CVA-6 (Rev. 02/2008)

VETERAN NAME:

CLAIMANT NAME:

C / XC:

VETERAN SSN:

CLAIMANT SSN:

SN:

DATE:

We are submitting a claim for benefits based upon the military service of the above-captioned veteran together with supporting evidence as indicated below.

	Form 20-572		Form 21-4165		Certified Birth Certificate (s)
	Form 21-0512		Form 21-5655		Certified Death Certificate
	Form 21-0779		Form 21-4185		Certified Discharge Certificate
	Form 21-22		Form 21-0849		Certified Dissolution of Marriage (s)
	Form 21-526		Form 21-8416		Certified Marriage Certificate
	Form 21-527		Form 22-1990		Application for State Benefits
	Form 21-530		Form 22-1995		Medical Documents/SMRs
	Form 21-534		Form 22-5490		VCAA
	Form 21-535		Form 26-1880		
	Form 21-686c		Form 28-1900		
	Form 21-2680		Form 29-4125		
	Form 21-4138		Form SF 180		
	Form 21-4142		NARA Form		

MEMO:

Sincerely,

CVA OFFICE USE ONLY:

DATE REC'D CVA

TO:

DATE:

VSO INITIALS:

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

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual As Claimant's Representative."

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER (Include prefix)

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on reverse side before selecting organization)

3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZED TO ACT ON VETERAN'S BEHALF

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) (Include letter prefix)
6A. SERVICE NUMBER(S)	**6B. BRANCH OF SERVICE**
7. NAME OF CLAIMANT (If other than veteran)	**8. RELATIONSHIP** (If other than veteran)
9. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)	10. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)
	A. DAYTIME / B. EVENING
	11. DATE OF THIS APPOINTMENT

12. 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 service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 3A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - My consent in Item 12 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:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 CFR 20.608. *Additionally, in those cases where a veteran's income is being developed because of an income verification necessitated by an Internal Revenue Service verification match, the assignment of the service organization as the veteran's representative is only valid for five years from the date this form is signed for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

14. SIGNATURE OF CLAIMANT (Do Not Print)	15. DATE SIGNED

VA USE ONLY	VA FORM 21-22-1 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)
	☐ CER FILE ☐ EDU FILE ☐ INSURANCE FILE ☐ CH. 30 ☐ DEA FILE ☐ LG FILE			

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

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

Department of Veterans Affairs

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

Department of Veterans Affairs

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Department of Veterans Affairs

OMB Approved No. 2900-0001
Respondent Burden: 1 hour 30 minutes

(DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION, VA Form 21-526, Part A: General information

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

SECTION I Tell us what you are applying for

Check the box that says what you are applying for. Be sure to complete the other Parts you need.

1. What are you applying for? If you are unsure please refer to the "General Instructions" page 2 Section 1: Preparing your application

- ☐ Compensation ► Fill out Part A of VA Form 21-526 and Parts B and C
- ☐ Pension ► Fill out Part A of VA Form 21-526 and Parts C and D
- ☐ Compensation and Pension ► Fill out Part A of VA Form 21-526 and Parts B, C and D

2a. Have you ever filed a claim with VA

☐ No *(If "No," skip Item 2b and go to Item 3)*

☐ Yes *(If "Yes," provide file number below)* _____ *(Go to 2b)*

2b. I filed a claim for

☐ Compensation ☐ Pension

Other _____

SECTION II Tell us about you

We need information about you to process your claim faster.

3. What is your name?

First Middle Last Suffix (If applicable)

4. What is your Social Security number?

5. What is your sex?

☐ Male ☐ Female

6a. Did you serve under another name?

☐ Yes *(If "Yes," go to Item 6b)*

☐ No *(If "No," go to Item 7)*

6b. Please list the other name(s) you served under

Give us your current mailing address in the space provided. If it will change within the next three months, give us that new address in block 29 "Remarks." Also in block 29, give us the date you think you will be at the new address.

7. What is your address?

8. What are your telephone numbers?

Daytime

Evening

9. What is your e-mail address?

10. What is your date of birth?

11. Where were you born?

City State Country

OWCP used to be called the U.S. Bureau of Employees Compensation

12a. Are you receiving disability benefits from the Office of Workers' Compensation *(OWCP)*?

