How to Prepare the Perfect VA Disability Claim

Course Companion eBook

with worksheets, checklists, example forms, and more!

Military Disability Made Easy

How to Prepare the Perfect VA Disability Claim
Course Companion eBook

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Build Your Timeline Worksheet

Use these questions to build your VA Claim Timeline.

1. Discharge Date:

- Are you currently Active Duty? If yes, you should have an idea of your anticipated discharge date. Use this, although it may change as you go through the IDES process or for other reasons.
- Are you a veteran? Use the official date on your DD214.
- Are you a National Guard or Reserve Member? Use the date of the end of your last period of active duty.

2. Start Your Claim:

- Are you submitting through eBenefits? If you are filing via eBenefits, this date is the first day you log in to your account, click "Apply" and "Disability Compensation," fill out the first section, and click "Save & Continue."
- Are you submitting a paper claim? The best option is to submit an Intent to File so that you can ensure an earlier effective date. If you do, then the day your Intent to File is submitted is the day your claim starts. If you do not file one, then you do not have an official start date.

3. Claim Submission Deadline: At this point, it's important to record your deadline so you can keep yourself on track.

- Are you submitting through eBenefits? Your deadline is 1 year from the date you start your claim.
- Are you submitting a paper claim? Your deadline is 1 year from the date you submit an Intent to File. If you do not submit an Intent to File, then you have no official deadline. Note, however, that without an Intent to File, your effective date will be delayed.
- Are you still Active Duty and within 180 and 90 days of your anticipated discharge date? If so, put the date that is 90 days before your discharge date as your Claim Submission Deadline.

4. Gather Evidence: You need to gather all of the supporting evidence pertinent to your case that we discussed in Lesson 3. Use the timeline to keep track of when you request information and when you actually receive it. Add extra lines, if needed, and ignore evidence your claim does not need.

5. Special Circumstances: If you are applying for any of the special circumstances discussed in Lesson 4, then keep track of your completion of the required forms and the gathering of any evidence needed.

6. Evidence Complete and Organized:

- Do you have everything from #3 and #4?
- Is it all sorted and organized?
- Once you answer yes to both of the above, put the date for this section.

7. Claim Complete:

- Are you submitting via eBenefits? Your claim is complete once you've answered all the questions, submitted all of your evidence, and there are no errors. Is it complete? Record the date.
- Are you submitting a paper claim? Your claim is complete once you've filled out the claim form completely and correctly, attached all of your evidence, and put it in an addressed envelope. Is it ready to mail? Record the date.

8. Claim Submitted:

- Are you submitting via eBenefits? Hit the "Submit" button. Once you see a confirmation, record the date.
- Are you submitting a paper claim? The claim submitted date is the date the VA receives your claim. If you mail the claim with a confirmation of receipt, record the receipt date. If you don't have a receipt confirmation, record the date you mailed it. It's close enough.

9. Effective Date: This is the date your benefits will be effective once the VA determines your claim.

- Are you still Active Duty? Your effective date will be the day after your date of discharge.
- Were you discharged within the past year? As long as your official Claim Start date is within 1-year of your discharge, your effective date will be the day after your date of discharge.
- Were you discharged more than 1 year ago? Your effective date will be the day of the first month after you began your eBenefits claim or submitted an Intent to File.
- Are you submitting a paper claim, but did not submit an Intent to File? Your effective date is the first day of the month after the VA receives your claim.

The Effective Date determines the amount of Back Pay you will receive. Learn more here:
www.militarydisabilitymadeeasy.com/vadisabilitybackpay.html

Your VA Claim Timeline

Insert your dates based on your answers in the Worksheet.

