Form Approved, OMB No. 2900-0605
Respondent Burden: 45 minutes

Department of Veterans Affairs

APPLICATION FOR ACCREDITATION AS A CLAIMS AGENT OR ATTORNEY

INSTRUCTIONS: Please provide the applicable personal and employment data, then read each question and provide complete answers to all questions that apply to you. If additional space is needed, please attach a supplementary page(s). After providing all of the requested information, sign and date your application. Unsigned or incomplete applications will not be processed. Send completed applications to: Department of Veterans Affairs, Office of the General Counsel (022D), 810 Vermont Avenue, NW, Washington, D.C. 20420. After an affirmative determination of character and fitness for practice before the VA, claims agent applicants must achieve a score of 75 percent or more on a written examination administered VA as a prerequisite to acreditation. Claims agent applicants will be given written instructions for arranging to take the examination if initial eligibility is established. Attorney applicants must be in good standing with a State bar and are not required to take an examination administered by VA as a prerequisite to accreditation. Denials of initial eligibility for accreditation as a claims agent or attorney are final and are not subject to appeal, but applicants may reapply.

1. LAST NAME - FIRST NAME - MIDDLE NAME	2A. HOME ADDRESS *(street, city, state, ZIP Code)*	2B. PHONE NUMBER *(Including area code)*
		2C. E-MAIL ADDRESS *(If available)*

3A. EMPLOYMENT STATUS	3B. WORK ADDRESS *(street, city, state, ZIP Code)*	5. PLACE OF BIRTH *(City, State, Country)*	
☐ EMPLOYED *(Complete Item 3B)*		6. BRANCH OF SERVICE	7. CHARACTER OF DISCHARGE
☐ UNEMPLOYED *(Skip Item 3B)*			
☐ SELF-EMPLOYED *(Skip Item 3B)*			
☐ STUDENT *(Skip Item 3B)*	4. DATE OF BIRTH *(Month, day, year)*	8. LIST DATES OF ALL ACTIVE MILITARY SERVICE	

9. EMPLOYMENT *(Provide information for past five years - use additional sheets if necessary)*

A. EMPLOYER NAME AND ADDRESS *(street, city, state, ZIP Code)*	B. EMPLOYER PHONE NO. *(Include area code)*	C. POSITION TITLE	D. EMPLOYMENT DATES *(Month/Day/Year)*	E. NAME OF SUPERVISOR
	EXTENSION:			
	EXTENSION:			
	EXTENSION:			

10. EDUCATION *(Provide information for high school graduation and list all colleges or universities attended and degrees received)*

A. NAME AND ADDRESS OF INSTITUTION *(street, city, state, ZIP Code)*	B. DATES ATTENDED *(Month/Year)*	C. DEGREE RECEIVED/MAJOR

11A. ARE YOU CURRENTLY A MEMBER IN GOOD STANDING OF THE BAR OF THE HIGHEST COURT OF A STATE OR TERRITORY OF THE UNITED STATES?	11B. IF "YES," LIST EACH JURISDICTION IN WHICH ADMITTED, THE DATE OF ADMISSION, AND MEMBERSHIP OR REGISTRATION NUMBER.		
	JURISDICTION IN WHICH ADMITTED	**DATE OF ADMISSION**	**MEMBERSHIP OR REGISTRATION NO.**
☐ YES ☐ NO			

12A. ARE YOU CURRENTLY ADMITTED TO PRACTICE BEFORE ANY STATE OR FEDERAL AGENCY OR ANY FEDERAL COURT?	12B. IF "YES," LIST EACH AGENCY OR FEDERAL COURT TO WHICH ADMITTED, THE DATE OF ADMISSION, AND MEMBERSHIP OR REGISTRATION NUMBER.		
	AGENCY IN WHICH ADMITTED	**DATE OF ADMISSION**	**MEMBERSHIP OR REGISTRATION NO.**
☐ YES ☐ NO			

BACKGROUND INFORMATION: Truthfulness and candor are essential elements of good moral character and reputation relevant to practice before the Department of Veterans Affairs. It is in your best interest, therefore, to provide the Office of the General Counsel with all available information in responding to the questions asked below. ***For each question answered "YES," provide a detailed statement setting forth all relevant facts and dates along with copies of relevant documents.***

Your responses must be updated as necessary prior to your accreditation. Failure to disclose the requested information may result in denial of accreditation under 38 C.F.R. § 14.629 or in disciplinary proceedings under 38 C.F.R. § 14.633 if you are already accredited.

For questions 13 through 15 your answers should include convictions resulting from a plea of nolo contendere *(no contest)*, but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, and (3) any conviction for which the record was expunged under Federal or state law.

13A. HAVE YOU EVER BEEN CONVICTED, IMPRISONED, SENTENCED TO PROBATION OR PAROLE? *(Include felonies, firearms or explosives violations, misdemeanors, and all other offenses.)* ☐ YES ☐ NO	13B. IF "YES," PROVIDE THE DATE, EXPLANATION OF THE VIOLATION, PLACE OF OCCURRENCE, AND THE NAME AND ADDRESS OF THE MILITARY AUTHORITY OR COURT INVOLVED.
14A. HAVE YOU EVER BEEN CONVICTED, BY A MILITARY COURT-MARTIAL? *(If no military service, answer "NO.")* ☐ YES ☐ NO	14B. IF "YES," PROVIDE THE DATE, EXPLANATION OF THE VIOLATION, PLACE OF OCCURRENCE, AND THE NAME AND ADDRESS OF THE MILITARY AUTHORITY OR COURT INVOLVED.
15A. ARE YOU NOW UNDER CHARGES FOR ANY VIOLATION OF LAW? ☐ YES ☐ NO	15B. IF "YES," PROVIDE THE DATE, EXPLANATION OF THE VIOLATION, PLACE OF OCCURENCE, AND THE NAME AND ADDRESS OF THE MILITARY AUTHORITY OR COURT INVOLVED.

16. HAVE YOU EVER BEEN SUSPENDED, EXPELLED OR ASKED TO RESIGN OR WITHDRAW FROM ANY EDUCATIONAL INSTITUTION, OR HAVE YOU RESIGNED OR WITHDRAWN FROM ANY SUCH INSTITUTION IN TIME TO AVOID DISCIPLINE, SUSPENSION, OR EXPULSION FOR CONDUCT INVOLVING DISHONESTY, FRAUD, MISREPRESENTATION, OR DECEIT?

☐ YES ☐ NO

17. HAVE YOU EVER BEEN DISCIPLINED, REPRIMANDED, SUSPENDED OR TERMINATED IN ANY JOB FOR CONDUCT INVOLVING DISHONESTY, FRAUD, MISREPRESENTATION, DECEIT, OR ANY VIOLATION OF FEDERAL OR STATE LAWS OR REGULATIONS?

☐ YES ☐ NO

18. HAVE YOU EVER RESIGNED, RETIRED FROM, OR QUIT A JOB WHEN YOU WERE UNDER INVESTIGATION OR INQUIRY FOR CONDUCT WHICH COULD HAVE BEEN CONSIDERED AS INVOLVING DISHONESTY, FRAUD, MISREPRESENTATION, DECEIT, OR VIOLATION OF FEDERAL OR STATE LAWS OR REGULATIONS, OR AFTER RECEIVING NOTICE OR BEING ADVISED OF POSSIBLE INVESTIGATION, INQUIRY, OR DISCIPLINARY ACTION FOR SUCH CONDUCT?

☐ YES ☐ NO

19. HAVE YOU EVER FUNCTIONED AS A REPRESENTATIVE, AGENT, OR ATTORNEY BEFORE A STATE OR FEDERAL DEPARTMENT OR AGENCY?

☐ YES ☐ NO

20. HAVE YOU EVER BEEN REPRIMANDED, SUSPENDED, OR BARRED FROM PRACTICE BEFORE ANY COURT, BAR, OR FEDERAL OR STATE AGENCY, OR HAVE YOU RESIGNED MEMBERSHIP IN THE BAR OF ANY COURT, OR FEDERAL OR STATE AGENCY TO AVOID REPRIMAND, SUSPENSION, OR DISBARMENT FOR CONDUCT INVOLVING DISHONESTY, FRAUD, MISREPRESENTATION, OR DECEIT?

☐ YES ☐ NO

21. HAVE YOU EVER APPLIED FOR ACCREDITATION BY THE DEPARTMENT OF VETERANS AFFAIRS AS A REPRESENTATIVE OF A VETERANS SERVICE ORGANIZATION, AGENT, OR ATTORNEY?

☐ YES ☐ NO

22. IF YOU WERE PREVIOUSLY ACCREDITED AS A REPRESENTATIVE OF A VETERANS SERVICE ORGANIZATION, WAS THAT ACCREDITATION TERMINATED OR SUSPENDED AT THE REQUEST OF THE ORGANIZATION?

☐ YES ☐ NO

23A. DO YOU HAVE ANY CONDITION OR IMPAIRMENT (SUCH AS SUBSTANCE ABUSE, ALCOHOL ABUSE, OR A MENTAL, EMOTIONAL, NERVOUS, OR BEHAVIORAL DISORDER OR CONDITION) THAT IN ANY WAY CURRENTLY AFFECTS, OR, IF UNTREATED OR NOT OTHERWISE ACTIVELY MANAGED, COULD AFFECT YOUR ABILITY TO REPRESENT CLAIMANTS IN A COMPETENT AND PROFESSIONAL MANNER?

☐ YES ☐ NO

23B. IF YOU ANSWERED "YES," TO ITEM 23A, PLEASE DESCRIBE THE CONDITION OR IMPAIRMENT, AND ANY TREATMENT YOU RECEIVED IN THE PAST YEAR OR RECEIVE NOW. IF YOU HAVE BEEN UNDER THE CARE OR SUPERVISION OF A HEALTH-CARE PROFESSIONAL, SUBMIT A STATEMENT BY THE HEALTH-CARE PROFESSIONAL SPECIFYING YOUR CURRENT DIAGNOSIS, TREATMENT REGIMEN, AND PROGNOSIS, AND ITS BEARING ON YOUR FITNESS TO REPRESENT CLAIMANTS BEFORE THE DEPARTMENT OF VETERANS AFFAIRS.

24A. DO YOU HAVE ANY PHYSICAL LIMITATIONS WHICH WOULD INTERFERE WITH YOUR COMPLETION OF A WRITTEN EXAMINATION ADMINISTERED UNDER THE SUPERVISION OF A VA REGIONAL COUNSEL *(Claims agent applicants only)* ?

☐ YES ☐ NO

24B. IF "YES," PLEASE STATE THE NATURE OF SUCH LIMITATIONS AND PROVIDE DETAILS OF ANY SPECIAL ACCOMMODATIONS DEEMED NECESSARY.

25. CHARACTER REFERENCES

(Please provide the full names, addresses, and current phone numbers of three individuals who are not immediate family members and who have personal knowledge of your character and qualifications to serve as a claims agent or attorney.)

NAME	ADDRESS	PHONE NUMBER *(Include area code)*	RELATIONSHIP TO APPLICANT
		EXTENSION:	
		EXTENSION:	
		EXTENSION:	

CERTIFICATION: I CERTIFY THAT the statements and entries on this form are true and correct. *(A willfully false statement or certification is a criminal offense and is punishable by law [18 U.S.C. 1001]).*

SIGNATURE OF APPLICANT	DATE SIGNED

PRIVACY ACT INFORMATION: The information requested on this form is solicited under Section 5904, Title 38, United States Code and Section 14.629(b) of Title 38, Code of Federal Regulations. It will enable VA to determine initial eligibility for accreditation as a claims agent or attorney to represent claimants before VA. Any information on this form may be disclosed outside VA only if authorized under the Privacy Act, including the routine uses identified in the VA system of records, 01VA022, Current and Former Accredited Representative, Claims Agent, Attorney, and Representative, Claims Agent, and Attorney Applicant and Rejected Applicant Records--VA, published in the Federal Register. Routine disclosures may be made for the following purposes: civil or criminal law enforcement or investigation; congressional communications; communications relevant to the delivery of VA benefits; verification of identity and status; litigation conducted by the Department of Justice; and communication with employing entities and governmental licensing organizations concerning information relevant to employment or licensing of a prospective, present, or former representative, claims agent or attorney. Providing the requested information is voluntary; however, failure to furnish information may delay or prevent action on the application.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information send your comments to VA Clearance Officer (005R1B), 810 Vermont Avenue, NW, Washington, D.C. 20420. Please do not send applications for accreditation to this address.

Department of Veterans Affairs

INSTRUCTIONS FOR VA FORM 21-601
APPLICATION FOR ACCRUED AMOUNTS DUE A DECEASED BENEFICIARY

Note: **Do not complete this form if you have applied for death benefits by using VA Form 21-534 or 21-535. Read very carefully, detach, and keep these instructions for your reference.**

A. How can I contact VA if I have questions?

If you have questions about this form, how to fill it out, or about benefits, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government, Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line 1-800-829-4833). You may also contact VA by Internet at http://iris.va.gov.

B. What do I use VA Form 21-601 for?

Use VA Form 21-601 to apply for accrued benefits due the beneficiary but not paid prior to death. Each person claiming a share of accrued benefits must complete a separate VA Form 21-601.