☐ Yes ☐ No

(If "Yes," answer 12b and 12c also)

12b. When was the claim filed?

12c. What disability are you receiving benefits for?

13a. What is the name of your nearest relative or other person we could contact if necessary?

13b. What is his/her telephone number?

Daytime

Evening

13c. What is this person's address?

13d. How is this person related to you?

SECTION III Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed use Item 29 "Remarks".

2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

14a. I entered active service the **first** time. . . mo day yr	**14b.** Place:	**14c.** My service number was . . .	
14d. I left this active service. . . mo day yr	**14e.** Place:	**14f.** Branch of Service	**14g.** Grade, rank, or rating
14h. I entered my **second** period of active service. . . mo day yr	**14i.** Place:	**14j.** My service number was . . .	
14k. I left this active service. . . mo day yr	**14l.** Place:	**14m.** Branch of Service	**14n.** Grade, rank, or rating

The VA has a registry of veterans who served in the Gulf War. This area has also been called the "Persian Gulf." If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 16b. For more information about the registry, see page 4 of the General Instructions for VA Form 21-526.

15a. Did you serve in Vietnam? ☐ Yes ☐ No (If "Yes," answer Item 15b also)	**15b.** When were you in Vietnam? from mo day yr to mo day yr
16a. Were you stationed in the Gulf after August 1, 1990? ☐ Yes ☐ No (If "Yes," answer Item 16b also)	**16b.** Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?" ☐ Yes ☐ No
17a. Have you ever been a prisoner of war? ☐ Yes ☐ No (If "Yes," answer Items 17b, 17c, and 17d also)	**17b.** What country or government imprisoned you?
17c. When were you confined? from mo day yr to mo day yr	**17d.** What was the name of the camp or sector and what are the names of the city and country near its location

SECTION IV Tell us about your reserve duty

18a. Are you currently assigned to an active reserve unit? ☐ Yes ☐ No (If "Yes," answer Item 18b also)	**18b.** What is the name, mailing address, and telephone number of your current unit?
18c. Were you previously assigned to an active reserve unit within the last 2 years? ☐ Yes ☐ No (If "Yes," answer Item 18d also)	**18d.** What is the name, mailing address, and telephone number of that unit?

SECTION IV (*Continued*) Tell us about your reserve duty

18e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)

☐ Yes ☐ No ☐ Don't know

(If "Yes," answer Item 18f also)

18f. What is your reserve obligation termination date?

mo day yr

Instructions 18g-18k

If you are currently or have ever been a full time reservist for operational or support duty,

1. Complete 18g-18k for that service only.
2. Attach proof of reserve service

18g. I entered reserve service. . .

mo day yr | Place: | **18h.** My service number was . . .

18i. I left reserve service. . .

mo day yr | Place: | **18j.** Branch of of service | **18k.** Grade, rank, or rating

Instructions 18l-18p

If your disability occurred or was aggravated during any period of reserve duty,

1. Complete 18l-18p for the period when your disability occurred.
2. Attach proof that your disability occurred during reserve service.

18l. I entered reserve service. . . **18m.** My service number was . . .

mo day yr | Place:

18n. I left reserve service. . .

mo day yr | Place: | **18o.** Branch of service | **18p.** Grade, rank, or rating

SECTION V Tell us about your National Guard duty

19a. Are you currently a member of the National Guard?

☐ Yes ☐ No ☐ Not assigned yet

(If "Yes," answer Item 19b also)

19b. What is the name, mailing address, and telephone number of your current unit?

19c. Were you previously assigned to a guard unit within the last 2 years?

☐ Yes ☐ No

(If "Yes," answer Item 19d also)

19d. What is the name, mailing address, and telephone number of that unit?

Instructions 19e-19i

If you were activated to Federal Active Duty under the Authority of Title 10, United States Code,

1. Complete 19e-19i for that service only
2. Attach proof of this Federal Active Duty.

19e. I entered Federal Active Duty. . .

mo day yr | Place: | **19f.** My service number was . . .

