, first, middle)
2. VETERAN'S SOCIAL SECURITY NUMBER
3. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
4. VETERAN'S SEX ☐ MALE ☐ FEMALE
5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO (If "Yes," provide the file number in Item 6)
6. VA FILE NUMBER
7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ☐ YES ☐ NO
8. WHAT IS THE VETERAN'S DATE OF DEATH? (MM,DD,YYYY)
9. WHAT IS YOUR NAME? (First, middle, last name)
10. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one) ☐ SURVIVING SPOUSE ☐ PARENT ☐ CHILD ☐ CUSTODIAN FILING FOR CHILD
11. WHAT IS YOUR SOCIAL SECURITY NUMBER?
12. WHAT IS YOUR DATE OF BIRTH? (MM,DD,YYYY)
13. ARE YOU A VETERAN? ☐ YES ☐ NO
14A. WHAT IS YOUR ADDRESS?
Street address, rural route, or P.O. Box — Apt. number
City — State — ZIP Code — Country
14B. YOUR TELEPHONE NUMBER(S) (include Area Code)
DAYTIME ( )
EVENING ( )
CELL PHONE ( )
15A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)
15B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)
16. WHAT ARE YOU CLAIMING? (Check all that apply)
☐ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ DEATH PENSION ☐ ACCRUED BENEFITS

SECTION II: VETERAN'S SERVICE INFORMATION *(COMPLETE ONLY IF THE VETERAN WAS NOT RECEIVING VA COMPENSATION OR PENSION BENEFITS AT THE TIME OF DEATH)*

(Skip to Section III if the veteran was receiving VA compensation or pension benefits at the time of his or her death)

17A. DID THE VETERAN SERVE UNDER ANOTHER NAME? ☐ YES ☐ NO (If "Yes," complete Item 17B) (If "No," skip to Item 18A)
17B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:
18A. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)
18B. BRANCH OF SERVICE
18C. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)
18D. DID THE VETERAN SERVE IN A COMBAT ZONE SINCE 9-11-2001? ☐ YES ☐ NO
18E. PLACE OF LAST SEPARATION
19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*? ☐ YES ☐ NO (If "Yes," answer Items 19B, 19C and 19D)
19B. DATE OF ACTIVATION (MM,DD,YYYY)
19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?
19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code) ( )
20A. WAS THE VETERAN EVER A PRISONER OF WAR? ☐ YES ☐ NO (If "Yes," complete Item 20B) (If "No," skip to Section III)
20B. DATES OF CONFINEMENT FROM: TO:

SECTION III- MARITAL INFORMATION *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)*

*(Skip to Section IV if you are **NOT** claiming benefits as the surviving spouse of the veteran)*

TELL US ABOUT THE VETERAN'S MARRIAGES

21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)?

21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	21C. TO WHOM MARRIED (first, middle, last name)	21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21E. HOW MARRIAGE TERMINATED (death, divorce)	21F. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

21G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21D, PLEASE EXPLAIN:

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

☐ YES ☐ NO

22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

22C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	22D. TO WHOM MARRIED (first, middle, last name)	22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22F. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	22G. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

22H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22E, PLEASE EXPLAIN:

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

☐ YES ☐ NO

24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

☐ YES ☐ NO

25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

☐ YES ☐ NO (If "No," complete Item 26)

26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

☐ YES ☐ NO (If "Yes," provide explanation):

SECTION IV: DEPENDENT CHILDREN *(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)*

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)*

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who ***do not*** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION V: VETERAN'S PARENT *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)*

*(Skip to Section VI if you are **NOT** claiming benefits as the parent of a veteran)*

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE

☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION ***(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)***

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?

31D. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO (If "Yes," complete Item 31E)	31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)

32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF *MAJORITY* (AGE 18 IN MOST STATES)? ☐ YES ☐ NO (If "Yes," skip to Item 34)	32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control) (MM DD YYYY) *to* (MM DD YYYY) (MM DD YYYY) *to* (MM DD YYYY)

32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B

A. NAME (FIRST, MIDDLE, LAST)	B. ADDRESS
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country

34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE OF DEATH.

