Common Mistakes Found On VA Forms Submitted through the American Legion

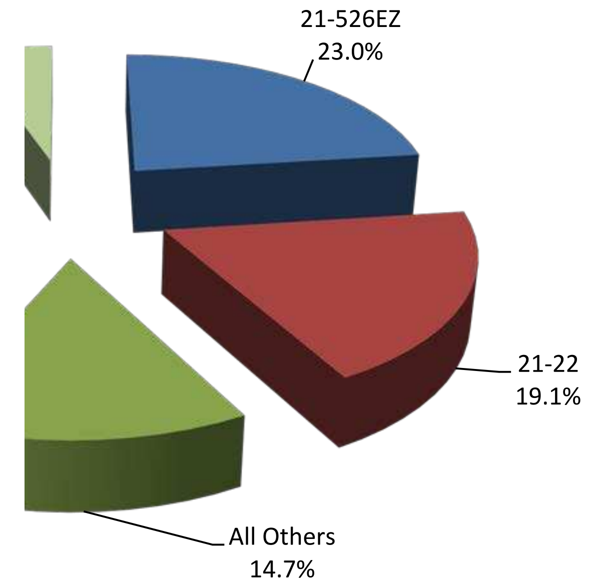
Data Collected from Claims Submitted to AL
(May 19 – Aug 26, 2014)

From May 19, 2014 thru August 26, 2014

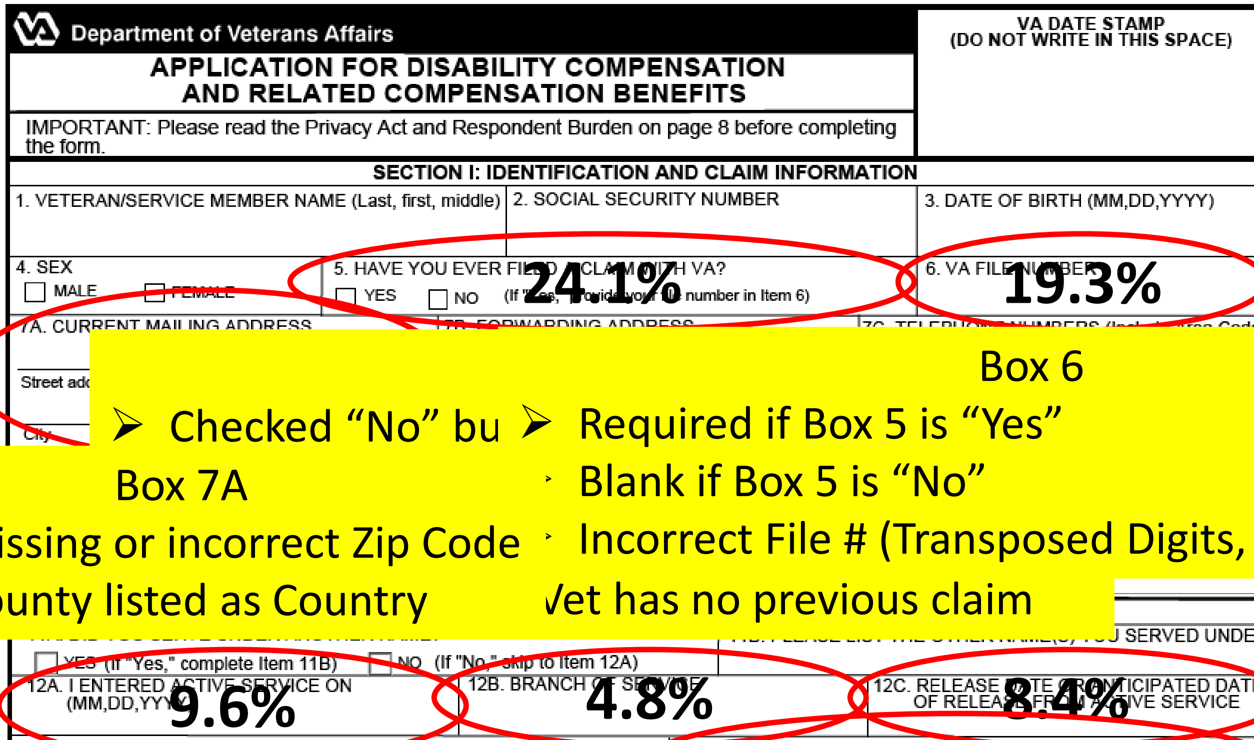
- **581** Claims cross my desk
- **179** had one or more errors (**30.8%**)
  - Approximately 1 of every 3 claims a call needs to be made back to the county