19g. I left Federal Active Duty. . .

mo day yr | Place: | **19h.** Branch of service | **19i.** Grade, rank, or rating

Instructions 19j-19n

If your disability occurred or was aggravated during any period of guard duty,

1. Complete 19j-19n for the period when your disability occurred
2. Attach proof that your disability occurred during National Guard Service.

19j. I entered National Guard. . .

mo day yr | Place: | **19k.** My service number was . . .

19l. I left National Guard. . .

mo day yr | Place: | **19m.** Branch of service | **19n.** Grade, rank, or rating

SECTION VI Tell us about your travel status

20a. Were you injured while traveling to or from your military assignment? (If "Yes," answer Items 20b thru 20e and Section I of Part B: Compensation) ☐ Yes ☐ No	20b. When did your injury happen? mo day yr	20c. Where did your injury happen? (City,State,Country)	20d. Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)	20e. What agency did you file an accident report with?

SECTION VII Tell us about your military benefits

When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that 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.

You must sign 21e if you want to keep getting military retired pay instead of VA compensation.

Please see page 4 of the General Instructions for VA Form 21-526.

If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, by the Department of Defense

21a. Are you receiving or will you receive retired or retainer pay that is based on your military service? ☐ Yes ☐ No (If "Yes," answer Items 21b thru 21f. If "No," skip to Item 22)	21b. What branch of service is paying or will pay your retired or retainer pay?	21c. What is the monthly amount? $.

21d. What is your retirement based on?

☐ Length of service ☐ Disability ☐ TDRL (Temporary Disability Retired List)

21e. Sign here if you want to receive military retired pay *instead of* VA compensation

_____

21f. Have you received or will you receive any of the following military benefits?
(Please check the appropriate boxes and tell us the amount)

Benefit	*Amount*
(1) ☐ Lump Sum Readjustment Pay	$.
(2) ☐ Separation pay under 10 USC 1174	$.
(3) ☐ Special Separation Benefit (SSB)	$.
(4) ☐ Voluntary Separation Incentive (VSI)	$.
(5) ☐ Disability Severance Pay (name of disability_____)	$.
(6) ☐ Other (tell us the type of benefit_____)	$.

SECTION VIII Give us direct deposit information

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 22, 23 and 24 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 22. 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.

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 22-24 to the right.

22. 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 _____

23. Name of financial institution

_____

24. Routing or transit number

_____

SECTION IX 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.

25. Your signature	**26.** Today's date mo day yr

27a. Signature of witness (If claimant signed above using an "X")	**27b.** Printed name and address of witness
28c. Signature of witness (If claimant signed above using an "X")	**28b.** Printed name and address of witness

SECTION X

Remarks— Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension

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.

29. 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).*
(See page 5 "Tips For Filling Out Your VA Form 21-526.")

Department of Veterans Affairs

VA Form 21-526, Part C: Dependency

Use this form to tell us more about your dependents. Remember that you must also fill out a VA Form 21-526, Part A: General Information, Part B and/or Part D, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 3.

SECTION I Tell us about your marriage

NOTE: You should provide a copy of your marriage certificate.

1. What is your marital status?

☐ Married ☐ Surviving Spouse ☐ Divorced ☐ Never married

(If your spouse died, you are "divorced," or "never married" skip to Section III beginning on page 2)

2. When were you married?

_____
mo day yr

3. Where did you get married?
(city/state or country)

_____

4. What is your spouse's name?

_____
First Middle Last

5. When is your spouse's birthday?

_____
mo day yr

6. What is your spouse's Social Security number?

_____

7a. Is your spouse also a veteran?

☐ Yes ☐ No

(If "Yes," answer Item 7b also)

7b. What is your spouse's VA file number (If any)?

_____

8. Do you live with your spouse?

☐ Yes
☐ No

9. What is your spouse's address?

10. Tell us why you are not living with your spouse

11. How much do you contribute monthly to your spouse's support?

$ _____ .