Your Discharge Date: _____

Start Your Claim: _____

Gather Evidence:

- Military Service Records:
  - Requested: _____
  - Received: _____
- Service Treatment Records (military medical records):
  - Requested: _____
  - Received: _____
- Line of Duty, Exposure, Incident Reports, etc.:
  - Requested: _____
  - Received: _____
- Civilian Medical Records:
  - Medical Facility _____
    - Requested: _____
    - Received: _____
  - Medical Facility _____
    - Requested: _____
    - Received: _____
  - Medical Facility _____
    - Requested: _____
    - Received: _____
  - Medical Facility _____
    - Requested: _____
    - Received: _____
- NEXUS Letters:
  - Requested: _____
  - Received: _____
- Medical Publications:
  - Acquired: _____
- Commander's Letter, Buddy Letters, Other:
  - Requested: _____
  - Received: _____
- ALL RECEIVED: _____

Special Circumstances:

- Completed Forms: _____
- Gathered Evidence:
  - Requested: _____
  - Received: _____
- ALL RECEIVED: _____

Evidence Complete and Organized: _____

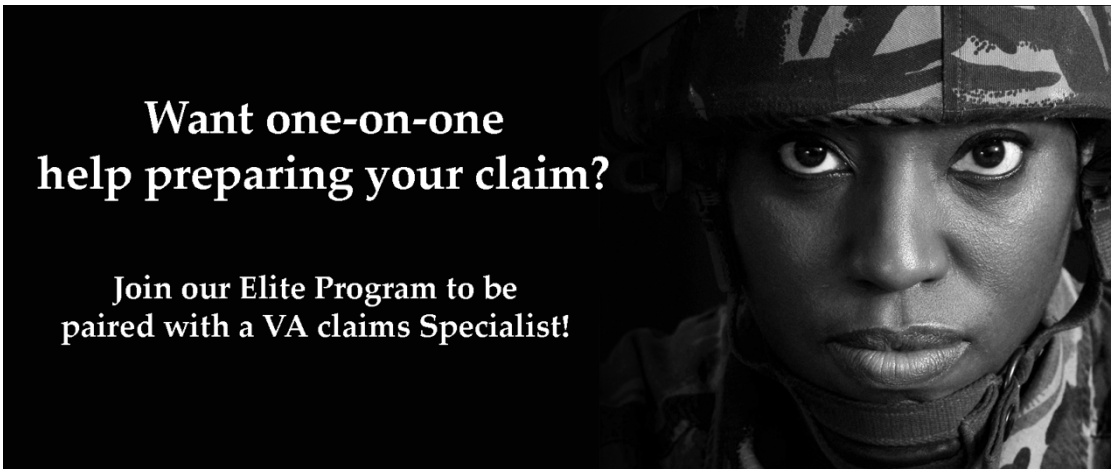
Claim Complete: _____

Claim Submitted: _____

Claim Submission Deadline: _____

If you made the deadline:

Effective Date: _____



Find out more: https://vaclaimsinsider.clickfunnels.com/MDME

VA Disability Claim Checklist

Make sure you have EVERYTHING you need to submit the perfect claim. Use this checklist to keep track of your evidence.

By document type:

- ☐ Military Service Records
  - ☐ DD214
  - ☐ MEB/PEB decisions
  - ☐ Deployment Records
  - ☐ Other
- ☐ Service Treatment Records (military medical records)
- ☐ Exposure records
- ☐ Incident Reports
- ☐ Civilian Medical Records
- ☐ VA Medical Records
- ☐ Commander's Letters
- ☐ Buddy Letters
- ☐ Personal Statement
- ☐ Spouse Letter
- ☐ NEXUS letters

National Guard and Reserve Members:

- ☐ All service treatment records (not just those pertinent to conditions)
- ☐ All military personnel records
- ☐ Line of Duty determination

Special Circumstances:

Aid and Attendance:
- ☐ VA Form 21-2680 or VA Form 21-0779

Adaptive Automobile Allowance:
- ☐ VA Form 21-4502

Specially Adapted Housing:
- ☐ VA Form 26-4555

Temporary Total Disability:
- ☐ Evidence of hospitalization or convalescent period

Claiming Dependents:
- ☐ Dependent's information and relationship records
- ☐ VA Form 21-686c
- ☐ VA Form 21-674
- ☐ VA Form 21P-509