- Total Errors = **361**
- Biggest offenders
  - 21-526EZ (83 Err
  - 21-22 (69 Errors)
  - All Others (53 Er
  - CVSO Cvr Ltr (35
  - 21-686c (34 Errc
  - 21-534EZ (26 Err
  - 21-2680 (21 Errc
  - 21-4138 (21 Errc
  - 21-527EZ (19 Err

"



21-526EZ



Box 6
- Required if Box 5 is "Yes"
- Blank if Box 5 is "No"
- Incorrect File # (Transposed Digits, Vet's Service #)
- Vet has no previous claim

- Checked "No" bu

Box 7A
- Missing or incorrect Zip Code
- County listed as Country

Box 12A
- Does not match DD214
- Entered Incorrectly (Check format (MM/DD/Y
- Blank

Box 12B
- Blank

Box 12C

Box 12E
- Blank
- Does not match DD214

4

21-526EZ Con't.

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 18, 19 and 20 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

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

✓ CHECKING Account No.: "Established"

✓ SAVINGS Account No.: "Established"

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

19. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	20. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION V: CLAIM CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

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

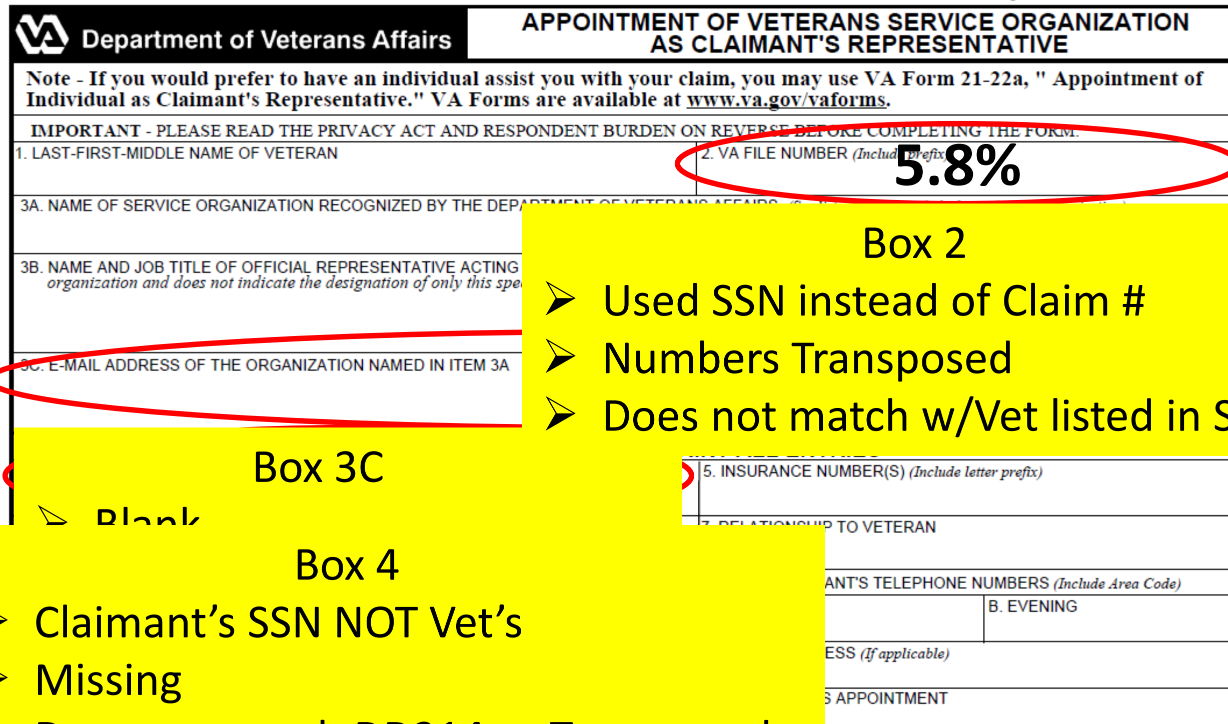
I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 21, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

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

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

22A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**)	22B. DATE SIGNED

21-22



21-22 Con't.