12. How were you married?

a. ☐ Ceremony by a clergyman or other authorized public official

b. ☐ Common-law

c. ☐ Tribal

d. ☐ Proxy

e. ☐ Other (please describe in the space below)

SECTION II Tell us about any previous marriages

NOTE: You should provide copies of divorce decrees or death certificates

In the table below, tell us about:
- Your previous marriages, and
- Your spouse's previous marriages

Your previous marriages

13a. How many times have you been married before? _____

13b. When were you married?	**13c.** Where were you married? (city/state or country)	**13d.** Who were you married to? (first, middle initial, last)	**13e.** When did your marriage end?	**13f.** Why did your marriage end? (death, divorce)	**13g.** Where did your marriage end? (city/state or country)
mo day yr			mo day yr		
mo day yr			mo day yr		

Your spouse's previous marriages

14a. How many times has your current spouse been married before? _____

14b. When was your spouse married?	**14c.** Where was your spouse married? (city/state or country)	**14d.** Who was your spouse married to? (first, middle initial, last)	**14e.** When did your spouse's marriage end?	**14f.** Why did your spouse's marriage end? (death, divorce)	**14g.** Where did your spouse's marriage end? (city/state or country)
mo day yr			/ / mo day yr		
mo day yr			/ / mo day yr		

SECTION III Tell us about your other dependents

In this section we want to know whether your parents are financially dependent on you (Question **15**) and more about your **dependent children.** VA may recognize a veteran's biological children, adopted children, and stepchildren as dependent. These children must be unmarried and:
- be under the age of 18, **or**
- be at least 18 but under 23 and pursuing an approved course of education, **or**
- have become permanently unable to support themselves before reaching the age of 18.

You should provide: a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child.

15. Are your parents financially dependent on you?

☐ Yes ☐ No (If "Yes," we will request additional information from you later.)

16. Do you have dependent children?

☐ Yes

(If "No," Skip Items 17-21f.) Go to the bottom of page 3 and write your name and Social Security number.)

☐ No

17. How many dependent children do you have?

_____

Give us more information about these children in the tables on the next page (Items 18 through 21f).

SECTION III Tell us about your dependents (continued)

18a. What is the name of your unmarried child(ren)? (first, middle initial, last)	**18b**. Date and place of birth (city/state or country)	**18c**. Social Security Number	**19a.** Biological	**19b.** Adopted	**19c.** Stepchild	**20a.** 18-23 yrs. old and in school	**20b**. Seriously disabled before age 18	**20c.** Child previously married
	mo day yr Place:		☐	☐	☐	☐	☐	☐
	mo day yr Place:		☐	☐	☐	☐	☐	☐
	mo day yr Place:		☐	☐	☐	☐	☐	☐
	mo day yr Place:		☐	☐	☐	☐	☐	☐

Tell us about your dependents listed above who *don't live with you*

21a. Do all the children listed above live with you?

☐ Yes (If "Yes," skip Items 21b thru 21f and write your name and Social Security number below.)

☐ No (If "No," complete Item 21b and the table below (Items 21c -21f) and write your name and Social Security number below.)

21b. How many of the children do not live with you?

_____

21c. What is the name of your child? (first, middle initial, last)	**21d.** What is your child's complete address?	**21e**. What is the name of the person your child lives with (If applicable)? (first, middle initial, last)	**21f.** How much do you contribute each month to the support of your child?
			$.
			$.
			$.
			$.

Your name	**Your Social Security Number**

Department of Veterans Affairs

VA Form 21-526, Part D: Pension

Use this form to apply for pension. Remember that you must also fill out a VA Form 21-526, Part A: General Information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 4.

SECTION I Tell us about your disability and background

Complete this section if you are claiming pension because of permanent and total disability not caused by your military service.

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

Note: 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.

1a. What disability(ies) prevent you from working?

1b. When did the disability(ies) begin?

mo day yr

2. Are you claiming a special monthly pension because you need the regular assistance of another person, are blind, nearly blind, or having severe visual problems, or are housebound?

☐ Yes ☐ No

3a. Are you now, or have you recently been hospitalized or given outpatient or home-based care?

☐ Yes ☐ No

(If "Yes," answer Items 3b and 3c also)

3b. Tell us the dates of the recent hospitalization or care

Began mo day yr

Ended mo day yr

3c. What is the name and complete mailing address of the facility or doctor?

4a. Are you now employed?

☐ Yes ☐ No

(If "No," answer Item 4b also)

4b. When did you last work?

mo day yr

4c. Were you self-employed before becoming totally disabled?

☐ Yes ☐ No

(If "Yes," answer Item 4d and 4e also)

4d. What kind of work did you do?