Post-Traumatic Stress Disorder (PTSD):
- ☐ VA Form 21-0781 or VA Form 21-0781a

Individual Unemployability:
- ☐ VA Form 21-8940
- ☐ Employment History and other evidence of unemployability
- ☐ VA Form 21-4192 from employers

Special Monthly Compensation:
- ☐ Evidence to support your qualification

By Condition:

Condition #1: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #2: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #3: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #4: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #5: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #6: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #7: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Condition #8: _____

- ☐ Evidence of Service-Connection (if needed)
  - ☐ Medical Research/Publications
  - ☐ NEXUS letter
- ☐ Evidence of a current disability
- ☐ Evidence linking the current disability to your cause of service-connection
- ☐ Current evidence needed to rate the condition

Sample Forms

The following is a selection of the forms you could be required to fill out to submit your VA Disability Claim. This is not an exclusive list, but we've included samples of the main types of forms to help you see how to fill it out.

DISCLAIMER: All of the information contained in these forms is completely fictitious and only examples to give you an idea. Make sure to provide enough information for the VA to fully understand your situation and needs. In many instances, you will need to put more thorough information than we did for the examples. Do not copy them.

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

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

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

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

- [X] FULLY DEVELOPED CLAIM (FDC) PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

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

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

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*: JANE L DOE

3. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*: 999 – 99 – 9999

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

5. VA FILE NUMBER:

6. DATE OF BIRTH *(MM-DD-YYYY)*: 02 – 21 – 1975

7. VETERAN'S SERVICE NUMBER *(If applicable)*: 123-45-67

8. SEX: ○ MALE [X] FEMALE

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

10. TELEPHONE NUMBER(S) *(Optional) (Include Area Code)*
- Daytime: 999 – 999 – 9999
- Evening: 999 – 999 – 9999
- Cell phone: 999 – 999 – 9999

11. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
- No. & Street: 1234 SAN PEDRO ST
- Apt./Unit Number:
- City: SANTA BARBARA
- State/Province: CA
- Country: US
- ZIP Code/Postal Code: 12345 – 6789

12. EMAIL ADDRESS *(Optional)*: email@gmail.com

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

SECTION II: CHANGE OF ADDRESS

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

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

○ TEMPORARY ○ PERMANENT

14B. NEW ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
- No. & Street:
- Apt./Unit Number:
- City:
- State/Province:
- Country:
- ZIP Code/Postal Code: –

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

	Month	Day	Year		Month	Day	Year
BEGINNING DATE:				**ENDING DATE:**			

VETERANS SOCIAL SECURITY NO. 999 – 99 – 9999

SECTION III: HOMELESS INFORMATION

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

15A. ARE YOU CURRENTLY HOMELESS?

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

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

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

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

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

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

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

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

15F. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*: 9998765432

SECTION IV: CLAIM INFORMATION

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

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

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

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	PTSD (reopen)	Military Sexual Trauma	PTSD was caused by MST reported 6/12/2005	6/10/2005
2.	FSAD, secondary to PTSD		PTSD was caused by MST reported 6/12/2005	6/10/2005
3.	Bilateral Plantar Fasciitis		Started while on active duty	April 2008
4.	Fibromyalgia	Gulf War Deployment	Meets qualifications for Gulf War Veterans on the Presumptive List	July 2010
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

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17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT:

NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-DD-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
VA Medical Center, Santa Barbara, CA	01 – 17 – 2015	○ Don't have date
	– –	○ Don't have date
	– –	○ Don't have date
	– –	○ Don't have date

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

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

SECTION V: SERVICE INFORMATION

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

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

19A. BRANCH OF SERVICE
○ ARMY ○ NAVY ○ MARINE CORPS
☒ AIR FORCE ○ COAST GUARD

19B. COMPONENT
☒ ACTIVE ○ RESERVES ○ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES *(MM,DD,YYYY)*
ENTRY DATE: Month 09 – Day 15 – Year 1999
EXIT DATE: Month 03 – Day 20 – Year 2014

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
FORT WAINWRIGHT ALASKA

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

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate enlistment and discharge date(s), if applicable)*
Enlistment Date(s): Month – Day – Year Month – Day – Year
Discharge Date(s): Month – Day – Year Month – Day – Year