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

...tion named on this appointment form any records that may be in my file relating to ...n immunodeficiency virus (HIV), or sickle cell anemia.

...the service organization named in Item 3A all treatment records relating to ...virus (HIV), or sickle cell anemia. Redisclosure of these records by my ...als for Veterans Claims, is not authorized without my further written consent. This ...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.

Box 12

- Not Checked

3%

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

- [ ] DRUG ABUSE
- [ ] INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
- [ ] ALCOHOLISM OR ALCOHOL ABUSE
- [ ] SICKLE CELL ANEMIA

14. A... ...g the box below, I authorize the organization named in Item 3A to act on my behalf ...to act on my behalf to change my address in my VA records. This authorization does ...authorization will remain in effect until the earlier of the following events: (1) I file ...) I have been determined unable to manage my financial affairs and the individual or

Box 14

- Not Checked

.1%

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

15. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	16. DATE SIGNED
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*	18. DATE SIGNED
	REVOKED *(Reason and date)*

20.3%

...as the sole representative for preparation, ...n with your claim or any portion thereof.

Box 17

- Not Signed by CVSO
- Not Signed by Rep listed in Box 3

All Others

- 21-530 (Superseded by Form 21P-530)
- Release Of Information
- 21-4142
- 21-4502
- 21P-8416
- 20-572
- 21-0779
- 21-0781
- 21-0847
- 21-0960A-1
- 28-1900

Two Biggest Issues

Transposed Social Securities Numbers

Missing Signatures

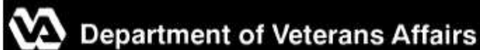
CVSO's Cover Letters

- Missing (States Doc is in package but it is not)
- Xtra (Shows up but is not listed)

- Address (Does not match Address on other Forms.)
- Social Security Number (Numbers transposed)
- Claim # (Does not match other Documents)

21-686c

OMB Approved No. 2900-0043
Respondent Burden: 15 minutes
Expiration Date: 4-30-2017



DECLARATION OF STATUS OF DEPENDENTS

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

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

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

1A. FIRST - MIDDLE - LAST NAME OF VETERAN

2A. NAME OF CLAIMANT *(If other than veteran)*

3. FILE NUMBER

1B. VETERAN'S SOCIAL SECURITY NUMBER

2B. CLAIMANT'

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

4B. E-MAIL ADDRESS OF CLAIMANT

5A. MARITAL STATUS

☐ MARRIED

☐ WIDOWED

☐ SEPARATED

DATE OF BIRTH

month day year

NOTE: You must furnish complete information about all your and your current spouse's previous marriages. If you or your spouse have been married more than three times, list additional marriages in Item 16, "Remarks, " or attach a separate sheet.

Box 5B

- ➢ Does not match Marriage or Birth Cert.
- ➢ Blank

is not married

23.5%

Box 4A

- ➢ Address changed without notification

21-686c (Con't.)

SECTION I - VETERAN'S MARRIAGES

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

7A. DATE AND PLACE OF MARRIAGE *(City,/State or Country)*	7B. TO WHOM MARRIED *(First, middle, last name)*	7C. SOCIAL SECURITY NUMBER	7D. HOW MARRIAGE TERMINATED *(Death, Divorce)*	7E. DATE AND PLACE TERMINATED *(City/County/State or Country)*
14.7% *month day year* *Place:*				
				month day year
				month day year

Box 7A

- Does not match Marriage Cert.
- "UNK" should not be used when supporting Docs list date (Divorce Decree)