A. NAME (FIRST, MIDDLE, LAST)	B. DATE OF DEATH (MM,DD,YYYY)

SECTION VI: DIC *(COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))*

*(Skip to Section VII if you are **NOT** claiming DIC)*

35. WHAT BENEFIT ARE YOU CLAIMING?

☐ DIC ☐ DIC under 38 U.S.C. 1151 (RARE)

36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION VII: NET WORTH *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

37. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your net worth and the child's net worth, if any.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$		REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$	
INTEREST-BEARING BANK ACCOUNTS	$		OTHER PROPERTY *(Provide source)*	$	
IRA'S, KEOGH PLANS, ETC.	$		OTHER PROPERTY *(Provide source)*	$	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$		OTHER *(Provide source)*	$	

SECTION VIII: GROSS MONTHLY INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

38. **GROSS MONTHLY INCOME** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your income and the child's income, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$		SERVICE RETIREMENT/ SURVIVOR BENEFIT PLAN (SBP) ANNUITY	$	
SOCIAL SECURITY	$		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	$	
U.S. CIVIL SERVICE	$		OTHER *(Provide source)*	$	
U.S. RAILROAD RETIREMENT	$		OTHER *(Provide source)*	$	
BLACK LUNG BENEFITS	$		OTHER *(Provide source)*	$	

SECTION IX: EXPECTED INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

39. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the 12 month period following the veteran's death. If the claim is filed more than one year after the veteran died, report the expected total household income for the 12 month period from the date you sign this application. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report ***your expected income*** and the ***child's expected income***, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
TOTAL DIVIDENDS AND INTEREST	$		OTHER INCOME EXPECTED *(Provide source)*	$	

SECTION X: MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension or parents DIC)*

40. MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any continuing family medical expenses such as the monthly Medicare deduction or nursing home costs you pay. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim.

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yyyy)	PURPOSE (Medicare deduction, nursing home costs, burial expenses, etc.)	PAID TO (Name of nursing home, hospital, funeral home, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
$				
$				
$				
$				
$				

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 41, 42, and 43 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

41. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☐ CHECKING Account No.: _____

☐ SAVINGS Account No.: _____

☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

42. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	43. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

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 except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.*

I certify I have enclosed all 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 44, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

44. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

45A. CLAIMANT'S SIGNATURE **(REQUIRED)**	45B. DATE SIGNED

SECTION XIII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")*

46A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	46B. PRINTED NAME AND ADDRESS OF WITNESS
47A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	47B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or pension 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 pension. 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.

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 4/30/2016

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 8 before completing the form.

SECTION I: VETERAN'S PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, first, middle)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (MM,DD,YYYY)

4. SEX	5. HAVE YOU EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
☐ MALE ☐ FEMALE	☐ YES ☐ NO (If "Yes," provide your file number in Item 6)	

7A. MAILING ADDRESS	7B. TELEPHONE NUMBERS (Include Area Code)
Street address, rural route, or P.O. Box Apt. number	DAYTIME ( )
	EVENING ( )
City State ZIP Code Country	CELL PHONE ( )

8A. PREFERRED E-MAIL ADDRESS (If applicable)	8B. ALTERNATE E-MAIL ADDRESS (If applicable)

9. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

A. DISABILITY(IES)	B. DATE DISABILITY(IES) BEGAN

10. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION II: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

11A. DID YOU SERVE UNDER ANOTHER NAME?	11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER
☐ YES (If "Yes," complete Item 11B) ☐ NO (If "No," skip to Item 12A)	

12A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	12B. BRANCH OF SERVICE	12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE

12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?	12E. PLACE OF LAST OR ANTICIPATED SEPARATION
☐ YES ☐ NO	

13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. (National Guard)?	13B. DATE OF ACTIVATION (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," provide date of activation in Item 13B)	

14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?	14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code)
	( )

15A. HAVE YOU EVER BEEN A PRISONER OF WAR?	15B. DATES OF CONFINEMENT ON (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," complete Item 15B) (If "No," skip to Item 16A)	From: To:

16A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE RETIRED PAY?	16B. LIST AMOUNT (If known)	16C. LIST TYPE (If known)
☐ YES ☐ NO (If "Yes," complete Items 16B and 16C)	$	