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

21B. COMPONENT
○ NATIONAL GUARD
○ RESERVES

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

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

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

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

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

22B. DATE OF ACTIVATION: *(MM,DD,YYYY)* Month – Day – Year

22C. ANTICIPATED SEPARATION DATE: *(MM,DD,YYYY)* Month – Day – Year

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

23B. DATES OF CONFINEMENT *(MM,DD,YYYY)*

From:	To:
Month – Day – Year	Month – Day – Year
Month – Day – Year	Month – Day – Year

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

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

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

24C. BRANCH OF SERVICE
- [ ] ARMY [ ] NAVY [ ] MARINE CORPS
- [X] AIR FORCE [ ] COAST GUARD

24D. MONTHLY AMOUNT
$ 1,750.00

25. RETIRED STATUS
- [ ] RETIRED [X] PERMANENT DISABILITY RETIRED LIST
- [ ] TEMPORARY DISABILITY RETIRED LIST

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

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

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

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

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

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

27C. BRANCH OF SERVICE
- [ ] ARMY [ ] NAVY [ ] MARINE CORPS
- [ ] AIR FORCE [ ] COAST GUARD

27D. AMOUNT RECEIVED *(Provide pre-tax amount)*
$,.00

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

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

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

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

SECTION VII: DIRECT DEPOSIT INFORMATION

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

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

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

Account No.: 1111111111111111 [X] CHECKING [ ] SAVINGS

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

32. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*
111111111

VETERANS SOCIAL SECURITY NO. 9 9 9 – 9 9 – 9 9 9 9

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

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

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

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

33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**) *(Sign in ink)*	33B. DATE SIGNED *(MM-DD-YYYY)*
Signature	0 6 – 0 4 – 2 0 2 0

SECTION IX: WITNESSES TO SIGNATURE

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

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

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

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

36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**) *(Sign in ink)*	36B. DATE SIGNED *(MM-DD-YYYY)*
	– –

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

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

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE *(Sign in ink)*	37B. DATE SIGNED *(MM-DD-YYYY)*
	– –

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

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

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

VA Form 21-0966, Intent to File a Claim

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

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

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

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

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

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

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

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*: JANE L DOE

2. CLAIMANT'S SOCIAL SECURITY NUMBER: 999-99-9999

3. VA FILE NUMBER *(If applicable)*:

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY): Month 03 – Day 22 – Year 1975

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

6. VETERAN'S SOCIAL SECURITY NUMBER: 999-99-9999

7. VETERAN'S SEX: ☐ MALE ☒ FEMALE

8. VETERAN'S SERVICE NUMBER *(If applicable)*: 123-45-67

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

No. & Street: 1234 SAN PEDRO ST

Apt./Unit Number:

City: SANTA BARBARA

State/Province: CA

Country: US

ZIP Code/Postal Code: 98765-4321

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? ☐ YES ☒ NO

11. TELEPHONE NUMBER *(Include Area Code)*: 999-999-9999

12. EMAIL ADDRESS *(If applicable)*: email@gmail.com

SECTION II: GENERAL BENEFIT ELECTION

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

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

☒ **COMPENSATION** ☐ **PENSION**

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

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

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

SECTION III: DECLARATION OF INTENT

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

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE: Signature

14B. DATE SIGNED *(MM,DD,YYYY)*: 07/05/2020

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

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

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

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

VA FORM AUG 2018 **21-0966** SUPERSEDES VA FORM 21-0966, MAR 2017.