SECTION II - SPOUSE'S PREVIOUS MARRIAGES

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

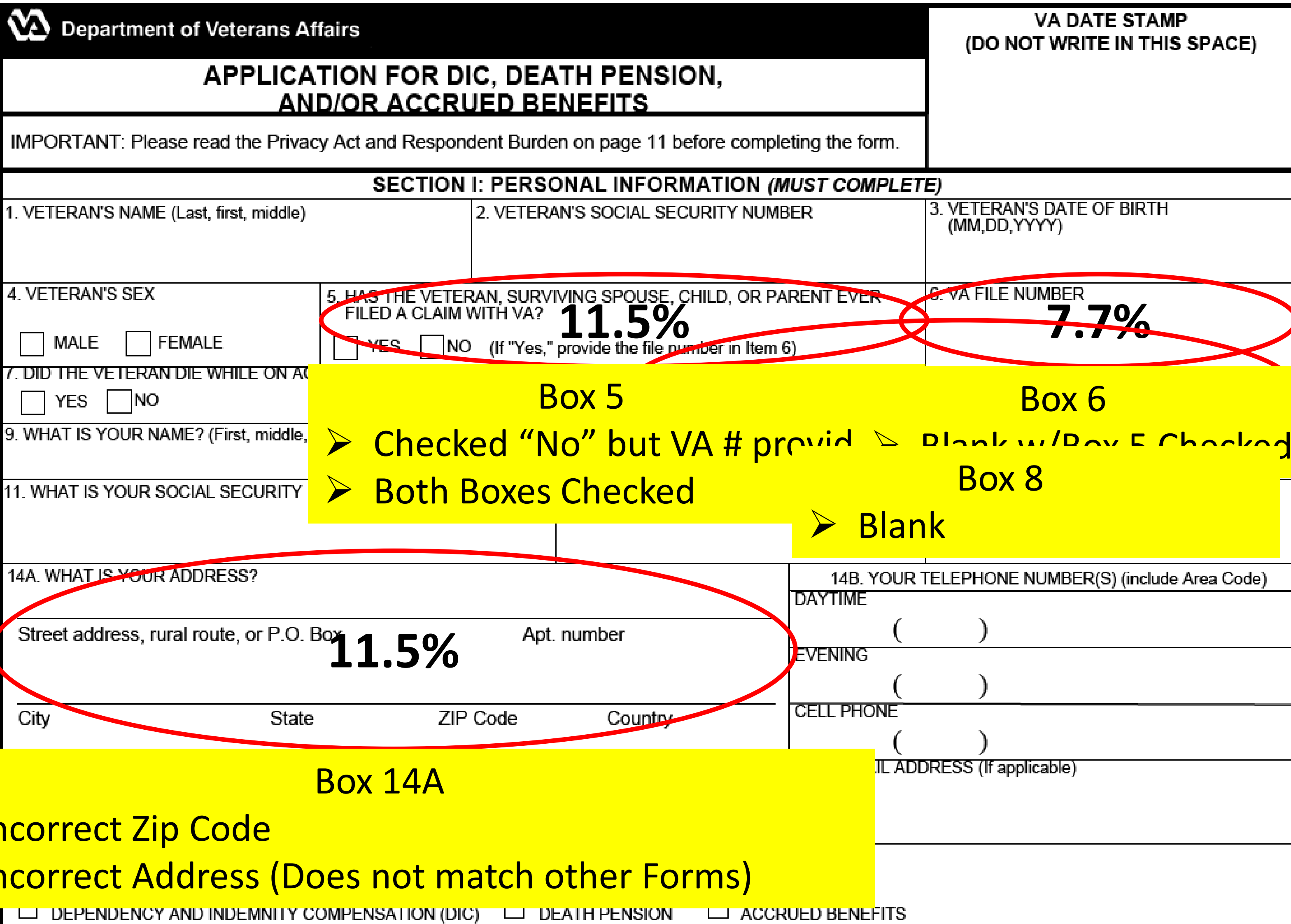
9A. DATE AND PLACE OF MARRIAGE	9B. TO WHOM MARRIED *(First, middle, last name)*	9C. HOW MARRIAGE TERMINATED *(Death, Divorce)*	9D. DATE AND PLACE TERMINATED
8.8% *month day year* *Place:*			*month day year* *Place:*
			month day year
month day year *Place:*			*month day year* *Place:*

Box 9A

- Does not match Marriage Cert.

VA FORM JUN 2014 **21- 686c** SUPERSEDES VA FORM 21-686c, APR 2014, WHICH WILL NOT BE USED.