Note: If you are a deceased veteran's surviving spouse, child, or dependent parent, you should apply for death benefits, including accrued benefits, using VA Form 21-534, Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable) **or** VA Form 21-535, Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation, When Applicable).

C. What are accrued benefits and how does VA decide what I will or will not receive?

Accrued benefits are benefits that were due the beneficiary at the time of death but not paid prior to death. Entitlement to accrued benefits is determined according to the line of succession established by law.

Benefits are payable to the first living person listed below. The fact that a preferred beneficiary fails to file or prosecute a claim does not permit payment of his/her share of accrued benefits to a person or persons having an equal or lower preference. A waiver of right also does not permit such payment. If there are no living persons who are entitled on the basis of relationship, accrued benefits may be payable as reimbursement for last illness and burial expenses (see Paragraph D).

When the deceased beneficiary is a veteran, accrued is payable	**When the deceased beneficiary is a surviving spouse, accrued is payable**	**When the deceased beneficiary is a child, accrued is payable**
• in full to the surviving spouse, **or** • in equal shares to the veteran's children (see definition of "child" below), **or** • in equal shares to the veteran's parents, if they are dependent upon the veteran at the date of the veteran's death, **or** • in full to the sole surviving parent, if he/she is dependent upon the veteran at the date of the veteran's death.	• in equal shares to the veteran's children (see definition of "child" below).	• in equal shares to the veteran's children who are entitled to death compensation, dependency and indemnity compensation, or death pension (see definition of "child" below).

Definitions:
Child means an unmarried child of the veteran who is under 18 years of age, or at least 18 but under 23 years of age and pursuing an approved course of education, or became incapable of self support prior to reaching age 18. However, benefits may be payable to the veteran's children, regardless of age or marital status, if lump sum accrued benefits are payable.

Lump sum accrued benefits are amounts withheld from a competent veteran's Old Law Pension benefits (fixed rate since 1960) during hospital treatment, or institutional or domiciliary care.

EXISTING STOCKS OF VA FORM 21-601, MAY 2005, WILL BE USED.

D. Who may file a claim for reimbursement for last illness and burial expenses?

If there are no living persons who are entitled on the basis of relationship, accrued benefits may be used to reimburse the person or persons who paid for or are responsible to pay the expenses of last illness and burial of a beneficiary. The claim should be filed by the person or persons whose funds were or will be used to pay such expenses. If the expenses were paid from funds of the deceased beneficiary's estate, the claim should be filed by the executor or administrator of the estate. If the expenses have not been paid, the claim may be filed by the person who is responsible for the payment of these expenses. However, all unpaid creditors must sign Part IV, Reimbursement Waiver.

E. What are the time limits to apply for accrued benefits?

A claim for accrued benefits must be filed within one year from the date of death of the deceased beneficiary.

Exception: A claim for lump sum accrued benefits (benefits that were withheld from a competent veteran during hospital treatment, institutional, or domiciliary care) must be filed within five years from the veteran's date of death. However, if the person who is entitled to the lump sum accrued benefits has been declared incompetent by a court of law or Federal or State government agency at the time of the veteran's death, the five year period begins from the date of termination or removal of the finding of incompetency.

F. What evidence should I submit?

1. Furnish a copy of the death certificate unless the beneficiary died in a VA medical facility.

2. If an executor or administrator of the beneficiary's estate has been assigned, submit a certified copy of the letters of administration or letters testamentary bearing the signature and seal of the appointing court.

3. If you are claiming reimbursement for last illness and burial expenses of a beneficiary, submit all bills and statements of account covering the services and supplies that were provided in connection with these expenses. The bill or statement of account should be submitted on the regular billhead of the creditor and show:

- the dates, nature, and costs of services or supplies provided,
- the name of the deceased for whom the expenses were incurred, and
- whether the expense has been paid, and, if so, by whom.

G. How do I complete my application?

Print all answers clearly. If an answer is "none" or "0," write that. Your answer to every question is important to help us complete your claim. If you do not know the answer, write "unknown." For additional space, use Item 23, "Remarks, " or attach a separate sheet, indicating the item number to which the answers apply. Write the veteran's name and VA file number on all attachments. Make sure you sign and date this application (Items 20a and 20b).

H. What do I do when I have completed my application?

When you have completed this application mail it or take it to a VA regional office. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before you mail it.

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 5, 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 required to obtain or retain benefits. 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 payment of accrued benefits under 38 U.S.C. 5121. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 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 http: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.

Department of Veterans Affairs

Application for Accrued Amounts Due a Deceased Beneficiary

OMB Approved No. 2900-0216
Respondent Burden: 30 minutes

VA DATE STAMP
(Do not write in this space)

Please read the attached "Instructions" before you fill out this form.

SECTION I

Tell us about you and the deceased beneficiary

1. What is the veteran's name?

First Middle Last

2. What is the veteran's Social Security Number?

3. What is the VA file number?

4. What is the name of the deceased beneficiary? *(If other than veteran)*

First Middle Last

5. What is the date of death of the beneficiary?

mo day yr

6. What is your name?

First Middle Last

7. What is your address?

Street address, Rural Route, or P.O. Box Apt. number

City State ZIP Code Country

8. What are your telephone numbers? *(Include Area Code)*

Daytime

Evening

9. What is your relationship to the deceased beneficiary?

SECTION II

Tell us about the deceased beneficiary's surviving relatives

10. Who are the deceased beneficiary's surviving relatives? *(Check all that apply)*

☐ Spouse ☐ Child or Children ☐ Mother ☐ Father ☐ None *(If "NONE," Skip to Section II)*

If any boxes are checked in Item 10, list each person separately in Item 11a through 11d.

11. Relatives Surviving Beneficiary at time of death

11a. Name *(First, Middle Initial, Last)*	11b. Relationship to Beneficiary	11c. Date of Birth *(mm/dd/yyyy)*	11d. Complete Mailing Address

SECTION III

Tell us about the debts and expenses of the last sickness and burial of the deceased beneficiary

Note: Read Paragraphs C and D of the "Instructions" before completing Section III. Skip to Section V if you are claiming accrued benefits based on your relationship to the deceased beneficiary.

12. List the expenses of last sickness and burial in Items 12a through 12e.

12a. Name of Person or Firm	12b. Nature of Expense *(For example, physician, hospital, burial expenses, etc.)*	12c. Amount	12d. Check One		12e. If Paid, Name of Person or Estate Whose Funds Were Used
			Paid	Unpaid	
		$	☐	☐	
		$	☐	☐	
		$	☐	☐	
		$	☐	☐	

13. Have you been reimbursed from any source for any of the expenses paid from your personal funds?

☐ Yes ☐ No *(If "YES," specify the amount and source)*

14. Did the beneficiary leave any other debts?

☐ Yes ☐ No *(If "YES," go to Item 15. If "NO," skip to Item 16.)*

15. List the other debts in Items 15a and 15b.

15a. Nature of Debt	15b. Amount
	$
	$
	$
	$

16. Has or will the beneficiary's estate be legally administered?

☐ Yes ☐ No *(If "YES," attach a copy of the letters of administration or letters testamentary bearing the signature and seal of the appointing court)*

SECTION IV

Give us a waiver of reimbursement from all unpaid creditors

Note: If any of the expenses listed in Item 12a are unpaid, Section IV must be completed and signed by all unpaid creditors. If you are a creditor who is claiming accrued benefits as reimbursement, Section IV must be completed by all other creditors and persons who provided services to the deceased beneficiary related to last illness or burial and hold the creditor responsible for payment of their claims. If you need additional space, please attach a separate sheet of paper providing the certification and information requested below.

I CERTIFY THAT the expense listed in Section III, Item 12a which was incurred by the claimant named in Item 6 in connection with the last sickness and burial of the beneficiary, is due and unpaid. I further certify that I hold the claimant responsible for the payment of any portion of the accrued benefit to which I may be entitled in the case of the beneficiary named in Item 1 or 4 and waive my right to any such benefit. This statement is true and correct to the best of my belief.

17a. Name of Unpaid Creditor or Firm No. 1

17b. Address of Creditor or Firm

17c. Signature of Creditor or Person Signing for Firm	17d. Title	17e. Date Signed mo day yr

18a. Name of Unpaid Creditor or Firm No. 2

18b. Address of Creditor or Firm

18c. Signature of Creditor or Person Signing for Firm	18d. Title	18e. Date Signed mo day yr

19a. Name of Unpaid Creditor or Firm No. 3

19b. Address of Creditor or Firm

19c. Signature of Creditor or Person Signing for Firm	19d. Title	19e. Date Signed mo day yr

SECTION V

Give us your Signature

If you sign with an "X," then you must have two people you know witness you as you sign. They must then sign the form and print their names and addresses also.

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

20a. Signature of claimant	20b. Today's date mo day yr

21a. Signature of witness (If claimant signed above using an "X")	21b. Printed name and address of witness

22a. Signature of witness (If claimant signed above using an "X")	22b. Printed name and address of witness

SECTION VI

Remarks - Use this space for any additional statements that you would like to make concerning your application.

IMPORTANT
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 which you are not entitled to.

23. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form, please identify your answer or statement by the Section and item number)*

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR BURIAL BENEFITS (UNDER 38 U.S.C., CHAPTER 23)

IMPORTANT - READ THESE INSTRUCTIONS CAREFULLY

PRIVACY ACT INFORMATION: The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only 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 and is required to obtain benefits. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility burial benefits. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 22 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 can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

1. GENERAL

a. BURIAL ALLOWANCE - An amount towards the expenses of the funeral and burial of the veteran's remains. Burial includes all recognized methods of interment.

b. PLOT ALLOWANCE - Plot means the final resting place of the remains. The allowance is payable towards:

(1) Expenses incurred for the plot or interment if burial was not in a national cemetery or other cemetery under the jurisdiction of the United States; OR

(2) Expenses payable to a State (or political subdivision) if the veteran died from non service-connected causes and was buried in a State-owned cemetery or section used solely for the remains of persons eligible for burial in a national cemetery.

c. BURIAL ALLOWANCE FOR SERVICE-CONNECTED DEATH - When the veteran's death occurred as the result of a service-connected disability, a special "service-connected" rate is payable.

d. TRANSPORTATION EXPENSES - The cost of transporting the body to the place of burial may be paid in addition to the burial allowance when:

(1) The veteran died of a service-connected disability or had a compensable service-connected disability and burial is in a national cemetery; OR

(2) The veteran died while in a hospital, domiciliary or nursing home to which he/she had been properly admitted under authority of VA; OR

(3) The veteran died en route while traveling under prior authorization of VA for the purpose of examination, treatment or care.

2. WHO SHOULD FILE A CLAIM

a. CREDITOR - If expenses have not been paid, the claim should be filed by the funeral director or crematory service by completing Parts I, II, and IV. If the funeral director or crematory service has paid or advanced funds for or furnished the plot or interment expenses, inclusion of these items on the statement of account will serve as claim for the plot allowance. If cemetery owner or other creditor has not been paid for the plot and related interment expenses, he/she may file claim by completing Parts I, III, and IV. If both the funeral director and cemetery owner are unpaid, each must submit a separate VA Form 21-530 signed by the person who authorized services.

b. PERSON WHOSE FUNDS WERE USED - If all creditors have been paid, the claim should be filed by the person or persons whose personal funds were used by completing Parts I, II, and IV.

c. VETERAN'S ESTATE - If the expenses were paid from the veteran's estate, the claim should be filed by the executor/ administrator by completing Parts I, II, and IV. Submit a copy of the letters of administration or letters testamentary certified over the signature and seal of the appointing court.
d. STATE - If a veteran whose death is non service-connected was buried without charge for plot or interment in a State-owned cemetery or section used for persons eligible in a national cemetery, the claim may be filed by the State official completing Parts I, III (Items 23 and 24), and IV.

3. TIME LIMIT FOR FILING A CLAIM - A claim for non service-connected burial expenses or plot allowance must be filed with VA within 2 years from the date of the veteran's permanent burial or cremation. If a veteran's discharge was corrected after death to "Under Conditions Other Than Dishonorable," the claim must be filed within 2 years from the date of correction. The 2-year limitation does not apply to service-connected burial benefits, transportation expenses or reimbursement of headstone expenses.

4. COMPLETING CLAIM BY A FIRM OR STATE AGENCY - The claim must be executed in the full name of the firm or State agency, and show the official position or connection of the individual who signs on its behalf.

5. PROOF OF DEATH TO ACCOMPANY CLAIM - Death in a government institution does not need to be proven. In other cases, the claimant must forward a copy of the public record of death. If proof has previously been furnished VA, it need not be submitted again.

6. STATEMENT OF ACCOUNT MUST ACCOMPANY CLAIM
a. FUNERAL DIRECTOR - A statement of account on the funeral director's letterhead must show the name of the veteran; the nature and cost of services, including any payments made to another funeral home (show name and address); all credits; and the name of the person or persons by whom payment in whole or in part was made.
b. TRANSPORTATION - If transported by common carrier, a receipt must accompany the claim. All receipts for transportation charges should show the name of the veteran, the name of the person who paid and the amount of the charges. The itemized statement of account should show the charges made for transportation. Failure to itemize charges may result in delay or payment of a lesser amount.
c. ACCOUNT PAID IN FULL - The statement of account should be receipted in the name of the firm or individual performing the services. Bills or receipts filed in support of this claim become a part of the permanent record and will not be returned, unless specifically requested.
d. PLOT ALLOWANCE ONLY - In a claim for the plot allowance only, the statement of account must show the cost of the veteran's individual grave site, the mausoleum vault, or the columbarium niche.