4e. Are you still self-employed?

☐ Yes ☐ No

(If "Yes," answer Item 4f also)

4f. What kind of work do you do now?

4g. Have you claimed or are you receiving disability benefits from the Social Security Administration (SSA)?

☐ Yes ☐ No

4h. Circle the highest year of education you completed:

Grade school

1 2 3 4 5 6 7 8 9 10 11 12

College

1 2 3 4 over 4

4i. List the other training or experience you have and any certificates that you hold.

SECTION II Tell us your work history

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

5a. What was the name and address of your employer?	**5b.** What was your job title?	**5c.** When did your work begin?	**5d.** When did your work end?	**5e.** How many days were lost due to disability?	**5f.** What were your total annual earnings?
		mo day yr	mo day yr		$.
		mo day yr	mo day yr		$.
		mo day yr	mo day yr		$.

SECTION III Tell us if you are in a nursing home

In this section, tell us if you are in a nursing home. If you are in a nursing home, give us more information about the nursing home.

To get your claim processed faster, provide 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 and tells us the daily charge for your care.

6a. Are you now in a nursing home?

☐ Yes ☐ No

(If "yes," answer Item 6b also)

6b. What is the name and complete mailing address of the facility or doctor?

6c. Does Medicaid cover all or part of your nursing home costs?

☐ Yes ☐ No

(If "no," answer Item 6d also)

6d. Have you applied for Medicaid?

☐ Yes ☐ No

SECTION IV Tell us the net worth of you and your dependents

In this section, we ask you to give us specific information about your net worth and the net worth of your dependents. You will need to enter this information in the tables on page 3.

You must include all assets in your net worth except those items you use everyday (See definition of net worth below.)
You should subtract from the market value of your real estate any amounts that you owe on it (such as mortgages, liens, etc.)
You can subtract mortgages on any property, and the value of the house or part of a building that you live in as your primary residence.
You can report farms or buildings that you or a dependent own by reporting its value as "real property."

*VA cannot pay you pension if your **net worth** is sizeable.*

Definitions:
Net worth is the market value of all interest and rights 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.

Go to Page 3 and fill out the table.

SECTION IV (Continued)

Tell us about your net worth and your dependents' net worth.

For items 7a-h: provide the amounts. If none, write "0" or "None"

Source	Veteran	Spouse	Child(ren) I. Name: (first, middle initial, last)	Child(ren) II. Name: (first, middle initial, last)	Child(ren) III. Name: (first, middle initial, last)
7a. Cash, non-interest bearing bank accounts					
7b. Interest bearing bank accounts,certificates of deposit (CDs)					
7c. IRAs, Keogh Plans, etc.					
7d. Stocks and bonds					
7e. Mutual funds					
7f. Value of business assets					
7g. Real property (not your home)					
7h. All other property					

SECTION V

Tell us about the income you have received and you expect to receive

In this section, we ask you to give us specific information about the income you have received and the income you expect to receive from all sources. You will need to enter this information in the tables on Page 4. In these tables,

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.

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

8. Will you receive any income from rental property or from operation of a business within 12 months of the day you sign this form?

☐ Yes ☐ No

9. Will you receive any income from the operation of a farm within 12 months of the day you sign this form?

☐ Yes ☐ No

10. Do you expect to receive money from a civilian agency, corporation, or individual, because of personal injury or death within 12 months of the day you sign this form?

☐ Yes ☐ No

SECTION V (Continued) Monthly Income—Tell us the income you and your dependents receive every month.

For Items 11a-12f if none write "0" or "None"

Sources of recurring monthly income	Veteran	Spouse	Child(ren) I. Name: (first, middle initial, last)	Child(ren) II. Name: (first, middle initial, last)	Child(ren) III. Name: (first, middle initial, last)
11a. Social Security					
11b. U.S. Civil Service					
11c. U.S. Railroad Retirement					
11d. Military Retired Pay					
11e. Black Lung Benefits					
11f. Supplemental Security (SSI)/Public Assistance)					
11g. Other income received monthly (Please write in the source below:)					

Next 12 months —Tell us about other income for you and your dependents

Sources of income for the next 12 months	Veteran	Spouse	Child(ren) I. Name: (first, middle initial, last)	Child(ren) II. Name: (first, middle initial, last)	Child(ren) III. Name: (first, middle initial, last)
12a. Gross wages and salary					
12b. Total interest and dividends					
12c. Worker's compensation for injury					
12d. Unemployment compensation					
12e. Other military benefit (Please write in the source below:)					
12f. Other one-time benefit (Please write in the source below:)					

SECTION VI

IMPORTANT– Items 13A through 13E should be completed only if you are applying for nonservice-connected pension.