SECTION III: VETERAN'S WORK HISTORY *(MUST COMPLETE)*

***NOTE**: In the table below, tell us about all of your employment, including self-employment, for **one** year before you became disabled to the present.*

17A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	17B. WHAT WAS YOUR JOB TITLE?	17C. WHEN DID YOUR JOB BEGIN?	17D. WHEN DID YOUR JOB END?	17E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	17F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					$
					$

SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

18A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED (Skip to Section VI if never married)

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

18B. HOW MANY TIMES HAVE YOU BEEN MARRIED (including current marriage)?

19A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country)	19B. TO WHOM MARRIED (first, middle, last name)	19C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	19D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	19E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country)

19F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 19C, PLEASE EXPLAIN:

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

20. HOW MANY TIMES HAS YOUR SPOUSE BEEN MARRIED (including current marriage)?

21A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country)	21B. TO WHOM MARRIED (first, middle, last name)	21C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	21E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country)

21F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21C, PLEASE EXPLAIN:

22A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (month, day, year)	22B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	22C. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO	22D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (if any)?

22E. DO YOU LIVE WITH YOUR SPOUSE?

☐ YES ☐ NO (If "Yes," skip to Section VI) (If "No," complete Items 22F - 22H)

22F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O., State, ZIP Code and country)

22G. TELL US THE REASON WHY YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e.; illness, work, etc.)

22H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?

$

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

Note - Skip to Section VII if you have no dependent children.

23A. NAME OF DEPENDENT CHILD (First, middle initial, last)	23B. DATE AND PLACE OF BIRTH (city, state or country)	23C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 23D. BIOLOGICAL	23E. ADOPTED	23F. STEPCHILD	23G. 18-23 YEARS OLD (In school)	23H. SERIOUSLY DISABLED	23I. CHILD MARRIED	23J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

Note - In Items 24A through 24D, tell us about the children listed in Item 23A who ***do not*** live with you.

24A. NAME OF DEPENDENT CHILD (First, middle initial, last)	24B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	24C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	24D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION VII: INCOME VERIFICATION - NET WORTH *(MUST COMPLETE)*

25. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. You must report your net worth and the net worth of your dependents (spouse, child, etc.), if any. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$		REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$	
INTEREST-BEARING BANK ACCOUNTS	$		ALL OTHER PROPERTY *(Please write source)*	$	
IRA'S, KEOGH PLANS, ETC.	$		ALL OTHER PROPERTY *(Please write source)*	$	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$		OTHER *(Provide source)*	$	

SECTION VIII: INCOME VERIFICATION - MONTHLY INCOME *(MUST COMPLETE)*

26. **GROSS MONTHLY INCOME** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. You must report your income and the income of your dependents (spouse, child, etc.), if any. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$		SERVICE RETIREMENT	$	
SOCIAL SECURITY	$		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	$	
U.S. CIVIL SERVICE	$		OTHER *(Provide source)*	$	
U.S. RAILROAD RETIREMENT	$		OTHER *(Provide source)*	$	
BLACK LUNG BENEFITS	$		OTHER *(Provide source)*	$	

SECTION IX: EXPECTED INCOME *(MUST COMPLETE)*

27. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the next 12 months. You must report your expected income and the expected income of your dependents (spouse, child, etc.), if any. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
TOTAL DIVIDENDS AND INTEREST	$		OTHER INCOME EXPECTED *(Provide source)*	$	

SECTION X: MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES *(MUST COMPLETE)*

28. MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES (IF NONE WRITE "0" OR "NONE")

Report your family medical expenses and certain other expenses actually paid by you that may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. ***Do not include any expenses for which you were reimbursed.***

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yy)	PURPOSE (Doctor's fees, hospital charges, attorney fees, tuition, education materials, etc.)	PAID TO (Name of doctor, hospital, pharmacy, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
$				
$				
$				
$				

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 29, 30, and 31 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

29. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☐ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:_____ Account No.:_____

30. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	31. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

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 and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension 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 32, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

32. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ I **DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

33A. VETERAN'S SIGNATURE (**REQUIRED**)	33B. DATE SIGNED

SECTION XIII: WITNESSES TO SIGNATURE *(MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 33A WITH AN "X")*

34A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	**35B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension 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 pension. 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.