7. BURIAL ASSOCIATION OR BURIAL INSURANCE - If the veteran was a member of a burial association or if any insurance company is obligated to pay all or part of the burial expenses, Item 22 should be answered "Yes." It will be necessary to support the claim with a statement from the association or insurance company setting forth the terms of the contract and how and with whom settlement was made.

8. SERVICE RECORD - The original or certified copy of the veteran's service separation document (DD214 or equivalent) which contains information as to the length, time, and character of service will permit prompt processing.

9. TOLL-FREE TELEPHONE ASSISTANCE - You can call us toll-free within the U.S. by dialing 1-800-827-1000. If you are located in the local dialing area of a VA regional office, you can also call us by checking your local telephone directory. For the hearing impaired, our TDD number is 1-800-829-4833.

10. WHERE DO I MAIL MY COMPLETED APPLICATION? - You should mail your application to the VA regional office located in your state. You can obtain the mailing address for VA regional offices by accessing the VA Internet web site at www.va.gov/directory. The address is also located in the government pages of your telephone book under "United States Government, Veterans."

OMB Approved No. 2900-0003
Respondent Burden: 22 minutes

Department of Veterans Affairs

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

APPLICATION FOR BURIAL BENEFITS
(Under 38 U.S.C. Chapter 23)

IMPORTANT - Read instructions carefully before completing form. YOUR COMPLIANCE WITH ALL INSTRUCTIONS WILL AVOID DELAY. Type or print all information.

1. FIRST, MIDDLE, LAST NAME OF DECEASED VETERAN

2. SOCIAL SECURITY NUMBER OF VETERAN | 3. VA FILE NUMBER

4. FIRST, MIDDLE, LAST NAME OF CLAIMANT

5. TELEPHONE NUMBER(S) *(Include Area Code)* | 5C. E-MAIL ADDRESS

A. DAYTIME | B. EVENING

6A. MAILING ADDRESS OF CLAIMANT *(Number and street or rural route, city or P.O., State and ZIP Code)*

6B. IF CLAIMANT IS A FUNERAL HOME PROVIDE THE EMPLOYER IDENTIFICATION NUMBER (EIN)

PART I - INFORMATION REGARDING VETERAN

7A. DATE OF BIRTH | 7B. PLACE OF BIRTH

8A. DATE OF DEATH | 8B. PLACE OF DEATH | 8C. DATE OF BURIAL

8D. WHERE DID THE VETERAN'S DEATH OCCUR? *(Check one)*

☐ VA MEDICAL CENTER ☐ NURSING HOME UNDER VA CONTRACT
☐ STATE VETERANS HOME ☐ OTHER *(Specify)*

SERVICE INFORMATION ***(The following information should be furnished for the periods of the VETERAN'S ACTIVE SERVICE)***

9A. ENTERED SERVICE		9B. SERVICE NUMBER	9C. SEPARATED FROM SERVICE		9D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	

10. IF VETERAN SERVED UNDER NAME OTHER THAN THAT SHOWN IN ITEM 1, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME

11. ARE YOU CLAIMING THAT THE CAUSE OF DEATH WAS DUE TO SERVICE?
☐ YES ☐ NO

PART II - CLAIM FOR BURIAL BENEFITS AND/OR INTERMENT ALLOWANCE IF PAID BY CLAIMANT

NOTE - If claiming Plot Allowance Only, do not complete Part II, but complete Parts III and IV on page 4.

12. PLACE OF BURIAL OR LOCATION OF CREMAINS

13. WAS BURIAL (WITHOUT CHARGE FOR PLOT OR INTERMENT) IN A STATE OWNED CEMETERY, OR SECTION THEREOF, USED SOLELY FOR PERSONS ELIGIBLE FOR BURIAL IN A NATIONAL CEMETERY?
☐ YES ☐ NO *(IF "No," complete Items 15 and 16)*

14. WAS BURIAL IN A NATIONAL CEMETERY OR CEMETERY OWNED BY THE FEDERAL GOVERNMENT?
☐ YES ☐ NO *(If "No," complete Items 15 and 16)*

15. BURIAL PLOT, MAUSOLEUM VAULT, COLUMBARIUM NICHE, ETC. COST IS: *(CHECK ONE)*

☐ PAID BY ANOTHER PERSON(S) ☐ PAID BY CLAIMANT FOR BURIAL
☐ DUE FUNERAL DIRECTOR ☐ NONE
☐ DUE CEMETERY OWNER

16. IF PLOT/INTERMENT EXPENSES ARE UNPAID, WHO WILL FILE CLAIM FOR EXPENSES? *(Name and Address)*

17. TOTAL EXPENSE OF BURIAL, FUNERAL, TRANSPORTATION, AND IF CLAIMED, BURIAL PLOT
$

18. AMOUNT PAID
$

19. WHOSE FUNDS WERE USED?

20A. HAS THE PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED?
☐ YES ☐ NO *(If "Yes," complete Items 20B and 20C)*

20B. AMOUNT OF REIMBURSEMENT
$

20C. SOURCE OF REIMBURSEMENT

21A. HAS ANY AMOUNT BEEN, OR WILL ANY AMOUNT BE ALLOWED ON EXPENSES BY LOCAL, STATE, OR FEDERAL AGENCY? ☐ YES ☐ NO *(If "Yes," complete Items 21B and 21C)*	21B. AMOUNT $	21C. SOURCE(S)

22. WAS THE VETERAN A MEMBER OF A BURIAL ASSOCIATION OR COVERED BY BURIAL INSURANCE?
☐ YES ☐ NO *(Before answering, read and comply with Instruction 7 on Page 2)*

PART III - CLAIM FOR PLOT COST ALLOWANCE

IMPORTANT - Complete only if burial was NOT in a national cemetery or cemetery owned by the Federal Government.

23. WAS BURIAL (WITHOUT CHARGE FOR PLOT OR INTERMENT) IN A STATE OWNED CEMETERY, OR SECTION THEREOF, USED SOLELY FOR PERSONS ELIGIBLE FOR BURIAL IN A NATIONAL CEMETERY? ☐ YES ☐ NO	24. PLACE OF BURIAL OR LOCATION OF CREMAINS	
25A. COST OF BURIAL PLOT *(Individual Grave Site, Mausoleum Vault, or Columbarium Niche)* $	25B. DATE OF PURCHASE	25C. DATE OF PAYMENT

26A. HAVE BILLS BEEN PAID IN FULL? ☐ YES ☐ NO *(If "No," complete Items 26B and 27)*	26B. AMOUNT PAID $	27. WHOSE FUNDS WERE USED?
28A. HAS PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED? ☐ YES ☐ NO *(If "Yes," complete Items 28B and 28C)*	28B. AMOUNT OF REIMBURSEMENT $	28C. SOURCE OF REIMBURSEMENT
29A. HAS ANY AMOUNT BEEN, OR WILL ANY AMOUNT BE ALLOWED ON EXPENSES BY STATE OR FEDERAL AGENCY? ☐ YES ☐ NO *(If "Yes," complete Items 29B and 29C)*	29B. AMOUNT $	29C. SOURCE

PART IV - CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statements made in connection with this application on account of the named veteran are true and correct to the best of my knowledge and belief.

30A. SIGNATURE OF CLAIMANT *(If signed using an "X", complete Items 36A thru 37B) (If signing for firm, corporation, or State agency, complete Items 30B thru 31)*	30B. OFFICIAL POSITION OF PERSON SIGNING ON BEHALF OF FIRM, CORPORATION OR STATE AGENCY

31. FULL NAME AND ADDRESS OF THE FIRM, CORPORATION, OR STATE AGENCY FILING AS CLAIMANT

NOTE - Where the claimant is a firm or other unpaid creditor, Items 32A thru 35 ***MUST*** be completed by the individual who authorized services.

I CERTIFY THAT the foregoing statements made by the claimant are correct to the best of my knowledge and belief.

32A. SIGNATURE OF PERSON WHO AUTHORIZED SERVICES *(If signed using an "X", complete Items 36A thru 37B)*	32B. NAME OF PERSON AUTHORIZING SERVICES *(Type or Print)*

33. ADDRESS *(Number and street or rural route, city or P.O., State and ZIP Code)*

34. DATE	35. RELATIONSHIP TO VETERAN

WITNESS TO SIGNATURE IF MADE BY "X"

NOTE - If claimant signed above using an "X", signature must be witnessed by two persons to whom the person making the statement is personally known, and the signatures and addresses of such witnesses must be shown below.

36A. SIGNATURE OF WITNESS	36B. ADDRESS OF WITNESS
37A. SIGNATURE OF WITNESS	37B. 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.

DEPARTMENT OF VETERANS AFFAIRS HEADSTONES AND MARKERS

The Department of Veterans Affairs will furnish, upon request, a Government headstone or marker at the expense of the United States for the unmarked graves of certain individuals eligible for burial in a national cemetery, but not buried there. These individuals include any veteran with an other than dishonorable discharge who dies after service or any serviceman or servicewoman who dies on active duty. Certain other individuals may also be eligible for the headstone or marker. Headstones or markers for all individuals in a national or post cemetery are furnished automatically without request from the family.

For additional information on burial benefits go to the web site, www.cem.va.gov/bbene_burial.asp. To obtain VA Form 40-1330, Application for Standard Government Headstone or Marker go to www.va.gov/vaforms or contact your local VA regional office. The address of that office can be found at to www.va.gov/directory.

Department of Veterans Affairs

INFORMATION AND INSTRUCTIONS FOR COMPLETING THE VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT- Please read the information below carefully to help you complete this form more quickly and accurately. Some parts of the form also contain notes or specific instructions for completing that part.

Frequently Asked Questions

For what do I use VA Form 21-526?

Use VA Form 21-526 to apply for compensation and/or pension benefits.

Should I apply for compensation or pension benefits?

You should apply for **compensation** benefits if:

- You currently have a disability that is the result of an injury, disease, or an event in military service.

You should apply for **pension** benefits if *all* of the following are true:

- You are age 65 or older or are permanently and totally disabled.
- You served on active duty with at least one day during a period of war.
- Your income and net worth does not exceed certain limits. Visit our website, http://www.vba.va.gov/bln/21/rates for the maximum yearly income we allow.

Note: Attach current medical evidence showing that you are permanently and totally disabled.

IMPORTANT: If you are a veteran who is age 65 or older, or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are filing for special monthly pension. Special monthly pension is an allowance that may be paid to individuals who, due to mental or physical disability, require the assistance of another person to perform the basic activities of daily living, or their ability to leave home is very limited.

May I apply electronically?

To file a claim for VA compensation or pension electronically, please complete and submit VA Form 21-526, Veteran's Application for Compensation and/or Pension, using VONAPP. The VONAPP (Veterans On Line Application) website is an official U.S. Department of Veterans Affairs (VA) website that enables service members, veterans and their beneficiaries, and other designated individuals to apply for benefits using the Internet. You can apply online at our website, http://vabenefits.vba.va.gov/vonapp/main.asp.

What parts of the form should I complete?

You should complete only the parts related to the benefit for which you are applying:

- If you are applying for compensation **ONLY**, skip parts VII, VIII, IX, X.
- If you are applying for pension, complete the **ENTIRE** form.
- If you need more space to answer a question or have a comment about a specific item on this form, please place it in Part XIII, Item 45, "Remarks." Please identify your answer or comment by the part and item number.

Where can I get help?

You can ask VA to help you fill out the form by contacting a regional office or call center. Before you contact us, make sure you gather the necessary materials and complete as much of the form as you can. You can contact VA in the following ways:

- **By internet:** https://iris.va.gov
- **In person:** You can locate the address of the closest regional office on the website http://www.va.gov/directory or in your telephone book blue pages under **"United States Government, Veterans"**
- **By telephone:** Please call one of the following telephone numbers:
  1-800-827-1000
  1-800-829-4833 (Hearing Impaired TDD line)
  1-412-395-6272 (If living outside the U.S.)

You can also contact a county or national veterans' service organization (VSO) representative to help you with your claim. If you want to use a representative to help you, consult your local telephone book to contact a particular VSO or contact the closest VA office. Depending on the type of representative you want to designate, we will send you one of the following forms:

- VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative
- VA Form 21-22A, Appointment of Individual as Claimant's Representative

What should I do when I have finished my application?

- You should provide your signature in Part XII, Item 42A. Be sure to sign every form you fill out before you send it to us. If you don't sign the form, VA will return it for you to sign, and it will take longer for us to process.
- Attach any materials that support and explain your claim.
- Mail or take your application to the closest VA regional office. VA regional office addresses are available on the internet at http://www.va.gov/directory

Do I need to keep a copy of my application?

It is important that you keep a copy of all completed forms and materials you give to VA.

Social Security and Supplemental Security Income Benefits

Social Security and Supplemental Security Income are two Federal programs that help people with disabilities. While these programs are different in many ways, the Social Security Administration (SSA) administers both programs. If you think you have a disabling condition, you may qualify for benefits under one or both of these programs and should contact Social Security.