Tell us any information concerning, Medical, Legal or Other Expenses Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid 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. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. **Do not** include any expenses for which you were reimbursed. Show the Medicare deduction in line 1. If more space is needed attach a separate sheet.

13A. AMOUNT PAID BY YOU	13B. DATE PAID	13C. PURPOSE *(Doctor's fees, hospital charges, Attorney fees,etc)*	13D. PAID TO *(Name of doctor, hospital, pharmacy, Attorney, etc.)*	13E. DISABILITY OR RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID

Your name	Your Social Security Number

OMB Approved No: 2900-0652
RESPONDENT BURDEN: 10 Minutes

Department of Veterans Affairs

REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE

VA DATE STAMP
(Do Not Write In This Space)

INSTRUCTIONS: The claimant named in Item 3 has filed a claim for aid and attendance benefits and has stated that he/she is in a nursing home. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Section II and return to VA at the address shown in Item 2. Please be sure to sign and date this form in Items 13A and 13B. For free help in completing this form, call VA toll-free at 1-800-827-1000. (Hearing Impaired TDD line 1-800-829-4833.)

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

1A. NAME OF NURSING HOME	1B. ADDRESS OF NURSING HOME

2. ADDRESS OF VA REGIONAL OFFICE

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

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER

SECTION II - NURSING HOME INFORMATION *(To be completed by a Nursing Home Official)*

6. DATE ADMITTED TO NURSING HOME *(Month, Day, Year)*	7. DATE MEDICAID BEGAN *(Month, Day, Year)*

8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET

$

9. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING:

☐ SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE

10. NURSING HOME OFFICIAL'S NAME *(First & Last) (Please print)*

11. NURSING HOME OFFICIAL'S TITLE *(Please print)*	12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)*

13A. SIGNATURE OF NURSING HOME OFFICIAL	13B. DATE SIGNED

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 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 Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

IMPORTANT NOTICE ABOUT INFORMATION COLLECTION: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/library/omb/OMBINVC.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0161
Respondent Burden: 30 minutes

Department of Veterans Affairs

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN *(First, middle, last)*		2. VA FILE NUMBER
3A. NAME AND ADDRESS OF CLAIMANT	3B. CHANGE OF ADDRESS *(Check box if address in Item 3A is different from last address furnished to VA)* ☐	4. VETERAN'S SOCIAL SECURITY NO.

NOTE: Family medical expenses are amounts actually paid by you during the income reporting year for medical expenses for which you are not reimbursed by insurance or any other source. Report the actual unreimbursed amount you paid for medical expenses for yourself and any relatives you are under an obligation to support. Do not report any expenses you have not paid or expenses paid for you by someone else. If there is not enough space to report all your expenses on this form, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

You may report any medical expenses which are reasonably related to medical care. Example of allowable medical expenses include the following: hospital expenses, office visits, drugs and medicines, eyeglasses, dental fees, medical insurance premiums (including the Medicare deduction), hearing aids, nursing home fees, home health services, and transportation for medical purposes (.20 per mile plus parking and tolls or fares for taxis, buses, etc.). If you are not sure whether a particular expense is allowable, list it and fully describe the nature of the expense. VA will determine whether it can form the basis for a deduction.

Report medical expenses for the period thru . If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates your medical expense report should cover.

5. ITEMIZATION OF MEDICAL EXPENSES

A. PURPOSE *(Physician or Hospital Charges Eyeglasses, Oxygen Rental Medical Insurance, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID (Mo/Day/Yr)	D. NAME OF PROVIDER *(Name of Doctor, Dentist, Hospital, Lab, etc.)*	E. FOR WHOM PAID (Self, spouse, child)
MEDICARE (PART B)			SOCIAL SECURITY	
PRIVATE MEDICAL INSURANCE				

IMPORTANT: Be sure to sign this form in Item 7A on the reverse side. Unsigned reports will be returned.