VA Form 21-2680, Aid and Attendance

(similar to VA Form 21-0779)

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1. VETERAN'S NAME *(First, Middle Initial, Last)*: JANE L DOE

2. SOCIAL SECURITY NUMBER: 999 - 99 - 9999

3. VA FILE NUMBER *(If applicable)*:

4. DATE OF BIRTH *(MM-DD-YYYY)*: 03 - 22 - 1975

5. VETERAN'S SERVICE NUMBER *(If applicable)*: 123-45-67

6. SEX: ( ) MALE (X) FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*: 999 - 999 - 9999

8. E-MAIL ADDRESS *(Optional)*: email@gmail.com

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

No. & Street: 1234 SAN PEDRO ST
Apt./Unit Number:
City: SANTA BARBARA
State/Province: CA
Country: US
ZIP Code/Postal Code: 98765 - 4321

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME (First, Middle Initial, Last) (Complete only if you are not the veteran)

11. CLAIMANT'S SOCIAL SECURITY NUMBER: - -

12. RELATIONSHIP OF CLAIMANT TO VETERAN: ( ) SPOUSE ( ) SELF

13. CLAIMANT'S HOME ADDRESS

No. & Street:
Apt./Unit Number:
City:
State/Province:
Country:
ZIP Code/Postal Code: -

14. BENEFIT YOU ARE APPLYING FOR *(Choose One)*

(X) **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

( ) **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

SECTION III: INFORMATION OF EXAMINATION

15. DATE OF EXAMINATION *(MM-DD-YYYY)*: 05 - 12 - 2020

16A. IS CLAIMANT HOSPITALIZED? ( ) YES (X) NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED *(MM-DD-YYYY)*: - -

17A. NAME OF HOSPITAL

17B. ADDRESS OF HOSPITAL

VA FORM SEP 2018 **21-2680** SUPERSEDES VA FORM 21-2680, MAY 2015. Page 1

PATIENT/VETERAN'S SOCIAL SECURITY NO. 999 – 99 – 9999

(To be completed by a physician)

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17C. COMPLETE DIAGNOSIS (Diagnosis needs to equate to the level of assistance described in questions 25 through 39)

MULTIPLE SCLEROSIS

18A. AGE	18B. WEIGHT		18C. HEIGHT	
40	ACTUAL LBS. 120	ESTIMATED LBS.	FEET 5	INCHES 03

19. NUTRITION: Diet limited to liquid food sources. Patient mildly malnourished.

20. GAIT: WHEELCHAIR BOUND

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
180	30	25	wheelchair bound, loss of limb coordination, muscle wasting due to Multple Sclerosis

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: 9 From 9 AM to 9 PM: 8

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? (Fill in Circle. If "No," provide explanation)

○ YES (X) NO — Loss of hand coordination

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? (Fill in Circle. If "No," provide explanation)

○ YES (X) NO — Loss of hand coordination

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? (If "Yes," provide explanation)

(X) YES ○ NO — Loss of limb coordination

29A. IS THE CLAIMANT LEGALLY BLIND? (If "Yes," provide explanation)

○ YES (X) NO

29B. CORRECTED VISION

LEFT EYE	RIGHT EYE

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

○ YES (X) NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? (If "Yes," provide explanation)

(X) YES ○ NO — Cannot manage or take meds on their own

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? (If "No," provide examples and rationale to support your conclusion)

(X) YES ○ NO

VA FORM 21-2680, SEP 2018 Page 2

PATIENT/VETERAN'S SOCIAL SECURITY NO. 999 – 99 – 9999 **(To be completed by physician)**

33. POSTURE AND GENERAL APPEARANCE (Attach a separate sheet of paper if additional space is needed)

Hunched posture. Wheelchair bound, muscle wasting

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE (Attach a separate sheet of paper if additional space is needed)

Loss of all fine motor skills

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREEMITY.

Muscle atrophy, loss of motion control, non-weight bearing

36. DESCRIBE RESTRICTION OF SPINE, TRUNK AND NECK

Spine and neck are hunched

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

Loss of bowel & bladder control

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

Able to leave home a couple times/week only w/ assistance

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? (If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)

(X) YES ( ) NO (If "YES," give distance) (Check applicable box or specify distance) ( ) 1 BLOCK (X) 5 OR 6 BLOCKS ( ) 1 MILE OTHER (Specify distance) _____

SECTION IV: CERTIFICATION AND SIGNATURE

40A. PRINTED NAME OF PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED *(MM-DD-YYYY)*
DAN DANIELS	Dr. Signature	05 – 30 – 2020

41. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	42A. TELEPHONE NUMBER OF MEDICAL FACILITY
1234567892	123–456–7898

42B. NAME OF MEDICAL FACILITY	42C. ADDESS OF MEDICAL FACILITY
VA MEDICAL CENTER	11 PARK ST ATLANTA GA 54321

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information 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 your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(e) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) 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 pate 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.