How can I contact SSA if I have questions?

You can find answers to most questions and file a claim online at www.socialsecurity.gov. Specific information is available for active duty military, veterans, and their families at www.socialsecurity.gov/woundedwarriors.

You can also contact SSA in the following ways:

- **By phone:** (Monday-Friday, 7 a.m. - 7 p.m. EST) at one of the following toll-free numbers:
  1-800-772-1213
  1-800-325-0778 (TTY if you are deaf or hard of hearing)
- **By mail or in person:** You can locate the address of the Social Security office nearest to you in your telephone book blue pages under **"United States Government, Social Security Administration".**

Part II - Nature and History of Service-Related Disability(ies)

What disabilities should I list?
List the disease(s) or medical condition(s) that form the basis of your claim for service connected compensation. Be as specific as you can. Indicate the approximate date the disability began and the place of treatment.

Do I have to include any records with this claim form?
If you have records that support your claim, you should attach them to this form. VA will help you obtain records by requesting them from the person, company, or agency that has them. On this form you must tell us the name and address of the person, company or agency that has these records, the approximate time frame covered by them, and the condition for which you were treated. If you received treatment from a non-VA health care provider complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). We will use this form to request these records. Due to Privacy Act regulations, please use only one source of information (Item 7) on each form, as some medical offices will not accept the forms otherwise, which may cause a delay in processing your claim. Additional 21-4142 forms can be obtained from the VA forms website at www.va.gov/vaforms.

Part III - Active Duty Service Information

Do I need to include my active duty service information?
Please provide the information for each period of active duty (provide a copy of your DD214 or other separation papers for all periods of active duty service).

Part IV - Reserve and National Guard Service Information

What If I have Reserve or National Guard Service?
This section tells us if you were a member of the Reserve or National Guard. Complete information for each period of Reserve and National Guard service. Provide a copy of your DD214 or other separation papers for all periods of active service.

Part V - Military Retired/Severance Pay

What If I have received or will receive military pay?
This section asks about your military severance or separation pay, the type, and the amount. If you currently receive military retired pay, we may reduce your retired pay by the amount of any compensation that we award. It is to your advantage because VA compensation is not taxable while retired pay is taxable. However, if you wish to receive military retired pay rather than VA compensation, you must check the box in Item 25. Some veterans receive various readjustment, separation, or severance pay from service departments which may be recouped in full or in part from VA benefit payments.

Part VI - Marital and Dependency Information

Who can I count as a dependent spouse?
A spouse is a person of the opposite sex who is married to the veteran (authority: 38 U.S.C. subsection 101(31)). The marriage must be valid under the law of the place where the parties resided at the time of marriage, or the law of the place where the parties resided when the right to benefits occurred.
Note: It is important that you provide your marital history and that of your spouse.

Who can be recognized as a dependent child?
VA recognizes the veteran's biological child, adopted child, and stepchild. However, the child must be unmarried and:

- under the age of 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- permanently incapable of self support before reaching the age of 18.

Part VII - Non-Service Connected Pension

This section asks you to provide the disabilities that prevent you from working. We also ask you to tell us if you require the regular assistance of another person, if you are housebound, if you are in a nursing home, if you are in receipt of Social Security, or if you have applied for Medicaid.

Part VIII - Income Information

This section asks you to provide specific information about the monthly income you and your dependants receive from all sources. Report the gross amount you receive monthly before deductions are taken out for taxes, health care, insurance, etc. Do **not** leave any blank boxes in this section! Complete each box with either a dollar figure, "0", or "none." If you expect to receive payment, but you don't know how much it will be, write "Unknown" in the space. If you are not sure about a particular type of income, report it and provide a full explanation of its source. If you are receiving monthly benefits from any source and have a copy of your most recent award letter, please include a copy of the letter with your application.

Part IX - Net Worth

This section asks you to provide specific information about your net worth and that of your dependents. **Do not leave any blank boxes in this section!** Complete each box with either a dollar figure, "0", or "none."

Net worth is the market value of all interest and rights in any kind of property, after subtracting any mortgages and other claims against the property. List all assets except the house in which you live, any reasonable area of land on which it sits, and those items you use everyday, such as your vehicle, clothing and furniture.

Clearly indicate if you and your spouse jointly share assets (such as money in a joint checking account). Report the value of farms or buildings that you or a dependent owns as "real property."

You must disclose all financial transactions that involve a transfer of assets, even if the transaction occurred prior to the date of your application for VA pension. A gift of property or a sale below the property's value to a relative residing in the same household does not reduce net worth. Likewise, a gift of property to someone other than a relative residing in your household does not reduce net worth unless it is clear that you have relinquished all rights of ownership, including the right to control the property.

Part X - Medical, Legal or Other Expenses

When determining your eligibility for pension, we may be able to deduct unreimbursed medical expenses from your income for the year in which the expenses are paid. Report the amount of unreimbursed medical expenses, including the Medicare deductions you paid (out-of-pocket) for yourself or relatives you are under an obligation to support. Also, show medical, legal, or other expenses you paid because of a disability for which civilian disability benefits have been awarded. **Do not** report any expenses you did not pay or expenses for which you were or will be reimbursed.

PRIVACY ACT INFORMATION: 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, no allowance of compensation or pension may be granted unless this form is completed fully as required by law. Giving us you and your dependents' Social Security numbers is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed 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 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 under the law. Information submitted is subject to verification through computer matching programs with other Federal or state agencies. Income and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103(1)(7)(D) of the Internal Revenue Code of 1986.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation and/or pension (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 1 hour 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. 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: 1 hour

Department of Veterans Affairs

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT - Read information and instructions carefully before completing the form. Type, print, or write plainly.

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

PART I - VETERAN'S INFORMATION

1. FOR WHAT BENEFIT ARE YOU APPLYING?
☐ COMPENSATION ☐ PENSION ☐ BOTH COMPENSATION AND PENSION

2. HAVE YOU PREVIOUSLY APPLIED FOR ANY VA BENEFIT(S)? *(Check applicable box)*
☐ PENSION ☐ COMPENSATION ☐ OTHER *(Specify)*

3. FIRST, MIDDLE, LAST NAME OF VETERAN

4A. VETERAN'S SOCIAL SECURITY NO.	4B. VA FILE NUMBER *(If applicable)*	4C. SPOUSE'S SOCIAL SECURITY NO.

4D. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.

5. MAILING ADDRESS *(Number and street or rural route, city or P.O., State and ZIP Code)*

6. TELEPHONE NUMBER(S) *(Include Area Code)*			7. E - MAIL ADDRESS *(If applicable)*
A. DAYTIME	B. EVENING	C. CELL	

8A. DATE OF BIRTH *(Month, day, year)*	8B. PLACE OF BIRTH	9. SEX
		☐ MALE ☐ FEMALE

10A. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? *(Formerly the U.S. Bureau of Employees Compensation)*	10B. WHEN WAS THE CLAIM FILED? *(Mo., day, yr.)*	10C. FOR WHAT DISABILITY ARE YOU RECEIVING BENEFITS?
☐ YES ☐ NO *(If "Yes," complete Items 10B & 10C)*		

PART II - NATURE AND HISTORY OF SERVICE-RELATED DISABILITY(IES) - If you need more space please use Item 45, "Remarks"

11. PLEASE PROVIDE NATURE OF SICKNESS, DISEASE, OR INJURIES FOR WHICH THIS CLAIM IS MADE; DATE EACH BEGAN; AND PLACE OF TREATMENT

A. LIST DISABILITY(IES)	B. DATE BEGAN	C. PLACE OF TREATMENT

12A. ARE YOU NOW OR HAVE YOU RECEIVED TREATMENT OR DOMICILIARY CARE AT A VA MEDICAL FACILITY?	12B. DATES OF TREATMENT/CARE			12C. NAME AND ADDRESS OF VA MEDICAL FACILITY *(If you need more space use Item 45, "Remarks")*
	Month	Day	Year	
☐ YES ☐ NO *(If "Yes," complete Items 12B &12C)*				

13A. HAVE YOU EVER BEEN A PRISONER OF WAR?	13B. NAME OF COUNTRY	13C. DATES OF CONFINEMENT	
		FROM	TO
☐ YES ☐ NO *(If "Yes," complete Items 13B and 13C)*			

14. ARE YOU CLAIMING A DISABILITY RELATED TO AGENT ORANGE OR OTHER HERBICIDE EXPOSURE? *(If "Yes," list disability(ies) below)*	15. ARE YOU CLAIMING A DISABILITY RELATED TO ASBESTOS EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO	☐ YES ☐ NO

16. ARE YOU CLAIMING A DISABILITY RELATED TO MUSTARD GAS EXPOSURE? *(If "Yes," list disability(ies) below)*	17. ARE YOU CLAIMING A DISABILITY RELATED TO IONIZING RADIATION EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO	☐ YES ☐ NO

18. ARE YOU CLAIMING A DISABILITY RELATED TO AN ENVIRONMENTAL HAZARD EXPOSURE DURING THE GULF WAR? *(If "Yes," list disability(ies) below)*

☐ YES ☐ NO

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART III - ACTIVE DUTY SERVICE INFORMATION

NOTE: Please complete the information for each period of active duty. Attach DD214 or other separation papers for all periods of active duty. If you do not have your DD214 form or other separation papers, check the box. ☐

19A. ENTERED INTO SERVICE		19B. SERVICE NUMBER	19C. SEPARATED FROM SERVICE		19D. BRANCH OF SERVICE	19E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

PART IV - RESERVE AND NATIONAL GUARD SERVICE INFORMATION

NOTE: Enter complete information for each period of Reserves and National Guard service. Attach any separation papers you have.

20A. ENTERED INTO SERVICE		20B. SERVICE NUMBER	20C. SEPARATED FROM SERVICE		20D. SERVICE STATUS *(Reserve, National Guard)*	20E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

21. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE	22A. ARE YOU NOW A MEMBER OF THE RESERVES OR NATIONAL GUARD? IF SO, GIVE THE BRANCH OF SERVICE ☐ YES ☐ NO BRANCH _____	22B. RESERVE STATUS ☐ ACTIVE ☐ RESERVE OBLIGATION ☐ INACTIVE

22C. NAME, ADDRESS AND PHONE NO. OF RESERVE OR NATIONAL GUARD UNIT *(If additional space is needed, use Item 45 "Remarks")*

PART V - MILITARY RETIRED/SEVERANCE PAY

IMPORTANT - Unless you check the box in Item 25 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 the amount of any compensation that you are awarded. 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 receive may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

23A. ARE YOU RECEIVING MILITARY RETIRED PAY? *(If "Yes," complete Items 23C & 23D)* ☐ YES ☐ NO	23B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? *(If "Yes," explain, i.e. Future Reserve/National Guard Retirement, Pending MEB/PEB)* ☐ YES ☐ NO _____	23C. BRANCH OF SERVICE	23D. MONTHLY AMOUNT $

24. RETIRED STATUS ☐ RETIRED ☐ TEMPORARY DISABILITY RETIRED LIST ☐ DISABLED RETIRED LIST	25. NO, I DO NOT WANT VA COMPENSATION IN LIEU OF MILITARY RETIRED PAY ☐ *(Check box, if applicable)*

26. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE/SEPARATION PAY, OR ANY OTHER LUMP SUM PAYMENT FROM THE ARMED FORCES? *(If "Yes," list type, amount, date it was received, and the branch of service below)*

☐ YES ☐ NO _____

PART VI - MARITAL AND DEPENDENCY INFORMATION

27A. MARITAL STATUS *(If married, complete Items 27B thru 29D)* ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NEVER MARRIED *(If never married, skip to Item 30)*			27B. SPOUSES'S BIRTHDATE *(Mo., day, yr.)*
27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED *(To include current marriage)*	27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED *(To include current marriage)*	27E. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO *(If "Yes," complete Item 27F)*	27F. SPOUSE'S VA FILE NUMBER *(If any)* C-
27G. DO YOU LIVE TOGETHER? ☐ YES ☐ NO *(If "No," complete Items 27H thru 27J)*		27H. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*	27I. PRESENT ADDRESS OF SPOUSE

27J. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S MONTHLY SUPPORT $	27K. HOW WERE YOU MARRIED? ☐ CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL ☐ TRIBAL ☐ OTHER *(Explain)* ☐ COMMON-LAW ☐ PROXY _____

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VI - MARITAL AND DEPENDENCY INFORMATION - CONTINUED *(If you need additional space, use Item 45 "Remarks")*

FURNISH THE FOLLOWING INFORMATION ABOUT EACH OF YOUR MARRIAGES *(IF NOT APPLICABLE, WRITE "N/A")*

28A. DATE AND PLACE OF MARRIAGE		28B. TO WHOM MARRIED	28C. TERMINATED *(Death, Divorce)*	28D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE *(IF NOT APPLICABLE, WRITE "N/A")*

29A. DATE AND PLACE OF MARRIAGE		29B. TO WHOM MARRIED	29C. TERMINATED *(Death, Divorce)*	29D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

DEPENDENCY - Dependent Children Information *(If you need additional space, use Item 45 "Remarks")*

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN

30A. NAME OF CHILD *(First, middle initial, last)*	30B. DATE & PLACE OF BIRTH *(City, state or country)*	30C. SOCIAL SECURITY NUMBER	30D. CHECK EACH APPLICABLE CATEGORY					
			BIOLOGICAL	ADOPTED	STEPCHILD	18-23 YRS. OLD AND IN SCHOOL	SERIOUSLY DISABLED BEFORE AGE 18	CHILD PREVIOUSLY MARRIED
	_____ *(Month, day, year)* Place:		☐	☐	☐	☐	☐	☐
	_____ *(Month, day, year)* Place:		☐	☐	☐	☐	☐	☐
	_____ *(Month, day, year)* Place:		☐	☐	☐	☐	☐	☐

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN WHO DO NOT LIVE WITH YOU

31A. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	31B. NAME AND ADDRESS OF PERSON HAVING CUSTODY	31C. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		$
		$

PART VII - NON-SERVICE CONNECTED PENSION *(If you need additional space use Item 45 "Remarks")*

NOTE: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

32. WHAT DISABILITIES PREVENT YOU FROM WORKING? *(List below)*	33. DO YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON OR ARE YOU GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?
	☐ YES ☐ NO

NURSING HOME INFORMATION

NOTE: You may submit a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.