OMB Control No. 2900-0065
Respondent Burden: 15 minutes
Expiration Date: 11/30/2017

Department of Veterans Affairs

REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH CLAIM FOR DISABILITY BENEFITS

SECTION I - IDENTIFICATION INFORMATION *(To be completed by VA)*

1. NAME AND ADDRESS OF EMPLOYER OF VETERAN *(Complete)*

RETURN TO

2. ADDRESS *(Complete)*

INSTRUCTIONS: The veteran named in Item 3 has filed a claim for veterans disability benefits and has stated that he/she was recently employed by you. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Sections II, III and IV and return to this office at the above address. Please be sure to sign and date this form in Items 21A and 21B. For free help in completing this form, call VA toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.

3. FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN

4. SOCIAL SECURITY NO. – –

5. VA FILE NO.

SECTION II - EMPLOYMENT INFORMATION *(To be completed by employer)*

6. BEGINNING DATE OF EMPLOYMENT
Month – Day – Year

7. ENDING DATE OF EMPLOYMENT
Month – Day – Year

8. AMOUNT EARNED DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (BEFORE DEDUCTIONS)
$

9. TIME LOST DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (DUE TO DISABILITY)

10. TYPE OF WORK PERFORMED

11. NUMBER OF HOURS WORKED

A. DAILY

B. WEEKLY

12. CONCESSIONS (IF ANY) MADE TO EMPLOYEE BY REASON OF AGE OR DISABILITY

13A. IF VETERAN IS NOT WORKING, STATE REASON FOR TERMINATION OF EMPLOYMENT:
(IF RETIRED ON DISABILITY, PLEASE SPECIFY)

13B. DATE LAST WORKED
Month – Day – Year

14A. DATE OF LAST PAYMENT
Month – Day – Year

14B. GROSS AMOUNT OF LAST PAYMENT
$

15A. WAS LUMP SUM PAYMENT MADE?
☐ YES ☐ NO *(If "Yes," complete Items 15B and 15C)*

15B. GROSS AMOUNT PAID
$

15C. DATE PAID
Month – Day – Year

SUPERSEDES VA FORM 21-4192, DEC 2010, WHICH WILL NOT BE USED.

SECTION III - RESERVE OR NATIONAL GUARD DUTY STATUS

(Only complete if claimant is currently serving in the Reserve or National Guard)

16A. WHAT IS THE VETERAN'S CURRENT DUTY STATUS?

16B. DOES THE VETERAN HAVE ANY DISABILITIES THAT PREVENT THEM FROM PERFORMING THEIR MILITARY DUTIES?

☐ YES ☐ NO

SECTION IV - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS *(To be completed by employer)*

17. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS?

☐ YES ☐ NO *(If "Yes," complete Items 18 through 20C)*

18. TYPE OF BENEFIT

19. GROSS MONTHLY AMOUNT OF BENEFIT

$

20A. DATE BENEFIT BEGAN	20B. DATE FIRST PAYMENT ISSUED	20C. DATE BENEFIT WILL STOP *(If known)*
Month – Day – Year	Month – Day – Year	Month – Day – Year

21A. SIGNATURE OF EMPLOYER OR SUPERVISOR *(If claimant is serving in the Reserves or National Guard, then signature of unit commander or designee is required)*	21B. DATE SIGNED
	Month – Day – Year

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. The requested information is considered relevant and necessary to determine maximum benefits 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 eligibility for disability benefits based on unemployability (38 U.S.C. 1521). 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.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

INSTRUCTIONS - COMPLETE AND ATTACH THIS FORM WITH A SIGNED VA FORM 21-4142, *AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)*. IF YOU HAVE MORE THAN THREE PROVIDERS, FILL OUT ADDITIONAL COPIES OF THIS FORM, AVAILABLE AT **WWW.VA.GOV/VAFORMS**.