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

VA Form 21-686c, Add Dependents

(Spouse and Children)

OMB Approved No. 2900-0043
Respondent Burden: 30 minutes
Expiration Date: 09/30/2021

Department of Veterans Affairs

APPLICATION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Make sure you sign and date this form in Items 26A and 26B. **Note**: Unless the claimant is the veteran's surviving spouse or a designated "alternate signer", the veteran ***must*** sign in Item 26A. When you have completed this form, you can mail or fax it to the address or the fax number shown at the bottom of Page 2. If you prefer you may complete and submit the form online at www.va.gov.

SECTION I: VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION
(Note: Completion of this section is REQUIRED to process your request; any omission may delay processing)

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

1. VETERAN'S NAME *(First, Middle Initial, Last)*: JANE L DOE

2. VETERAN'S SOCIAL SECURITY NUMBER: 999-99-9999

3. VA FILE NUMBER *(If known)*:

4. VETERAN'S DATE OF BIRTH *(MM-DD-YYYY)*: 03-22-1975

5. CLAIMANT'S NAME *(If other than veteran)* *(First, Middle Initial, Last)*:

6. CLAIMANT'S SOCIAL SECURITY NUMBER:

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

8. TELEPHONE NUMBER *(Include Area Code)*:

9. E-MAIL ADDRESS *(Optional)*: email@gmail.com

10. COMPLETE MAILING ADDRESS OF VETERAN/CLAIMANT (*Number and Street or Rural Route, P. O. Box, City, State, ZIP Code and Country*)

No. & Street: 1234 SAN PABLO

Apt./Unit Number:

City: SANTA BARBARA

State/Province: CA

Country: US

ZIP Code/Postal Code: 98765-4321

SECTION II: INFORMATION NEEDED TO ADD SPOUSE

11A. SPOUSE'S NAME *(First, Middle Initial, Last)*: JOHN DOE

11B. SPOUSE'S DATE OF BIRTH: 10-10-1972

11C. SPOUSE'S SOCIAL SECURITY NUMBER (SSN) (*If your spouse does not have an SSN, explain why in Section IX, Item 25, Remarks*): 777-77-7777

11D. DATE OF MARRIAGE: 12-20-1999

11E. PLACE OF MARRIAGE *(City and State, County and State, or City and Country)*

City or County: AUSTIN

State/Province: TX

Country: US

11F. HOW WERE YOU MARRIED? *(Check one)*

- ☐ RELIGIOUS CEREMONY *(i.e. Minister, Priest, Rabbi, etc.)* or CIVIL CEREMONY *(i.e. Justice of the Peace)*
- ☒ COMMON LAW
- ☐ TRIBAL
- ☐ PROXY
- ☐ OTHER *(Explain)*

12A. IS YOUR SPOUSE ALSO A VETERAN?

- ☐ YES *(If "YES," complete Items 12B and 12C)*
- ☒ NO

12B. SPOUSE'S VA FILE NUMBER *(If applicable)*:

12C. SPOUSE'S SERVICE NUMBER *(If applicable)*:

NOTE: If you are a veteran that VA is paying additional benefits for a stepchild and you no longer live with the stepchild's biological or adoptive parent, complete Section V.

13A. DO YOU LIVE TOGETHER?

- ☒ YES
- ☐ NO *(If "NO," complete Items 13B and 13C)*

13B. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*:

13C. CURRENT MAILING ADDRESS OF SPOUSE *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street:

Apt./Unit Number:

City:

State/Province:

Country:

ZIP Code/Postal Code:

VA FORM SEP 2018 **21-686c** SUPERSEDES VA FORM 21-686c, JUN 2017. Page 7

(Pages 8 and 9 intentionally left out. Complete if needed.)