34A. ARE YOU NOW IN A NURSING HOME?	34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY	34C. HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☐ NO *(If "YES," complete Items 34B thru 34D)*		☐ YES ☐ NO

34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION?	34E. ARE YOU RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSI BUT NO DECISION HAS BEEN MADE?
☐ YES ☐ NO ☐ APPLIED - NOT RECEIVED DECISION	☐ YES ☐ NO ☐ APPLIED - NOT RECEIVED DECISION

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VIII - INCOME INFORMATION *(Provide the income you received from all sources)*

NOTE: Report the total income before deductions for taxes, insurance, etc. If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space. If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid. Payments from any source will be counted, unless the law says that they don't need to be counted.

MONTHLY INCOME - Provide the income that you and your dependents receive every month. For items 35A -35F, if none, write "0" or "NONE." Do not leave blank spaces.

ITEM NO.	SOURCES OF RECURRING MONTHLY INCOME	VETERAN	SPOUSE	CHILD(REN) *(Provide the first, middle initial, and last name)* NAME	NAME	NAME
35A.	Social Security					
35B.	U.S. Civil Service					
35C.	U.S. Railroad Retirement					
35D.	Military Retired Pay					
35E.	Black Lung Benefits					
35F.	Other *(Interest, dividends, or one-time payments)*					

36A. WILL YOU RECEIVE ANY INCOME FROM RENTAL PROPERTY OR FROM THE OPERATION OF A BUSINESS WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?	36B. WILL YOU RECEIVE ANY INCOME FROM THE OPERATION OF A FARM WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?	36C. DO YOU THINK YOUR INCOME WILL CHANGE IN THE NEXT 12 MONTHS? *(If "Yes," explain below)*
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO _____ _____

PART IX - NET WORTH *(Provide specific information about the net worth of you and your dependents)*

NET WORTH is the market value of all interest and rights in any kind of property after subtracting any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal items such as your vehicle, clothing, and furniture.

NOTE: For Items 37A-37F provide amounts. If none, write "0" OR "NONE." Do not leave blank spaces.

ITEM NO.	SOURCE	VETERAN	SPOUSE	CHILD(REN) *(Provide the first, middle initial, and last name)* NAME	NAME	NAME
37A.	Cash, non-interest bearing bank accounts					
37B.	Interest bearing bank accounts, certificates of deposit *(CDs)*					
37C.	Retirement accounts *(IRAs, Keogh Plans, etc.)*					
37D.	Stocks, bonds, and mutual funds					
37E.	Value of business assets					
37F.	Real property *(not your home)*					

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART X - MEDICAL, LEGAL, OR OTHER EXPENSES

IMPORTANT - Complete items 38A through 38E only if you are applying for nonservice connected pension.

MEDICAL, LEGAL OR OTHER EXPENSES - Family medical expenses you actually paid (out-of-pocket) may be deducted from your income. Show the amount of unreimbursed medical expenses you paid for dependents you are under an obligation to support. Also, 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 increase benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Be sure to include the Medicare deduction. If more space is needed, you may use Item 45, "Remarks" or attach a separate sheet.

38A. AMOUNT YOU PAID	38B. DATE PAID *(Month, year)*	38C. PURPOSE *(Doctor's fees, hospital charges, attorney fees, etc.)*	38D. PAID TO *(Name of doctor, hospital, pharmacy, attorney, etc.)*	38E. PERSON FOR WHOM EXPENSE PAID *(Self, spouse, child)*

PART XI - DIRECT DEPOSIT

Generally, all Federal payments are required to 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 39, 40, and 41 to enroll in direct deposit. If you do not have a bank account you can receive a waiver from direct deposit, by checking the box below in Item 39. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in direct deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in direct deposit.

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

☐ CHECKING _____ (Account Number)

☐ SAVINGS _____ (Account Number)

☐ I certify that I do not have an account with a financial institution or certified payment agent

40. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit to go)*	41. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check or savings deposit slip)*

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART XII - CERTIFICATION, AUTHORIZATION, AND SIGNATURE(S)

I certify that the statements in this document are true and complete to the best of my knowledge and belief. 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.

IMPORTANT - If you sign with an "X", then you must have 2 people witness your signature. They must then print their names and addresses and sign the form.

42A. VETERAN'S SIGNATURE *(Do not print) (Please sign in ink)*	42B. VETERAN'S PRINTED NAME	42C. DATE SIGNED

43A. SIGNATURE OF WITNESS *(Do not print)*	43B. PRINTED NAME AND ADDRESS OF WITNESS

44A. SIGNATURE OF WITNESS *(Do not print)*	44B. PRINTED NAME AND ADDRESS OF WITNESS

PART XIII - REMARKS *(Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension)*

45. REMARKS *(If you need more space you may attach a separate sheet of paper)*

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.

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON THIS PAGE.

Department of Veterans Affairs

GENERAL INSTRUCTIONS

FOR APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION, DEATH PENSION AND ACCRUED BENEFITS BY A SURVIVING SPOUSE OR CHILD (INCLUDING DEATH COMPENSATION IF APPLICABLE)

VA FORM 21-534

Note: Read very carefully, detach, and keep these instructions for your reference.

A. How can I contact VA if I have questions?

If you have any questions about this form, how to fill it out, or about VA benefits, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government, Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line 1-800-829-4833). You may also contact VA by Internet at https://iris.va.gov .

B. What is the purpose of VA Form 21-534?

Use VA Form 21-534 to apply for:

- VA benefits you may be entitled to receive as a surviving spouse or child of a deceased veteran, and
- any money VA owes the veteran but did not pay prior to his/her death (accrued benefits).

If you apply for any one of these benefits, the law requires that we also consider you for the others.

C. What is the purpose of the attached SSA-24 form?

You can apply for Social Security (SS) benefits by using the SSA-24 form attached to this VA Form (see pages 9 and 10). You don't have to apply if you don't want to or have already done so. If you do want to apply, fill it out and leave it attached. We will send it to the Social Security Administration for you. They will then contact you.

D. What are dependency and indemnity compensation (DIC) and death pension benefits, and how does VA decide what I will or will not receive?

1. Dependency and indemnity compensation may be payable when:

- a veteran's death occurred in service, or
- a veteran dies of a service-connected disability, or
- in certain circumstances if a veteran rated totally disabled from service-connected disability dies from non-service-connected conditions.

2. Death pension may be payable when:

- the death of a veteran with wartime service is not due to service, and
- income is within applicable limits.

VA pays pension based on the amount of family income and the number of dependent children. This is based on law. VA must include as income all sources that Federal law specifies. If there is no surviving spouse, pension may be payable on behalf of a child or children.

Unless a claim for dependency and indemnity compensation or death pension is filed within one year from the date of the veteran's death, that benefit is not payable from a date earlier than the date the claim is received in the VA.

If it is determined that you are entitled to DIC and death pension, we will pay you whichever benefit entitles you to the most money. Benefit rates and income limits are frequently changed, so it is not possible to keep this information current in these instructions. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA regional office.

E. How do I apply for aid and attendance allowance and/or housebound benefits?

VA may pay a higher rate of DIC or pension to a surviving spouse who is blind, a patient in a nursing home, otherwise needs regular aid and attendance, or who is permanently confined to his or her home because of a disability. If you wish to apply for this benefit, check "Yes" for Item 31.

F. How do I complete my application?

Print all answers clearly. If an answer is "none" or "0," write that. Your answer to every question is important to help us complete your claim. If you do not know the answer, write "unknown." For additional space, use Item 48, "Remarks, " or attach a separate sheet, indicating the item number to which the answers apply. Make sure you sign and date this application (Items 44 and 45).

Note: If the claim is being made on behalf of a minor or incompetent person, the application form should be completed and filed by the legal guardian. If no legal guardian has been appointed, it may be completed and filed by some person acting on behalf of the minor or incompetent person.

G. What do I do when I have completed my application?

When you have completed this application mail it or take it to a VA regional office. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before mailing it.

H. How can I assign someone to act as my representative?

A representative can be an accredited member of an accredited organization or other service organization that the Secretary of Veterans Affairs recognizes, an agent recognized by VA, or a licensed lawyer. Agents and attorneys can charge you for services that you get from them only after the Board of Veteran's Appeals (BVA) gives you their final decision about your application. That means you can use an attorney during any stage of your application for benefits. However, the agent or attorney cannot charge your for services unless you are trying to resolve a dispute with VA after BVA has made a decision about your claim.

If you want to use a representative to help you with your application, contact the nearest VA office. Depending on the type of representative you want to designate, we will send you one of the following forms:

VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, or VA Form 22A, Appointment of Individual as Claimant's Representative. You may also download these forms at www.va.gov/vaforms. If you have already designated a representative, no further action is required on your part.

I. What if I believe that VA has made an error in processing or deciding my benefits?

You can ask for a personal hearing at any time during the processing of your claim. That means you can ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA office and tell them that you want a personal hearing on your case. Someone in the local VA office will arrange a time and place for your hearing. At this hearing, you can bring witnesses. VA will record whatever you and your witnesses say during the hearing and include it in the official record. VA will furnish the hearing room and officials, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing.

PRIVACY ACT INFORMATION: 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 l 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 determine eligibility for death benefits and accrued benefits under 38 U.S.C. 1310 through 1314, 1532 through 1543, and 5121. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Department of Veterans Affairs

OMB Approved No. 2900-0004
Respondent Burden: 1 hour 15 minutes

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable)
VA Form 21-534

Please read the attached "General Instructions" before you fill out this form.

SECTION I

Tell us what you are applying for and what you and the deceased veteran have applied for

1. Did the veteran ever file a claim with VA? ☐ YES ☐ NO *(If "Yes," answer Item 2)*

2. What is the VA file number?

3. Has the surviving spouse or child ever filed a claim with VA? ☐ YES ☐ NO *(If "Yes," answer Items 4 through 6)*

4. What is the VA file number?

5. What is the name of the person on whose service the claim was filed?
First Middle Last

6. What is your relationship to that person?

7. Are you claiming service connection for cause of death? ☐ YES ☐ NO

SECTION II

Tell us about you and the deceased veteran

8. What is the veteran's name?
First Middle Last Suffix *(If applicable)*

9. What is the veteran's Social Security number?

10a. Did the veteran serve under another name? ☐ YES ☐ NO *(If "Yes," answer Item 10b)*

10b. Please list the other name(s) the veteran served under:

11. What is the veteran's date of birth?
mo day yr

Attach a copy of the death certificate unless the veteran died in active service of the Army, Navy, Air Force, Marine Corps, or Coast Guard, or in a U.S. government institution. ▶

12. What is the veteran's date of death?
mo day yr

13. Was the veteran a former prisoner of war? ☐ YES ☐ NO

14. What is your name? *(First, Middle, Last Name)*

15. What is your relationship to the veteran? *(check one)* ☐ Surviving Spouse ☐ Child

16. What is your address?
Street address, Rural Route, or P.O. Box Apt. number
City State ZIP Code Country

17. What are your telephone numbers? *(Include Area Code)*
Daytime
Evening

18. What is your e-mail address?

19. What is your Social Security number?

20. What is your date of birth?
mo day yr

SECTION III

Tell us about the veteran's active duty service

1. Enter complete information for all periods of service. If more space is needed use Item 48 "Remarks."

2. If the veteran never filed a claim with VA, attach the original DD214 or a certified copy for each period of service listed. We will return original documents to you.

Note: Skip to Section IV if the veteran was receiving VA compensation or pension at the time of his/her death.

21a. Entered Active Service *(first period)* _____ mo day yr	21b. Place	21c. Service Number	
21d. Left This Active Service _____ mo day yr	21e. Place	21f. Branch of Service	21g. Grade, Rank, or Rating
21h. Entered Active Service *(second period)* _____ mo day yr	21i. Place	21j. Service Number	
21k. Left This Active Service _____ mo day yr	21l. Place	21m. Branch of Service	21n. Grade, Rank, or Rating

SECTION IV

Tell us about your and the veteran's marriages

Attach a copy of your marriage certificate showing your marriage to the veteran.