21-534EZ


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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, first, middle)
2. VETERAN'S SOCIAL SECURITY NUMBER
3. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
4. VETERAN'S SEX
MALE FEMALE
5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?
YES NO (If "Yes," provide the file number in Item 6)
6. VA FILE NUMBER
7. DID THE VETERAN DIE WHILE ON AC
YES NO
9. WHAT IS YOUR NAME? (First, middle,
11. WHAT IS YOUR SOCIAL SECURITY
14A. WHAT IS YOUR ADDRESS?
Street address, rural route, or P.O. Box
Apt. number
City
State
ZIP Code
Country
14B. YOUR TELEPHONE NUMBER(S) (include Area Code)
DAYTIME ( )
EVENING ( )
CELL PHONE ( )
IL ADDRESS (If applicable)
DEPENDENCY AND INDEMNITY COMPENSATION (DIC) DEATH PENSION ACCRUED BENEFITS

21-534EZ (Con't.)

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

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

17A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

YES NO (If "Yes," complete Item 17B)

(If "No," skip to Item 18A)

7.7%

17B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:

Box 17A

- Both boxes can not be checked
- Blank
  - Blank
  - Does not match Discharge Doc

18B. BRANCH OF SERVICE

18C. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)

7.7%

18E. PLACE OF

NDER AUTHORITY OF

Box 18C

- Blank
- Does not match Discharge Doc

19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

( )

20A. WAS THE VETERAN EVER A PRISONER OF WAR?

YES NO (If "Yes," complete Item 20B) (If "No," skip to Section III)

20B. DATES OF CONFINEMENT

FROM: TO:

VA FORM JUN 2014 **21-534EZ** SUPERSEDES VA FORM 21-534EZ, DEC 2012, WHICH WILL NOT BE USED. Page 7

21-2680

OMB Control No. 2900-0721
Respondent Burden: 30 minutes

Department of Veterans Affairs

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN
9.5%

2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*

3. RELATIONSHIP OF CLAIMANT TO VETERAN

SECURITY NUMBER
.0%

5. CLAIM NUMBER
14.3%

Box 1
- Blank
- Vet's Name not Claimant's

4B

Box 5
- Incorrect

Box 7
- Incorrect
- Blank

imant's

YES NO *(If "Yes," complete Items 8*

NOTE: EXAMINER PLEASE READ CARE
The purpose of this examination is to record ma … usebound (confined to the home or immediate premises) or in need of the regular a
The report should be in sufficient detail for the … e 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.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*
9.5%

Box 10
- Blank

WEIGHT
ACTUAL: LBS. ESTIMATED: LBS.