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER

SECTION II - MEDICAL PROVIDER INFORMATION

4A. PROVIDER OR FACILITY NAME		4B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)*
		From: To: From: To:
4C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
4D. CITY	4E. STATE AND ZIP CODE	4F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

5A. PROVIDER OR FACILITY NAME		5B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)*
		From: To: From: To:
5C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
5D. CITY	5E. STATE AND ZIP CODE	5F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

6A. PROVIDER OR FACILITY NAME		6B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)*
		From: To: From: To:
6C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
6D. CITY	6E. STATE AND ZIP CODE	6F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

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 the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The 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.

RESPONDENT BURDEN: We need this information to obtain your treatment records. 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. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE ENTIRE FORM *(both pages)* BEFORE SIGNING IN ITEM 11 BELOW.

SECTION I - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: ***All* my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, but not limited to:
   a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
   b. Drug abuse, alcoholism, or other substance abuse,
   c. Sickle cell anemia,
   d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
   e. Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months *after* the date this authorization is signed in Item 11, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME.

IMPORTANT - In accordance with 38 C.F.R. §3.159(c), **"VA will not pay any fees charged by a custodian to provide records requested."**

SECTION II - VETERAN IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME *(Type or print)*	2. DATE OF BIRTH *(MM,DD,YYYY)*	3. SOCIAL SECURITY NUMBER/VA FILE NUMBER

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

4. LAST NAME - FIRST NAME - MIDDLE NAME *(Type or print)*	5. DATE OF BIRTH *(MM,DD,YYYY)*	6. SOCIAL SECURITY NUMBER
7. STREET ADDRESS	8. CITY, STATE, ZIP CODE	9. TELEPHONE NUMBER *(Include Area Code)*

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

- **ALL** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities,
- Social workers/rehabilitation counselors,
- Consulting examiners used by VA,
- Employers, insurance companies, workers' compensation programs, and
- Others who may know about my condition (family, neighbors, friends, public officials).

SECTION V - AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

10. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE *(If this space is left blank, there is no limitation to records)*:

TO WHOM: The Department of Veterans Affairs (VA).
PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.
EXPIRES: This authorization is good for 12 months from the date shown in Item 12.

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above in Section I.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (See page 2 for details).
- I may write to VA and my source(s) to revoke this authorization at any time (See page 2 for details).
- VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgement on Page 2.**

11. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE ***(Required)***	12. DATE SIGNED *(MM,DD,YYYY)* ***(Required)***
13. PRINTED NAME OF PERSON SIGNING *(First, Middle Initial, Last)*	14. TELEPHONE NUMBER *(Include Area Code)*

15. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State, and ZIP code. All court appointments must include docket number, county, and State)*

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

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 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. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the source to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The 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.

If you do not revoke this authorization, it will automatically expire in 12 months from the date you sign and date the form. Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by VA without your consent if authorized by Federal laws such as the Privacy Act.

Under the Government Paperwork Elimination Act (GPEA) (Public Law 105-277), the Office of Management and Budget (OMB) ensures that agencies, when practicable, provide for the option of electronic maintenance, submission of disclosure of information and for the use and acceptance of electronic signatures. GPEA states that electronic records submitted or maintained in accordance with the procedures developed by OMB, or electronic signature or other forms of electronic authentication used in accordance with such procedures, "shall not be denied legal effect, validity, or enforceability merely because such records are in electronic form" (Public Law 105-277, section 1707).

RESPONDENT BURDEN: We need this information and your written authorization to obtain your treatment records to help us get the information required to process your claim. Title 38, United States Code, allows us to ask for this information. You can provide this authorization by signing VA Form 21-4142. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations. 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. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form. If you use the Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

PATIENT ACKNOWLEDGMENT: I HEREBY AUTHORIZE the sources listed in Section IV, to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the source being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it provides me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my source sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization in writing, at any time except to the extent a source of information has already relied on it to take an action. To revoke, I must send a written statement to the VA Regional Office handling my claim or the Board of Veterans' Appeals (if my claim is related to an appeal) and also send a copy directly to any of my sources that I no longer wish to disclose information about me. I understand that VA may use information disclosed prior to revocation to decide my claim.