You must furnish complete information about ***all*** marriages of the surviving spouse and the veteran. If you need additional space, please attach a separate sheet of paper providing the requested information.

If you are claiming benefits as the surviving spouse of the veteran you should complete Items 22a through 27. If you are not the surviving spouse, skip to Section V.

The veteran's marriages

22a. How many times was the veteran married? _____

22b. Date of Marriage *(month, day, year)*	22c. Place *(city/state or country)*	22d. To whom married *(first, middle initial, last name)*	22e. Type of marriage *(ceremonial, common-law, proxy, tribal or other*	22f. Date marriage ended *(month, day, year)*	22g. Place *(city/state or country)*	22h. How marriage ended *(death, divorce)*

22i. If you indicated "other" as type of marriage, please explain. _____

22j. 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 you answered "Yes," please explain.

23a. How many times were you married? _____ 23b. Have you remarried since the death of the veteran? ☐ YES ☐ NO

23c. Date of Marriage *(month, day, year)*	23d. Place *(city/state or country)*	23e. To whom married *(first, middle initial, last name)*	23f. Type of marriage *(ceremonial, common-law, proxy, tribal or other*	23g. Date marriage ended *(month, day, year)*	23h. Place *(city/state or country)*	23i. How marriage ended *(death, divorce)*

23j. If you indicated "other" as type of marriage, please explain. _____

SECTION IV Tell us about your and the veteran's marital history (continued)

Answer Item 24 only if you were married to the veteran for less than one year.

24. Was a child born to you and the veteran during your marriage or prior to your marriage?

☐ YES ☐ NO

25. Are you expecting the birth of a child of the veteran?

☐ YES ☐ NO

26. Did you live continuously with the veteran from the date of marriage to the date of his/her death?

☐ YES ☐ NO

(If "No", answer Item 27)

27. 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.

SECTION V

Tell us about the unmarried children of the veteran

Note: You should provide a copy of the public record of birth or a copy of the court record of adoption for each child listed in Item 28a ***unless*** the veteran was receiving additional VA benefits for the child.

If you need additional space, please attach a separate sheet of paper providing the requested information about each child.

Note: Skip to Section VI if you are not claiming benefits for any children that meet the following criteria.

VA recognizes the veteran's biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 29e) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note to surviving spouse: If entitlement to DIC is established, a "seriously disabled" child over age 18 is entitled to receive DIC benefits in his or her own right. A veteran's child who is seriously disabled and over age 18 must submit a separate VA Form 21-534 to apply for benefits.

28a. Name of child *(First, middle initial, Last)*	28b. Date and place of birth *(City/State or Country)*	28c. Social Security Number	29a. Biological	29b. Adopted	29c. Stepchild	29d. 18 - 23 yrs old and in school	29e. Seriously disabled	29f. Child previously married
	mo day yr		☐	☐	☐	☐	☐	☐
	mo day yr		☐	☐	☐	☐	☐	☐
	mo day yr		☐	☐	☐	☐	☐	☐

SECTION V Tell us about the unmarried children of the veteran (continued)

Tell us about the children listed above that don't live with you.

30a. Name of child *(first, middle initial, last)*	30b. Child's Complete Address	30c. Name of person the child lives with *(if applicable)*	30d. Monthly amount you contribute to child's support
			$
			$
			$
			$

SECTION VI

Tell us if you are housebound, in a nursing home or require aid and attendance

If you answered "yes" to Item 31 and are not in a nursing home, submit a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, the amount you pay out-of-pocket for your care, and whether Medicaid covers all or part of your nursing home costs.

31. Are you claiming aid and attendance allowance and/or housebound benefits because you need the regular assistance of another person, are having severe visual problems, or are housebound?

☐ YES ☐ NO

(If "No," skip to section VII)

32a. Are you now in a nursing home?

☐ YES ☐ NO

(If "Yes," answer Items 32b and 32c also)

32b. What is the name and complete mailing address of the facility?

32c. Does Medicaid cover all or part of your nursing home costs?

☐ YES ☐ NO

(If "No," answer Item 32d also)

32d. Have you applied for Medicaid?

☐ YES ☐ NO

SECTION VII

Tell us the net worth of you and your dependents

Note: If you are filing this application on behalf of a minor or incompetent child of the veteran and you are the child's custodian, you must report your net worth as well as the net worth of the child for whom benefits are claimed.

VA cannot pay you pension if your net worth is sizeable. Net worth is the market value of all interest and rights you have in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture. You must report net worth for yourself and all persons for whom you are claiming benefits.

For Items 33a through 33f, provide the amounts. If none, write "0" or "None."

Source	Surviving spouse or Custodian of children	Child(ren)		
		Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*
33a. Cash, bank accounts, certificates of deposit (CDs)				
33b. IRAs, Keogh Plans, etc.				
33c. Stocks, bonds, mutual funds				
33d. Value of business assets				
33e. Real property *(not your home)*				
33f. All other property				

SECTION VIII

Tell us about the income of you and your dependents

Payments from any source will be counted, unless the law says that they don't need to be counted. Report **all** income, and VA will determine any amount that does not count.

Note: If you are filing this application on behalf of a minor of whom you are the custodian, you must report your income as well as the income of each child for whom benefits are claimed.

Report the total amounts before you take out deductions for taxes, insurance, etc.
Do not report the same information in both tables.
If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.
If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space.
If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

34a. Have you claimed or are you receiving benefits from the Social Security Administration on your own behalf or on behalf of child(ren) in your custody?

☐ YES ☐ NO

(If "Yes," answer item 34b)

34b. Is Social Security based on your own employment?

☐ YES ☐ NO

35. Has a surviving spouse or child filed a claim for compensation from the Office of Worker's Compensation Programs based on the death of the veteran?

☐ YES ☐ NO

36. Has a court awarded damages based on the death of the veteran or is a claim or legal action for damages pending?

☐ YES ☐ NO

37. Have you claimed or are you receiving Survivor Benefit Plan (SBP) annuity from a service department based on the death of the veteran?

☐ YES ☐ NO

SECTION VIII Tell us about the income of you and your dependents (continued)

Monthly Income - Tell us the income you and your dependents receive every month

Source	Surviving spouse or Custodian of children	Child(ren)		
		Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*
38a. Social Security				
38b. U.S. Civil Service				
38c. U.S. Railroad Retirement				
38d. Military Retirement				
38e. Black Lung Benefits				
38f. Supplemental Security Income (SSI)/ Public Assistance				
38g. Other income received monthly *(Please write source below:)*				

Expected income next 12 months - Tell us about other income for you and your dependents

Report expected 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 income for the 12 month period from the date you sign this application.

Sources of income for the next 12 months	Surviving spouse or Custodian of children	Child(ren)		
		Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*
39a. Gross wages and salary				
39b. Total dividends and interest				
39c. Other income expected *(Please write source below:)*				
39d. Other income expected *(Please write source below:)*				

SECTION IX

Tell us about 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. If more space is needed attach a separate sheet.

40a. Amount paid by you	40b. Date Paid	40c. Purpose *(Medicare deduction, nursing home costs, burial expenses, etc.)*	40d. Paid to *(Name of nursing home, hospital, funeral home, etc.)*	40e. Relationship of person for whom expenses paid
$	mo day yr			
$	mo day yr			
$	mo day yr			
$	mo day yr			

SECTION X

Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All Federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer questions 41-43 to the right.

All Federal payments beginning January 2, 1999, must 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 we will give you a waiver from Direct Deposit, just check the box below in Item 41. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

41. Account number *(Please check the appropriate box and provide that account number, if applicable)*

☐ Checking ☐ Savings

☐ I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

42. Name of financial institution

_____

43. Routing or transit number

_____

SECTION XI

Give us your signature

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

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.

44. Your signature	45. Today's date

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

SECTION XII

Remarks - Use this space for any additional statements that you would like to make concerning your application.

48. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form please identify your answer or statement by the part and item number)*

IMPORTANT

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 which you are not entitled to.

Form Approved
OMB Approved No. 0960-0062

SOCIAL SECURITY ADMINISTRATION

APPLICATION FOR SURVIVORS BENEFITS

(PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT)

IMPORTANT - Read instructions before completing form. Detach and retain ONLY the instruction sheet.

(DO NOT WRITE IN THIS SPACE)
VA DATE STAMP

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	2. DATE OF DEATH

NOTE: If the veteran's Social Security No. is unknown, complete Items 4, 5, 6 and 7 about veteran.

3. SOCIAL SECURITY NO. OF VETERAN	4. DATE OF BIRTH	5. PLACE OF BIRTH

6. NAME OF FATHER	7. MAIDEN NAME OF MOTHER	8. DID THE VETERAN WORK IN THE RAILROAD INDUSTRY AT ANY TIME AFTER 1936? ☐ YES ☐ NO

NOTE: The following information should be furnished for each period of the veteran's active service (regular or reserves) after September 7, 1939, in the military service of the United States or service as a commissioned officer in the Public Health Service or the National Oceanic and Atmospheric Administration or during WWII, Philippine or Filipino or Allied country military service. If additional space is needed, attach a separate sheet.

9A. DATE ENTERED ACTIVE SERVICE	9B. SERVICE NO.	9C. DATE SEPARATED FROM ACTIVE SERVICE	9D. GRADE, RANK, OR RATING, ORGANIZATION AND BRANCH OF SERVICE

10. RELATIONSHIP OF APPLICANT TO VETERAN ☐ SURVIVING SPOUSE ☐ CHILD ☐ PARENT	11. DATE OF BIRTH OF APPLICANT	12. VA FILE NO.

CHILDREN: Show names of surviving children (including natural children, adopted children and stepchildren) or dependent grandchildren (including stepgrandchildren) who at any time since the veteran died, were unmarried and (a) under age 18; (b) age 18 to 19 and attending secondary school; (c) disabled or handicapped (18 or over and disability began before age 22).

13A.	13B.
13C.	13D.

I know that anyone who makes or causes to be made a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both. I affirm that all information I have given in this document is true.

14. DATE *(Month, day, year)*	15. SIGNATURE OF APPLICANT *(First name, middle initial, last name) (Sign in ink)*

16. MAILING ADDRESS OF APPLICANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	17. TELEPHONE NO. *(Include Area Code)*

WITNESSES REQUIRED ONLY IF SIGNATURE OF APPLICANT IS MADE BY "X" MARK ABOVE

18A. SIGNATURE OF WITNESS	18B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)*
19A. SIGNATURE OF WITNESS	**19B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)***

ITEMS BELOW TO BE COMPLETED BY THE DEPARTMENT OF VETERANS AFFAIRS Use reverse for "Remarks"

20. PROOFS RECEIVED		21. PROOFS REQUESTED FROM CLAIMANT OR OTHER *(Specify)*	
☐ DEATH	☐ MARRIAGE	☐ DEATH	☐ MARRIAGE
☐ AGE	_____ (NAME)	☐ AGE	_____ (NAME)
☐ OTHER *(Specify)*	_____ (NAME)	☐ OTHER *(Specify)*	_____ (NAME)
	_____ (NAME)		_____ (NAME)

22. DATE	23. NAME AND ADDRESS OF TRANSMITTING VA OFFICE

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE YOU COMPLETE THE SSA-24.
INSTRUCTIONS FOR COMPLETING FORM SSA-24, APPLICATION FOR SURVIVORS BENEFITS
(Payable Under Title II of the Social Security Act)

This application form, SSA-24, is an Application for Survivors Benefits Payable under Title II of the Social Security Act, as amended. Under authority of section 202(o) of the Social Security Act, the application requests information in order to determine eligibility to social security benefits.

You **do not** have to complete this application; there are no penalties under the law if you do not complete part or all of the SSA-24. However, it is usually to your advantage to provide the information because not providing it could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

If you **do** wish to supply the information requested on the SSA-24, this information will be forwarded to the Social Security Administration and used by them to determine whether social security benefits may be payable to surviving dependent(s) of the veteran. Social Security will then contact you regarding any social security benefits payable based on information given on this form.

Please understand that Social Security may, in certain instances, disclose the information on this form to another Federal, State or local agency or individual without your written consent. This would be done in order to:

- enable a third party or an agency to assist Social Security in establishing an individual's right to benefits or coverage;
- comply with Federal laws which require or authorize the release of information from social security records; and
- facilitate statistical research and audit activities necessary to assure the integrity and improvement of the social security programs.

If you should have any question about entitlement to social security benefits or the information you have provided on this form, please contact your local social security office.

Complete each item of the attached application, Form SSA-24, (except Items 20 through 23). When signed and dated the form SHOULD BE LEFT ATTACHED to your completed

- VA Form21-534, Application for Dependency and Indemnity Compensation, Death Pension a nd Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable) or
- VA Form 21-535, Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation When Applicable).

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 15 minutes to read the instructions, gather the necessary facts, and answer the questions.

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system, or dental benefits. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 45 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at http://www.va.gov and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started:

ALL VETERANS MUST COMPLETE SECTIONS I - IV.

Directions for Sections I - IV:

Section I - General Information: Answer all questions. **Note:** *Veterans determined by a VA clinician to be Catastrophically Disabled are enrolled in Priority Group 4, unless eligible for a higher Priority Group, and are exempt from inpatient, outpatient and prescription copays. However, these Veterans may still be subject to copayments for extended care (long-term) services.*

Section II - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Section III - Employment Information: If you are employed or retired, answer all questions.