13. HEIGHT
FEET: INCHES:

15. GAIT

RATE

18. RESPIRATORY RATE

19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

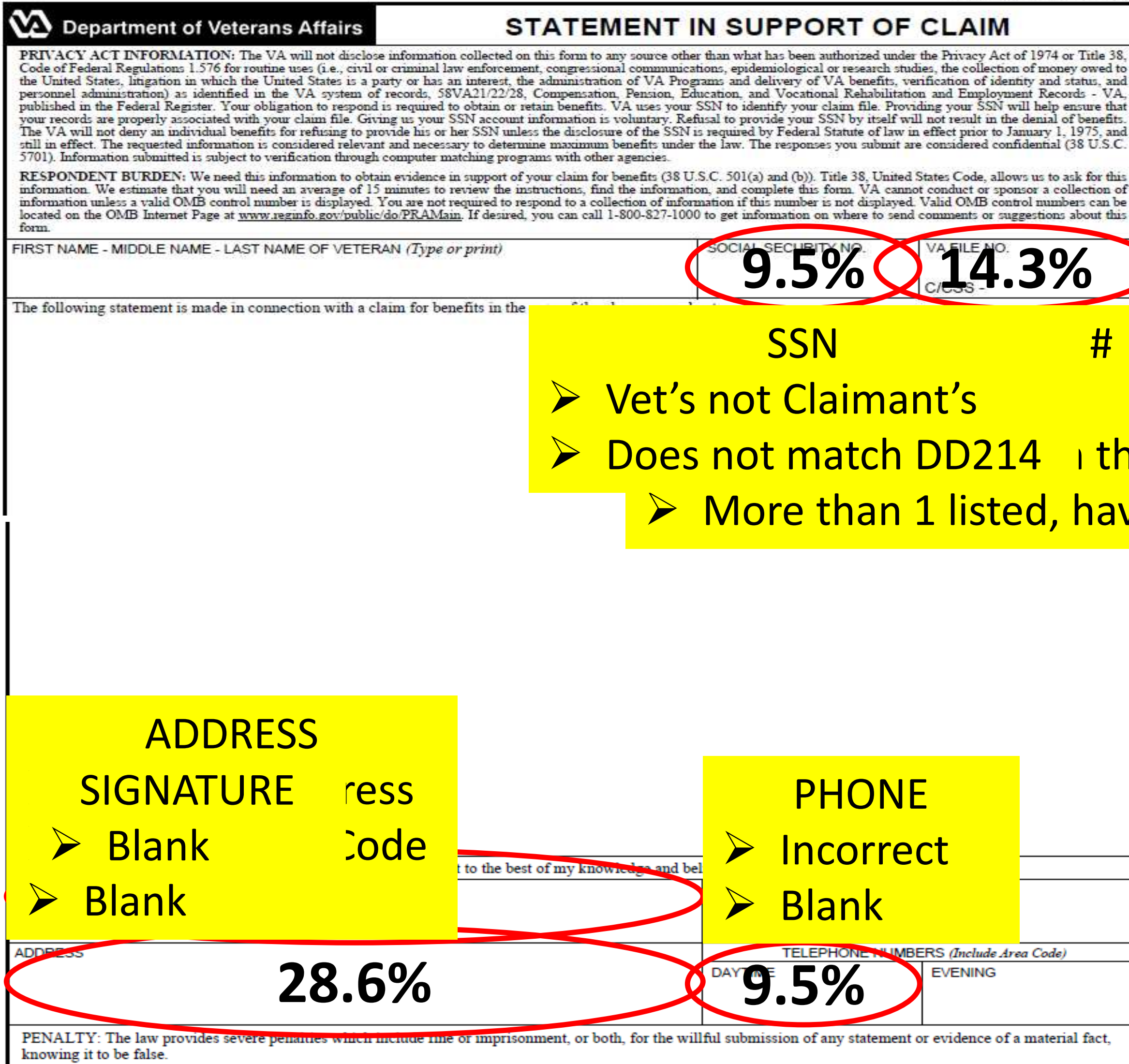
20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED
From 9 PM To 9 AM: From 9 AM To 9 PM:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*
YES NO