NOTE: For additional information regarding VA Form 21-4142, refer to the following website:
www.benefits.va.gov/compensation/consent_privateproviders.asp.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

INSTRUCTIONS - COMPLETE AND ATTACH THIS FORM WITH A SIGNED VA FORM 21-4142, *AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)*. IF YOU HAVE MORE THAN THREE PROVIDERS, FILL OUT ADDITIONAL COPIES OF THIS FORM, AVAILABLE AT **WWW.VA.GOV/VAFORMS**.

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER

SECTION II - MEDICAL PROVIDER INFORMATION

4A. PROVIDER OR FACILITY NAME	4B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)*
	From: To: From: To:

4C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

4D. CITY	4E. STATE AND ZIP CODE	4F. PROVIDER OR FACILITY TELEPHONE NUMBER *(Include Area Code)*

5A. PROVIDER OR FACILITY NAME	5B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)*
	From: To: From: To:

5C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

5D. CITY	5E. STATE AND ZIP CODE	5F. PROVIDER OR FACILITY TELEPHONE NUMBER *(Include Area Code)*

6A. PROVIDER OR FACILITY NAME	6B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)*
	From: To: From: To:

6C. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

6D. CITY	6E. STATE AND ZIP CODE	6F. PROVIDER OR FACILITY TELEPHONE NUMBER *(Include Area Code)*

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 the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The 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.

RESPONDENT BURDEN: We need this information to obtain your treatment records. 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. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

CSS

Veteran's Name: _____

Patient's Name: _____

Name of facility or care provider: _____

Phone number of facility or care provider: _____

Address of facility or care provider: _____

_____

_____

Date entered facility, or in-home care began: _____

Date patient left facility (if applicable): _____

Will the patient need this care indefinitely? _____ YES _____ NO

If no, when will this care end? _____

Has the patient applied for Medicaid? _____ YES _____ NO

Is part of the patient's cost covered by Medicaid, Medicare, or insurance?

_____ YES _____ NO

When did the coverage begin? _____

What monthly amount does the Veteran or patient pay from his/her own funds?

Effective date: _____ $ _____ per month

(prior) Effective date: _____ $ _____ per month

FOR NURSING HOME CARE, ALSO ANSWER:

Is your facility licensed by the State? _____ YES _____ NO

Is your facility Medicaid approved? _____ YES _____ NO

Is the patient in our nursing home care because of a physical or mental health disability?

_____ YES _____ NO

Do you provide either skilled or intermediate level nursing care to the patient?

_____ YES _____ NO

FOR NURSING HOME CARE, ALSO ANSWER *(cont.)*:

What was the admitting diagnosis? _____

_____

_____

Which of the following services do you provide?

_____ Assistance with bathing and/or showering

_____ Assistance with dressing

_____ Assistance with eating and/or drinking (not including meal preparation)

_____ Assistance with mobility (i.e.- getting in or out of bed, a chair, etc.)

_____ Assistance with personal hygiene needs (i.e. – using toilet, brushing teeth, etc.)

Describe any additional medial or nursing services you provide to the claimant:

_____

_____

Are you a licensed health professional? _____ YES _____ NO

(Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse)

If YES, please provide your license number: _____

If you charge by the hour, please list your hourly rate, and weekly hours worked:

Weekly Hours: _____ $ _____ per hour

FOR OTHER TYPES OF CARE FACILITIES, ALSO ANSWER:

Indicate the type of facility the claimant resides:

_____ Foster Home _____ Adult Day Care

_____ Rest Home _____ Group Home

_____ Assisted Living _____ Independent Living/Retirement Facility

Which of the following services do you provide?

_____ Assistance with bathing and/or showering

_____ Assistance with dressing

_____ Assistance with eating and/or drinking (not including meal preparation)

_____ Assistance with mobility (i.e.- getting in or out of bed, a chair, etc.)

_____ Assistance with personal hygiene needs (i.e. – using toilet, brushing teeth, etc.)

Describe any additional medial or nursing services you provide to the claimant:

_____

_____

If a 3rd party provides the services listed above, please list their name, address, and phone number:

Name: _____

Address: _____

Phone Number: _____

IMPORTANT: Please have the 3rd party complete the in-home care section above then sign and date the last section.