VETERAN'S SOCIAL SECURITY NO. 999 – 99 – 9999

City or County | State/Province | Country

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN)
(If claiming more than four children, fill out addendum (Page 15) and submit with application)

16A. NAME OF **FIRST** CHILD TO ADD *(First, Middle Initial, Last)*

SAM DOE

16B. SOCIAL SECURITY NUMBER

888 – 88 – 8888

16C. DATE OF BIRTH *(MM-DD-YYYY)*

06 – 03 – 2008

16D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*

City or County: ATLANTA State/Province: GA Country: US

16E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

16F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

16G. CHILD STATUS *(Check all that apply)*

(X) BIOLOGICAL ( ) 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ( ) ADOPTED ( ) CHILD INCAPABLE OF SELF-SUPPORT

( ) CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 17H)* ( ) STEPCHILD *(If checked, complete Item 17I)*

16H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)* – –

( ) DECLARED VOID ( ) OTHER *(Explain)*

( ) ANNULLED

16I. IF YOU CHECKED "STEPCHILD" IN ITEM 17G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

( ) YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)* – –

( ) NO

17A. NAME OF **SECOND** CHILD TO ADD *(First, Middle Initial, Last)*

17B. SOCIAL SECURITY NUMBER – –

17C. DATE OF BIRTH *(MM-DD-YYYY)* – –

17D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*

City or County | State/Province | Country

17E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

17F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

17G. CHILD STATUS *(Check all that apply)*

( ) BIOLOGICAL ( ) 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ( ) ADOPTED ( ) CHILD INCAPABLE OF SELF-SUPPORT

( ) CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 17H)* ( ) STEPCHILD *(If checked, complete Item 17I)*

17H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)* – –

( ) DECLARED VOID ( ) OTHER *(Explain)*

( ) ANNULLED

17I. IF YOU CHECKED "STEPCHILD" IN ITEM 17G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

( ) YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)* – –

( ) NO

(Pages 11-13 intentionally left out. Complete if needed.)

VETERAN'S SOCIAL SECURITY NO. 999 – 99 – 9999

SECTION IX: REMARKS

25. REMARKS *(If any)*

SECTION X: BENEFICIARY/CLAIMANT'S CERTIFICATION AND SIGNATURE
(Note: Completion of this section is REQUIRED to process your request)

IMPORTANT: The primary purpose of this form is to gather information or statements that may result in a change to your VA benefits. By signing this form you have given permission to make benefit payment changes that could result in the creation of an overpayment. If such adverse actions are taken you will receive additional notification from VA regarding repayment options.

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

26A. SIGNATURE OF BENEFICIARY/CLAIMANT OR ALTERNATE SIGNER* *(Please sign in ink)*	*(FOR USE BY VA ONLY)*	26B. DATE *(MM/DD/YYYY)*
Signature.		06 – 12 – 2020

*__ALTERNATE SIGNER__: By signing on behalf of the beneficiary/claimant, I certify that the claimant is:

- under the age of 18,
- mentally incompetent to provide substantially accurate information needed to complete the form or to certify that the statements made on the form are true and complete, or
- physically unable to sign the form

*__ALTERNATE SIGNER__: By signing on behalf of the beneficiary/claimant, I certify that I am:

- a court-appointed representative,
- an attorney in fact or agent authorized to act on behalf of the claimant under a durable power of attorney,
- a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative, or
- a manager or principal officer acting on behalf of an institution which is responsible for the care of the claimant.

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.

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 and Employment Records - VA, 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 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 **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.