5. ITEMIZATION OF MEDICAL EXPENSES *(Continued)*				
A. PURPOSE *(Physician or Hospital Charges Eyeglasses, Oxygen Rental Medical Insurance, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID (Mo/Day/Yr)	D. NAME OF PROVIDER *(Name of Doctor, Dentist, Hospital, Lab, etc.)*	E. FOR WHOM PAID (Self, spouse, child)

I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

6A. DAYTIME TELEPHONE NO. *(Include Area Code)*	6B. EVENING TELEPHONE NO. *(Include Area Code)*

7A. SIGNATURE OF CLAIMANT *(Do NOT print)*	7B. DATE

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.

PRIVACY ACT INFORMATION: No exclusion from income may be granted unless this form is completed and returned as required by existing law (38 CFR 3.272). The responses you submit are considered confidential (38 U.S.C. 5701) and may be disclosed outside 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 Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits provided under law. Information submitted is subject to verification through computer matching programs with other agencies. Income information 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. Any information provided by you, including your Social Security Number, may be used in matching programs conducted in connection with any proceeding for the collection of an amount owed the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

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 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing an reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

Physician's Statement
In Support of Claim for Housebound or A&A Benefits

VA FILE NUMBER:_____

SOCIAL SECURITY #:_____

NAME OF CLAIMANT:_____

Indicate if the claimant is competent to handle his/her own legal and financial affairs. If the claimant is not competent, please state the specific diagnosis affecting competency.

1. *GENERAL*: (Describe posture and general appearance)

Diagnosis:

2. *UPPER EXTREMITIES*: (Describe restrictions of each upper extremity)

3. *LOWER EXTREMITIES:* (Describe restriction of each lower extremity, with reference to extent of limitation of motion, atrophy, contractures or other interference, also if affected, please comment on weight bearing, balance, and propulsion of each lower extremity)

4. *SPINE*: (Describe restriction of the spine, trunk and neck)

5. *OTHER*: (Set forth all other pathology including the effects of advancing age, such as dizziness, loss of memory, poor balance, which affects the claimant's ability to perform self-care, ambulate, or travel.)

Indicate which of the below functions the claimant is unable or requires assistance in performing:

Dress and undress	Keep clean and presentable
Eat Meals	Attend to the needs of nature

6. *AMBULATION*: Indicate if the claimant can walk without ambulatory aids or the assistance of another person, and if so, indicate distance:

If ambulatory aids are required for locomotion, what aids are utilized (cane, braces, crutches, walker, etc.)? Also indicate the distance the claimant can walk with the aid.

State if the claimant is restricted to his/her immediate premises, and if bedridden, indicate the number of hours per day spent in bed.

Describe how often per day or week and under what circumstances the claimant is able to leave home or immediate premises.

7. *OTHER INFORMATION*: (Is the claimant blind? If so, indicate best corrected visual acuity)

_____ _____

Name and signature of physician Date

_____

Date of last examination or treatment

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

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, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. 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 obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). 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.whitehouse.gov/omb/library/OMBINV.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO.

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

(CONTINUE ON REVERSE)

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

SIGNATURE	DATE SIGNED

ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

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.

OMB Approved No. 2900-0001
Respondent Burden: 5 Mins.

Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

Important Notice About Information Collection: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. 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/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000

(TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME *(If other than Veteran)* LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. *(Include ZIP Codes, and also a telephone number, if available)*	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. *(Include month and year)*	7C. CONDITION(S) *(Illness, injury, etc.)*

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9C.

9A. 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 Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 7A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

9C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the source shown in Item 7A to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)*	10C. DATE

10D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	10E. TELEPHONE NUMBER *(Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS

OMB Approved No. 2900-0001
Respondent Burden: 5 Mins.

Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

Important Notice About Information Collection: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. 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/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000

(TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME *(If other than Veteran)* LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. *(Include ZIP Codes, and also a telephone number, if available)*	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. *(Include month and year)*	7C. CONDITION(S) *(Illness, injury, etc.)*

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

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