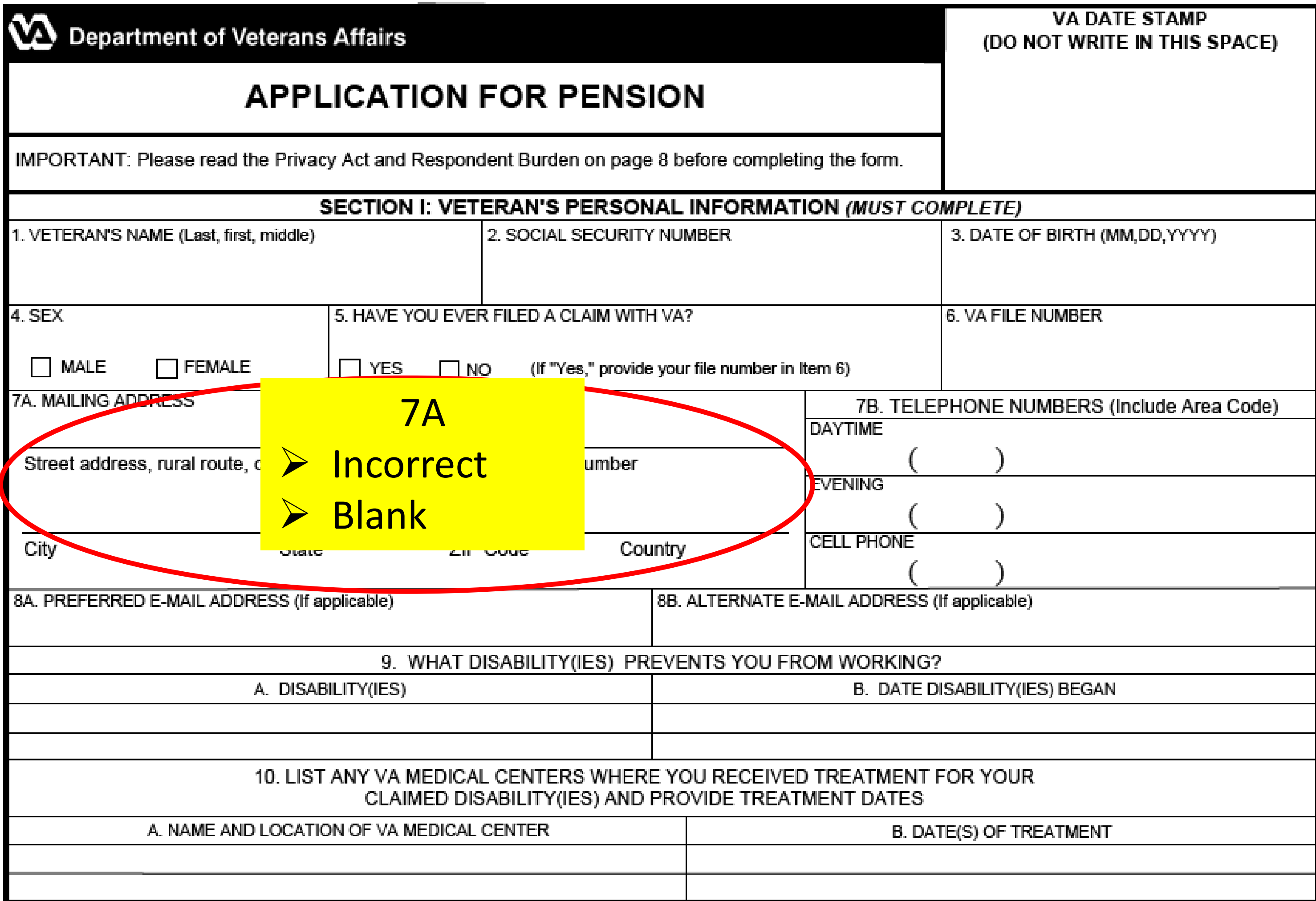
22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "Yes," provide explanation)*
YES NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*
YES NO

21-4138



21-527EZ


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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR PENSION

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

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

1. VETERAN'S NAME (Last, first, middle)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (MM,DD,YYYY)
4. SEX ☐ MALE ☐ FEMALE	5. HAVE YOU EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO (If "Yes," provide your file number in Item 6)	6. VA FILE NUMBER

7A. MAILING ADDRESS
Street address, rural route, ... umber
City State ZIP Code Country

7B. TELEPHONE NUMBERS (Include Area Code)
DAYTIME ( )
EVENING ( )
CELL PHONE ( )

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

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

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

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

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

21-527EZ (Con't.)

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

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

11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

12A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)

15.8%

12B. BRANCH OF SERVICE

12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE

LAST O

13 ... DD,YYYY)

14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code)
( )

12A

- Does not match DD214
- Cannot be the same as Separation Date
- "Late YYYY" unacceptable with DD214 attached

12E

- Blank

15A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES ☐ NO (If "Yes," complete Item 15B) (If "No," skip to Item 16A)

15B. DATES OF CONFINEMENT ON (MM,DD,YYYY)
From: To:

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

16B. LIST AMOUNT (If known)
$

16C. LIST TYPE (If known)

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

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

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

VA FORM JUN 2014 21-527 ... 1-527EZ, AUG 2011, ... Page 5

REV

- Not current Revision

Key Points of Interests

- Insure you are using the current version of VA Form.
  - ✓ If in doubt check on VA website http://www.va.gov/vaforms/

- Claims are being received without the DD214 Certified. (See Note)

- Make sure data in forms match data from attached Documents.
  - ✓ Marriage Cert., Death Cert., Birth Cert., Divorce Decrees, Discharge Docs, etc.

- Make sure Forms are signed, correct boxes checked, Claim # / SSN are correct, & Supporting forms are sent with FDC.
  FYI… FDC submitted with 21-4142's will be removed from FDC status.

- **Goal is to reduce errors from 30.8% to <10% during the 4th quarter & beyond!!!**

Remember…

So…………….

Any Questions?