Section IV - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Directions for Sections V - IX:

Section V - Financial Disclosure: ONLY NSC and 0% NONCOMPENSABLE SERVICE-CONNECTED VETERANS WHO ARE NOT:

- a former Prisoner of War or;
- in receipt of a Purple Heart or;
- a recently discharged Combat Veteran or;
- discharged for a disability incurred or aggravated in the line of duty or;
- receiving VA service-connected disability compensation or;
- receiving VA pension or;
- in receipt of Medicaid benefits or;
- determined by VA to be Catastrophically Disabled

MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA health care enrollment and/or care or services. *Failure to provide financial information, if required to do so, may result in denial of VA health care enrollment.*

Continued ...

Section VI - Dependent Information: Your spouse and dependent social security number(s) are required so we can verify their financial and insurance information through a computer-matching program.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children: Answer applicable questions

Section VIII - Previous Calendar Year Deductible Expenses: Answer applicable questions

Section IX - Previous Calendar Year Net Worth: Answer applicable questions

NOTE: All other Veterans may wish to provide this financial assessment to determine, **as applicable**, their eligibility for cost-free medication for their NSC conditions, beneficiary travel eligibility and/or waiver of the beneficiary travel deductible requirement.

Additional Information for Completing your application ...

Answer all questions in the appropriate sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information.

Include information for all health insurance policies that cover you, this includes coverage that is provided through a spouse or significant other. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information.

If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your Purple Heart status, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating your award. To reduce processing time, you may submit a copy of this documentation with your application.

Section V - Financial Disclosure.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information and agree to make co-payments for treatment of your NSC conditions. If a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of deductible, and you do not disclose your financial information, you may not be eligible for these benefits.

Section VI - Dependent Information - Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Continued ...

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI)and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payment; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report expenses of last illness and burial expenses, e.g., prepaid burial, paid by the veteran for spouse or dependent(s).

Section IX - Previous Calendar Net Worth.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Submitting your application.

1. Read Section X, Paperwork Reduction and Privacy Act Information , Section XI Consent to Copays and Section XII, Assignment of Benefits.
2. In Section XII, you or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to your local VA health care facility. You can find the address by calling VA at 1-877-222-VETS (8387), or on the Internet at http://www.va.gov.

OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.

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)

1. VETERAN'S NAME *(Last, First, Middle Name)*	2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER ☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO	6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER	8. VA CLAIM NUMBER	9. DATE OF BIRTH *(mm dd yyyy)*

9A. PLACE OF BIRTH *(City and State)*	10. RELIGION

11. PERMANENT ADDRESS *(Street)*	11A. CITY	11B. STATE	11C. ZIP CODE

11D. COUNTY	11E. HOME TELEPHONE NUMBER *(Include area code)*	11F. E-MAIL ADDRESS

11G. CELLULAR TELEPHONE NUMBER *(Include area code)*	12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)* ☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL

13. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.

15. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

16. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	16A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
	16B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
17. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT *(if different than 16)*	17A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
	17B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

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

1. ENTER 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	5A. EFFECTIVE DATE *(mm/dd/yyyy)*

6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO	6A. EFFECTIVE DATE *(mm/dd/yyyy)*
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? ☐ YES ☐ NO	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD	9. MEDICARE CLAIM NUMBER

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

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ***If employed or retired, complete item 1A*** ☐ PART TIME ☐ RETIRED *Date of retirement (mm dd yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ***If employed or retired, complete item 2A*** ☐ PART TIME ☐ RETIRED *Date of retirement (mm dd yyyy)*	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
C. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
D1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	I. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. **Recent Combat Veterans are eligible for enrollment without disclosing their financial information** but like other Veterans may provide it to establish their eligibility for travel assistance, cost-free medication and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VI through IX.** I understand that VA is not enrolling new applicants who do not provide this information and who do not have other qualifying eligibility factors [i.e., a former Prisoner of War; in receipt of a Purple Heart; a recently discharged Combat Veteran **(e.g., OEF/OIF/OND who were discharged within the past 5 years)**; discharged for a disability incurred or aggravated in the line of duty; receiving VA service-connected disability compensation; receiving VA pension; or in receipt of Medicaid benefits.] *Sign and date the form in Section XII.*

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable sections VI through IX. *Sign and date the form in Section XII.*

SECTION VI - 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 MAIDEN NAME OR OTHER NAMES USED	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ *Son* ☐ *Daughter* ☐ *Stepson* ☐ *Stepdaughter*
1B. SPOUSE'S SOCIAL SECURITY NUMBER	2B. CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm dd yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm dd yyyy)* / 1D. DATE OF MARRIAGE *(mm dd yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm dd yyyy)*
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 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)* $

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

SECTION VII - 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 *(eg., Social Security, compensation, pension interest, dividends)*. EXCLUDING WELFARE.	$	$	$

SECTION VIII - 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.*	$

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS *(e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second home and non-incoming producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION X - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may beverified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

SECTION XI - CONSENT TO COPAYS

By signing this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law.

SECTION XII - 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	DATE

OMB Control No. 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affair

1. VA FILE NO(S) *(Include prefix)*

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have a service organization assist you with your claim, you may use VA Form 21-22, "Appointment of Veterans Service Organization As Claimant's Representative."

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. However, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. 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 recognize the individuals appointed by claimants to act on their behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902, 5903, and 5904) and for those individuals to accept appointment. We will also use the information to verify consent for disclosure of VA records to the appointed representative (38 U.S.C. 5701(b) and 7332) Title 38, United States Code, allows us to ask for this information. We estimate that claimants and individuals appointed for purposes of representation will each 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. A Valid OMB control number can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

2. NAME OF CLAIMANT (*Veteran, guardian, beneficiary, dependent, or next of kin*)	3. ADDRESS OF CLAIMANT (*No. and street or rural route, city or P.O., State and ZIP Code*)
4. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	5. SERVICE NUMBERS

6. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify* _____)

7A. NAME OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE

7B. INDIVIDUAL IS *(check appropriate box)*

☐ ATTORNEY ☐ AGENT ☐ INDIVIDUAL PROVIDING REPRESENTATION UNDER SECTION 14.630 *(*See required statement below. Signatures are required in Items 7C and 7D)*

☐ SERVICE ORGANIZATION REPRESENTATIVE *(Specify organization below)*

_____

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

(Skip to Item 8, if the box for "Individual Providing Representation Under Section 14.630" was not checked in Item 7B)

The appointment of the individual named in Item 7A (the representative) authorizes the individual to represent the claimant named in Item 2 for a particular claim pursuant to the provisions of 38 CFR 14.630. By our signatures below, we, the representative and the claimant, attest that no compensation will be charged or paid for the individual named in Item 7A.

7C. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 7A

7D. SIGNATURE OF CLAIMANT NAMED IN ITEM 2

8. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE *(No. and street or rural route, city or P.O., State, and ZIP code)*

9. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 7A 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 individual named in Item 7A 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 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

10. LIMITATION OF CONSENT. My consent in Item 9 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

11. AUTHORIZATION FOR REPRESENTATIVE TO ACT ON CLAIMANT'S BEHALF TO CHANGE CLAIMANT'S ADDRESS

Unless I check the box below, I do not authorize the individual named in Item 7A to act on my behalf to change my address in my VA records.

☐ I authorize the individual named in Item 7A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual with out 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

CONDITIONS OF APPOINTMENT

I, the claimant named in Item 2, hereby appoint the individual named in Item 7A as my representative to prepare,present, and prosecute my claims for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 4. If the individual named in Item 7A is an accredited agent or attorney, the scope of representation provided before VA may be limited by the agent or attorney as indicated below in Item 15. If the individual indicated in Item 7A is providing representation under 14.630, such representation is limited to a particular claim only. I authorize VA to release any and all of my records (other than as provided in Items 9 and 10) to that individual appointed as my representative, and if the individual in Item 7A is an accredited agent or attorney, this authorization includes the following individually named administrative employees of my representative:

Signed and accepted subject to the foregoing conditions.

12. SIGNATURE OF CLAIMANT	13. DATE OF SIGNATURE	14. CLAIMANT'S RELATIONSHIP TO VETERAN *(If other than the veteran)*

15. LIMITATIONS ON REPRESENTATION - AGENTS OR ATTORNEYS ONLY *(Unless limited by an agent or attorney, this power of attorney revokes all previously existing powers of attorney)*

16. SIGNATURE OF REPRESENTATIVE	17. DATE OF SIGNATURE

FEES: Section 5904, Title 38, United States Code, contains provisions regarding fees that may be charged, allowed, or paid for services of agents or attorneys in connection with a proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Department.

OMB Approved No. 2900-0043
Respondent Burden: 15 minutes

Department of Veterans Affairs — DECLARATION OF STATUS OF DEPENDENTS

Privacy Act Information: 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 Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your and your dependents' SSN account information is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed 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. 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 determine marital status and eligibility for an additional allowance for dependents under 38 U.S.C. 1115. 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 unless a valid OMB 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

INSTRUCTIONS: Print all answers clearly. Make sure you sign and date this form (Items 17 and 18). Note: Unless the claimant is the veteran's surviving spouse, the veteran must sign in Item 17. When you have completed this form, mail it or take it to a VA regional office.

1A. FIRST - MIDDLE - LAST NAME OF VETERAN	2A. NAME OF CLAIMANT *(If other than veteran)*	3. FILE NUMBER
1B. VETERAN'S SOCIAL SECURITY NUMBER	2B. CLAIMANT'S SOCIAL SECURITY NUMBER	C-

4A. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*

4B. E-MAIL ADDRESS OF CLAIMANT *(If applicable)*

5A. MARITAL STATUS *(Check one)*
☐ MARRIED ☐ DIVORCED ☐ NEVER MARRIED *"(If checked, skip to Item 14)"*
☐ WIDOWED ☐ SEPARATED

5B. IF MARRIED, SPOUSE'S DATE OF BIRTH
_____
month day year

NOTE: You must furnish complete information about all your and your current spouse's previous marriages. If you or your spouse have been married more than three times, list additional marriages in Item 17, "Remarks, " or attach a separate sheet.

SECTION I - VETERAN'S MARRIAGES

6. HOW MANY TIMES HAVE YOU BEEN MARRIED? *(Including current marriage)*

7A. DATE AND PLACE OF MARRIAGE *(City, State or Country)*	7B. TO WHOM MARRIED *(First, middle, last name)*	7C. SOCIAL SECURITY NUMBER	7D. HOW MARRIAGE TERMINATED *(Death, Divorce)*	7E. DATE AND PLACE TERMINATED *(City/State or Country)*
_____ *month day year* *Place:*				
_____ *month day year* *Place:*				_____ *month day year* *Place:*
_____ *month day year* *Place:*				_____ *month day year* *Place:*

SECTION II - SPOUSE'S PREVIOUS MARRIAGES

8. HOW MANY TIMES HAS THE VETERAN'S CURRENT SPOUSE OR SURVIVING SPOUSE BEEN MARRIED? *(Including current marriage)*

9A. DATE AND PLACE OF MARRIAGE	9B. TO WHOM MARRIED *(First, middle, last name)*	9C. HOW MARRIAGE TERMINATED *(Death, Divorce)*	9D. DATE AND PLACE TERMINATED
_____ *month day year* *Place:*			_____ *month day year* *Place:*
_____ *month day year* *Place:*			_____ *month day year* *Place:*
_____ *month day year* *Place:*			_____ *month day year* *Place:*

10A. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO *(If "Yes," answer Item 10B also. If "No," skip to Item 11.)*	10B. WHAT IS YOUR SPOUSE'S VA FILE NUMBER *(If any)*?
11. DO YOU LIVE WITH YOUR SPOUSE? ☐ YES ☐ NO *(If "Yes," skip to Item 14A. If "No, answer Items 12 and 13 also.)*	12. WHAT IS YOUR SPOUSE'S ADDRESS?
13. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? $	

SECTION III - VETERAN'S UNMARRIED CHILDREN

NOTE: If any child is claimed as "seriously disabled" (Item 14H), it must be shown that the child became permanently unable to support him/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note: In Items 14A through 14I, check all boxes that apply.

14A. NAME OF CHILD *(first, middle initial, last)*	14B. DATE AND PLACE OF BIRTH *(city, state or country)*	14C. SOCIAL SECURITY NUMBER	14D. BIO - LOGICAL	14E. ADOPT - ED	14F. STEP - CHILD	14G. 18-23 YRS. OLD AND IN SCHOOL	14H. SERIOUSLY DISABLED	14I. CHILD PREVIOUSLY MARRIED
	mo day yr PLACE:		☐	☐	☐	☐	☐	☐
	mo day yr PLACE:		☐	☐	☐	☐	☐	☐
	mo day yr PLACE:		☐	☐	☐	☐	☐	☐

Note: If any of the children listed above don't live with you, complete Items 15A through 15C.

15A. NAME OF CHILD *(First, middle initial, last)*	15B. CHILD'S COMPLETE ADDRESS	15C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable)*

16. REMARKS

I HEREBY CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief.