VA Form 21-0781, PTSD

(Similar to VA Form 21-0781a for PTSD due to MST)

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

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

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

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

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1. VETERAN NAME *(First, Middle Initial, Last)*: JANE L DOE

2. SOCIAL SECURITY NUMBER: 999-99-9999

3. VA FILE NUMBER *(If applicable)*:

4. DATE OF BIRTH *(MM/DD/YYYY)*: Month 03 – Day 22 – Year 1975

5. VETERAN'S SERVICE NUMBER *(If applicable)*: 123-45-67

6. TELEPHONE NUMBER *(Include Area Code)*: 8887778909

7. E-MAIL ADDRESS *(Optional)*: email@gmail.com

SECTION II: STRESSFUL INCIDENTS

8A. DATE ***FIRST*** INCIDENT OCCURRED *(MM/DD/YYYY)*: Month 03 – Day 09 – Year 2005

8B. DATES OF UNIT ASSIGNMENT *(MM/DD/YYYY)*: FROM: Month 10 – Day 10 – Year 2004 TO: Month 09 – Day 14 – Year 2006

8C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*: BAGRAM AIR BASE AFGHANISTAN

8D. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*: 1.5 WING

8E. DESCRIPTION OF THE INCIDENT: IED BLAST ON PATROL

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

VA FORM JUL 2017 **21-0781** SUPERSEDES VA FORM 21-0781, AUG 2014, WHICH WILL NOT BE USED. PAGE 1

VETERAN'S SOCIAL SECURITY NO. 999-99-9999

SECTION II: STRESSFUL INCIDENTS *(Continued)*

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

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

9B. RANK *(If applicable)*	9C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* Month Day Year	9D. PLEASE CHECK ONE
E-1	03-09-2005	(X) KILLED IN ACTION ( ) WOUNDED IN ACTION ( ) OTHER ( ) KILLED NON-BATTLE ( ) INJURED NON-BATTLE

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

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

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

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

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

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

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

11E. DESCRIPTION OF THE INCIDENT

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

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VETERAN'S SOCIAL SECURITY NO. 999-99-9999

SECTION II: STRESSFUL INCIDENTS *(Continued)*

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

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

12B. RANK *(If applicable)*	12C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* Month Day Year	12D. PLEASE CHECK ONE
	– –	○ KILLED IN ACTION ○ WOUNDED IN ACTION ○ OTHER ○ KILLED NON-BATTLE ○ INJURED NON-BATTLE

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

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

13B. RANK *(If applicable)*	13C. DATE OF INJURY/DEATH *(MM/DD/YYYY)* Month Day Year	13D. PLEASE CHECK ONE
	– –	○ KILLED IN ACTION ○ WOUNDED IN ACTION ○ OTHER ○ KILLED NON-BATTLE ○ INJURED NON-BATTLE

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

14. REMARKS

I witnessed the death of my friend while patrolling. He sacrificed his life to save mine.

SECTION III: VETERAN SIGNATURE

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

15. SIGNATURE	16. DATE SIGNED *(MM/DD/YYYY)*
Signature.	06-20-2020

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

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

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

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Sample NEXUS Letter

(Sample letters are most powerful from the physician most familiar with your condition. This is a sample of only the BASIC items needed in a letter. Your letter needs to have far more detail, medical reasonings, etc., to strongly prove your case.)

Veteran's name: _____
Veteran's SS#: _____
Veteran's VA File #: _____

(Date)

To Whom It May Concern –

I have been asked to write a letter in support of _____'s claim. I am board certified as _____. My full credentials can be found below.

I have reviewed the veteran's NARSUM, service treatment records and subsequent medical records regarding _____ condition, and _____ documents detailing _____ pertinent events that occurred during his military service. These documents include _____ *(list vital evidence found in the document, i.e. the triggering event or exposure, the original diagnosis and continued treatment of the primary condition, etc. Also include any important dates or date ranges.)*

The veteran has been my patient since _____. I continued to treat _____ condition and first diagnosed a secondary condition _____ on _____. The tests performed on _____ support my diagnosis. *(list any tests performed and their conclusions)*

It is my professional opinion that the veteran's current diagnosis is *("more likely than not" "less likely than not" "at least as likely as not")* a direct result of _____ *("service-connected condition" or "event that occurred during the veteran's military service").*

In my professional experience, _____ *(give medical rationale to support the opinion).* The following medical references and studies also support my opinion _____ *(list any supportive literature).*

Signed,

_____
Dr. (print name)
(Include full pertinent credentials)