17. SIGNATURE OF CLAIMANT	18. DATE	19. TELEPHONE NUMBER (S) *(Include Area Code)*	
		A. DAYTIME	B. NIGHTTIME

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.

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next of kin using eVetRecs at http://www.archives.gov/veterans/evetrecs/.

2. Personnel records and Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and STR's are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **must provide proof of death**, such as a copy of a death certificate, letter from funeral home or obituary.

b. Fees for records: There is no charge for most services provided to service members or next of kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified as soon as that determination is made.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 or more years** ago have been transferred to the legal custody of NARA and are referred to as "archival" records.

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next of kin is not required. However, in order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Standard Form 180 (Rev. 10/10) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

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

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	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 COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy.** When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: 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.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission **must** be provided:

☐ **Other** (Specify):

2. **PURPOSE:** (An explanation of the purpose of the request is **strictly voluntary**; however, such information 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.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain:

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER IS:** (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above

☐ Next of kin of deceased veteran **(Must provide proof of death).**

Show relationship: _____

(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)

☐ Other (specify) _____

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

Name

Street Apt.

City State Zip Code

3. **AUTHORIZATION SIGNATURE REQUIRED** *(See items 2a or 3a on accompanying instructions.)* 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 III is true and correct.

Signature Required - Do not print

Date of this request ( ) Daytime phone

Email address

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

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Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	14
	Discharged, deceased, or retired after 10/16/1992	14	11
	Active enlisted, officers (including National Guard and Army Reserve on active duty in the U.S. Army)	7	
	National Guard enlisted and officers not on active duty in Army	13	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSSRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center /DSMR HQ ARPC/DPSSA/B 6760 E. Irvington Place, Suite 4600 Denver, CO 80280-4600	7	U.S. Army Human Resources Command *www.hrc.army.mil*	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, CGPC-adm-3 USCG Personnel Command 4200 Wilson Blvd., Suite 1100 Arlington, VA 22203-1804	8	*Reserved.*	13	The Adjutant General (of the appropriate state, DC, or Puerto Rico)
4	Headquarters U.S. Marine Corps Personnel Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030	9	*Reserved.*	14	National Personnel Records Center (Military Personnel Records) 9700 Page Ave. St. Louis, MO 63132-5100 *e*VetRecs! *www.archives.gov/veterans/evetrecs/*
5	Marine Forces Reserve 4400 Dauphine St. New Orleans, LA 70146-5400	10	Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120		

Veterans Affairs Aid and Attendance Benefits

What Are Aid and Attendance benefits?

Aid and Attendance is a benefit paid by Veterans Affairs (VA) to veterans, veteran spouses or surviving spouses. It is paid in *addition* to a veteran's basic pension. The benefit may not be paid without eligibility to a VA basic pension. Aid and Attendance is for applicants who need financial help for in–home care, to pay for an assisted living facility or a nursing home. It is a non–service connected disability benefit, meaning the disability does not have to be a result of service. You cannot receive non–service and service–connected compensation at the same time. Aid and Attendance benefits are paid to those applicants who:

- Are eligible for a VA pension
- Meet service requirements
- Meet certain disability requirements
- Meet income and asset limitations

Who is Eligible for Veterans Affairs Basic Pension and Aid and Attendance?

A pension is a benefit that the VA pays to wartime veterans who have limited or no income and who are at least 65 years old or, if under 65, are permanently or completely disabled. There are also "Death Pensions," which are needs based for a surviving spouse of a deceased wartime veteran who has not remarried.

What are the Service Requirements for Aid and Attendance?

A veteran or the veteran's surviving spouse may be eligible if the veteran:

- Was discharged from a branch of the United States Armed Forces under conditions that were not dishonorable **AND**
- Served at least one day (did not have to be served in combat) during the following wartime periods and had 90 days of continuous military service:
  - World War I: April 6, 1917, through November 11, 1918
  - World War II: December 7, 1941, through December 31, 1946
  - Korean War: June 27, 1950, through January 31, 1955
  - Vietnam War: August 5, 1964 (February 28, 1961, for veterans who served "in country" before August 5, 1964), through May 7, 1975
  - Persian Gulf War: August 2, 1990, through a date to be set by Presidential Proclamation or Law.

If the veteran entered active duty after September 7, 1980, generally he/she must have served at least 24 months or the full period for which called or ordered to active duty (there are exceptions to this rule).

What are the Disability Requirements for Aid and Attendance?

Veterans, spouses of veterans or surviving spouses can be eligible for Aid and Attendance benefits if they meet the following disability requirements:

- The aid of another person is needed in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, toileting, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment; or
- The claimant is bedridden, in that his/her disability or disabilities require that he/she remain in bed apart from any prescribed course of convalescence or treatment; or
- The claimant is in a nursing home due to mental or physical incapacity; or
- The claimant is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less.

What are the Income Requirements for Aid and Attendance?

The claimant's *countable family income* must be below *a yearly limit* set by law. *Countable Income* means income received by the claimant and his or her dependents. It includes earnings, disability and retirement payments, interest and dividends, and net income from farming or business. A claimant must report all income, but the VA will exclude any income that the law allows. Public assistance, like SSI, is not counted as part of *countable income*. The annual income limits for the Aid and Attendance program are higher than those set for the basic pension. The maximum Aid and Attendance benefit that can be paid monthly to a single veteran is $1,645, but the veteran must have *countable* income of $0 to receive the maximum benefit.

The following chart includes the set yearly income rate/annual pension Aid and Attendance limit set by Congress; it also includes the maximum monthly benefit:

Aid and Attendance Maximum Annual Pension Rate (MAPR) Category If you are a…	Basic Pension MAPR	5% of Basic Pension MAPR (The amount you subtract from medical expenses…)	Annual Aid and Attendance Pension Rate Your yearly income must be less than…
Single Veteran	$12,256 ($1,021 per month)	$613	$20,447 ($1,704 per month)
Veteran with Spouse/ Dependent	$16,051 ($1,337 per month)	$803	$24,239 ($2,020 per month)
Two Veterans Married to Each Other	$16,051 $1,337 per month)	$803	$31,578 ($2,631 per month)
Surviving Spouse	$8,219 ($684 per month)	$411	$13,138 ($1,094 per month)
Surviving Spouse with One Dependent	$10,759 ($896 per month)	$538	$15,673 ($1,306 per month)

Unreimbursed Medical Expenses

A portion of unreimbursed medical expenses paid by claimants may reduce the countable income.

Unreimbursed medical expenses include: cost of a long term care institution or assisted living, health related insurance premiums (including Medicare premiums), diabetic supplies, private caregivers, incontinence supplies, prescriptions and dialysis not covered by any other health plan. **Only the portion of the unreimbursed medical expenses that exceed 5% of the basic pension MAPR may be deducted** *(see above chart for this amount)*.

Example A: Single Veteran/No Spouse or Dependents — Income Less Than MAPR

- Jim is disabled and needs help paying for care. His yearly income is $40,000 and he has $35,000 unreimbursed medical expenses this year.
  - $12,256 basic pension MAPR x 0.05 = $613
  - $35,000 medical expenses – $613 = $34,387 medical deduction
  - $40,000 Jim's income – $34,387 = $5,613Countable Income
- The countable income is subtracted from the maximum annual Aid and Attendance Rate to determine the benefit amount.
  - $20,447 (Aid and Attendance Rate)– $5,613 (countable income)= $14,834
- Jim's Aid and Attendance benefit would be $14,834 or $1,236/monthly

Example B: Single Veteran/No Spouse or Dependents — Income Over MAPR — No Med Deduction

- Frank's countable income is $1,300 per month ($15,600 per year). Because his annual income is more than $12,256 (more than $1,021 monthly), and he does not have any medical expenses to deduct, he is not eligible for VA Veterans Pension with Aid and Attendance.
- Frank may reapply again when his countable income falls below the limit or when he has unreimbursed medical expenses that would reduce his income.

Example C: Married Veterans — Income Below MAPR — Need Aid and Attendance

- Both Carlos and Patricia live in a senior apartment and need a caregiver 24 hours a day to remain safely in their house. SSI is their only monthly income. Since SSI is not counted, their countable income for VA purposes is $0. They are eligible for $2,631 per month ($31,578 annually), the maximum benefit to help pay for their care.

Example D: Surviving Spouse of Veteran — Income Above MAPR — In Assisted Living

- June is an assisted living facility. Her income is $12,000 per year in Social Security. Her children help pay for the assisted living cost of about $4,000 monthly. Thus, June's unreimbursed medical expenses are $4,000 per month or $48,000 per year.
  - $8,219 MAPR x 0.05 = $411
  - $48,000 – 411 = $47,589 total unreimbursed medical expenses
  - $12,000 income - $47,589 expenses = June has $0 countable income.
- Thus, June would be eligible for the maximum benefit of $1,094 to help her children pay for the assisted living facility.

What are the Asset Requirements for Aid and Attendance?

Net Worth (the value of your assets) also affects eligibility. VA pensions are a need–based benefit, and a large net worth might affect your eligibility. All personal goods are exempt from the net worth. These goods include the home you live in, a vehicle used for the care of the claimant, and household goods and personal effects such as clothes, jewelry and furniture. Unfortunately, there is no asset limit set by law, and the determination of eligibility can be made at the discretion of a VA caseworker.

How does Aid and Attendance affect Medi-Cal Benefits?

In the community:

Aid and Attendance payments are not counted as income for Medi-Cal or IHSS purposes for those beneficiaries who reside at home (not in an institution). However, the basic pension does count as income.

In a Nursing Home:

If you are in nursing home under Medi-Cal, you are allowed to keep $35 out of your monthly income for personal needs. If you receive Aid and Attendance benefits, you will be allowed to keep an additional $90 ($125 total) for the monthly personal needs allowance; the remaining Aid and Attendance payments will be counted as income and will need to be paid as part of your monthly share of cost, unless there is a community spouse or dependent child at home.

How do You Apply for Veterans Affairs Benefits?

Applying for VA pension is often complicated and may take some time. It is a good idea to keep copies of all unreimbursed medical bills for at least twelve months. The average wait for approval is six months. However, the benefits are retroactive to the date of application.

There are several ways you can apply for non–service connected pensions:

1. You can contact the VA at 1–800–827–1000.

2. You can apply online at: http://vabenefits.vba.va.gov/vonapp/main.asp

3. Veteran's applying for the first time can download the "VA Form 21–526, Veteran's Application for Compensation and/or Pension" at www.vba.va.gov/pubs/forms/VBA-21-526-ARE.pdf and send the completed application to the VA regional office that serves your county (listed below). If you have applied for pension, compensation or Dependency and Indemnity Compensation (DIC) in the past there may be other applications you can use (i.e. VA Form 21–527).

4. Surviving spouse's applying for the first time can download the "VA Form 21–534, Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by Surviving Spouse or Child" at http://www.vba.va.gov/pubs/forms/VBA-21-534-ARE.pdf and send the completed application to the VA regional office that serves your county. If you have applied for pension, compensation or DIC in the past there may be other applications you can use (i.e. VA Form 21–0518 or 21–0519).

   VA Regional Offices:

   - The Los Angeles Regional Office covers the following counties:
     Inyo, Kern, Los Angeles, San Luis Obispo, Santa Barbara, and Ventura.

     Los Angeles Regional Office
     Federal Building, 11000 Wilshire Boulevard
     Los Angeles, CA 90024

   - The San Diego Regional Office covers the following counties: Imperial, Orange, Riverside and San Diego.

     San Diego Regional Office
     8810 Rio San Diego Drive
     San Diego, CA 92108

   - The Reno Regional Office covers the following counties:
     Alpine, Lassen, Modoc, and Mono.

     Reno Regional Office
     5460 Reno Corporate Drive
     Reno, NV 89511

- The Oakland Regional Office covers all remaining counties.

  Oakland Regional Office
  1301 Clay Street, Room 1300 North
  Oakland, CA 94612

Or

5. The claimant may also contact a Veterans Service Officer (VSO) from a veteran's service organization in their county. A VSO is a professional veteran affairs advocate. They play a critical role in advocacy and are often the initial contact in the community for veteran services. A VSO can help fill out the application. To search for the nearest VSO see: http://www.va.gov/ogc/apps/accreditation/index.asp

What Documents are needed to apply for Aid and Attendance?

The veteran or surviving spouse will need to gather the following VA Forms (Forms can be found at http://www.va.gov/vaforms/) before applying for benefits:

- Discharge or Separation Documents (DD 214)
- VA Form 21-22 if a Veteran's Service Organization or 21-22a if individual is acting as the claimant's representative
- Form 21-4142: Authorization and Consent to Release Information to the Department of Veterans Affairs
- Letter from the claimant's attending physician VDVA Form 10
- Physician Statement, VA Form 21-2680 or Nursing Home Statement, VA Form 21-0779
- Medical Expenses incurred, VA Form 21-8416

In addition to the VA forms, an applicant will need to gather the following documents:

- Marriage Certificate and Death Certificate (Surviving Spouses only)
- Asset Information (bank account statements, etc.)
- Verification of Income (social security award letter, and statements from pensions, IRAs, annuities, etc)
- Proof of Medical Premiums (Insurance Statements, Medication or Medical bills that are not reimbursed by Medi-Cal or Medicare)
- Voided Check for Aid and Attendance Direct Deposit