Surviving Spouse Data Workbook

The following pages contain information that we must have returned to our office by the 25th of the month in order to reserve a **Retroactive Payment Date** of the first of the following month.

- The first few pages contain information we need filled out for the **CLAIMANT** and VETERAN.
- After this packet, you will find our Fee Agreement, Advisement Agreement, and Transfer Signature Agreement.
- Following the CARE SEPARATION PAGE, you will find an "**Examination of Housebound Status**" which must be completed by the CLAIMANT'S DOCTOR.
- Next, you will find an **Affidavit of Custodial Care**. This form must be completed by the Agency or Individual providing the CLAIMANT'S care. We have provided you with two forms which you may copy as needed.
- Following the SIGNATURE SEPARATION PAGE, we no longer require you to complete the forms. We only ask that the CLAIMANT signs the signature blanks.

The above words written in **bold** are further defined on our FAQs page from the Client Login Home.

If you are an un-remarried, surviving spouse we must have the following supporting documents:

- *a copy of your late spouse's military discharge papers showing date of enlistment, date of discharge and character of discharge (Honorable, Under Honorable Conditions, etc.)*
- *a copy of a marriage certificate. If no marriage certificate is available and there were children born of the marriage, a copy of a child's birth certificate showing mother and father will suffice (this option should be used as a last resort only; lack of actual marriage certificate could result in delayed processing times*
- *A copy of the Veterans' death certificate*

If you don't have a copy of the military discharge papers, your assigned CFEVR paralegal will order a certified copy for you from the National Personnel Records Center in St. Louis.

If the claimant has impaired cognitive ability, the VA may propose to find the claimant incompetent to handle his/her financial affairs. If this occurs, the VA will withhold the retroactive payment until a fiduciary is appointed to handle the claimant's financial affairs. They will release the monthly benefit amount going forward. A family member will most likely be the appointed fiduciary. The VA has their own process for this. They do not honor civil powers of attorney.

In the case where the claimant passes away while the claim is pending before the VA and there is no surviving spouse, the law does not entitle his/her estate or the next of kin to make a claim for what benefits he/she was entitled to during his/her life. The law does allow for the next of kin to make a claim for reimbursement for any monies that are paid by the next of kin on his/her funeral or burial. If the claimant is survived by a spouse, the spouse may make a claim for any VA benefits owed to the claimant at the time of his/her death.

Center for Elder Veterans' Rights

Mailing Address Information

This is the address we will send our documents to and also the address we will provide the VA with for correspondence. If you wish to have your VA correspondence to another location (the claimant's address, etc) please indicate in the following section.

Your Name: _____

Are you the claimant's preferred contact? ☐ Yes ☐ No

Are you the claimant's next of kin? ☐ Yes ☐ No

If you are not one of the above, what is your relation to the claimant? _____

Your address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

I want my VA correspondence sent to this address.

Name and Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Veteran's Service Information

Military Service ID Number:	
Veteran's Branch of Service:	
Served During Which War Time:	
Date of Enlistment:	
Place of Enlistment:	
Date of Discharge:	

Character of Discharge:	

Data for Claim Gathering Purposes:

Information:	**Veteran**	**Claimant**
Name:		
Social Security Number:		
Date of Birth:		
Place of Birth:		
Date of Marriage:		
Place of Marriage:		

Date of Death:	
Place of Death:	

Primary Care Physician Information:

Information	**Claimant**
Physician's Name:	
Address:	
City, State, Zip:	
Telephone:	
Fax:	

Medical Expenses to Date:

Expense (Monthly)	Claimant
Room/Board/Care:	
Private Care Provider:	
Medicare Part B:	
Medicare Supplemental Insurance:	
Prescription Insurance:	
Prescription Co Pay:	

Net worth/ Income/ Asset Information:

The VA has and exercises the ability to reference check their claims with the IRS. CFEVR cannot be held responsible for false information provided to them by the claimant, the claimant's family, or the claimant's court- appointed fiduciary. CFEVR is not responsible for a refund of Legal Opinion Fee if the firm was provided false information.

If you have/ had assets please include a tax return from the previous year.

Please include income sources you receive on behalf of the veteran. If you don't currently have the following investments please leave the corresponding blank empty.

Net Worth	Veteran	Claimant
Checking Account Balance:		
Savings Account Balance:		
Interest (Include Rate):		
Other (Include Source):		
Other (Include Source):		
Other (Include Source):		

Income Information:

Income	Veteran	Claimant
Social Security Income:		
U.S. Civil Service:		
U.S. Railroad Retirement:		
Black Lung Benefits:		
Service Retirement:		
Other (Include Source):		

Assets Information:

Asset	Veteran	Claimant
IRA Balance:		
401K Balance:		
Money Market Account:		
Mutual Fund:		
Stocks:		
Bonds:		
Real Estate (Other than Home):		
Annuity:		
Irrevocable Trust (Please Include Copy):		

Other (Include Source):		

Previous Marriage Information:

If you have no previous marriage information, please continue to the next page.

Information	Veteran	Claimant
Name of Previous Spouse:		
Date of Marriage:		
Place of Marriage:		
Date of Termination:		
Place of Termination:		
Conditions of Termination:		

Name of Previous Spouse:		
Date of Marriage:		
Place of Marriage:		
Date of Termination:		
Place of Termination:		
Conditions of Termination:		

Direct Deposit Information:

The VA requires direct deposit information unless there is no bank account capable of handling electronic transfers.

Name of Bank:	
Type of Account:	Savings ☐ Checking ☐
ABA Routing Code:	
Account Number:	

If you're having trouble finding your Account or Routing Number look at the example below as if you were looking at the bottom of a check.

123456789	*0000987654321*	*0001*
9 Digit Routing Number	Account Number	Check Number

CARE SEPARATION PAGE

The following pages should be completed by your doctor and care giver.

CARE SEPARATION PAGE

CARE SEPARATION PAGE

FOR YOUR DOCTOR TO COMPLETE – ONE PER CLAIMANT

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

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

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.

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

11A. AGE	11B. SEX	12. WEIGHT	13. HEIGHT
		ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE 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

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

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

☐ YES ☐ NO

26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*

☐ YES ☐ NO

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

29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE 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)*

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

32. 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.

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

34. 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)*

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

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation Records - VA, and 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. 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 of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits 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(c) 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 page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA Claim Number or Veteran's Social Security Number: _____

Supplemental Medical Evidence for Pension Claim

Date: _____

Patient Name: _____

Address: _____

Residing at: _____

Address: _____

Statement of Attending Physician Per Fast Letter 12-23

" _____is *well-known to me and is seen in my practice on a regular basis. In my professional opinion, due to medical deficits, my patient is required to reside in the protective environment provided by _____ in order to separately contract for regular assistance with two or more basic activities of daily living ("custodial care") from a third-party care provider, (insert name of third-party here)_____.*
This care is provided my patient on a regular basis."

_____ _____
Signature of Physician Date:

_____ _____
Printed Name: Address:

_____
Telephone Number:

AFFIDAVIT OF CUSTODIAL CARE

Veteran's Full Name: _____

VA Claim Number or Social Security Number: _____

Claimant's Full Name (if not the Veteran): _____

Veteran or Claimant's Street Address: _____

Veteran or Claimant's City, State and Zip Code: _____

Affidavit of Care Provider

Provider of custodial care is *(check one)* ( ) assisted living facility ( ) third-party care provider ( ) in-home care provider ( ) family member

Care is provided under the direction of an appropriately licensed medical professional: ( ) Yes ( ) No

Name of Care Provider *(individual or company)* : _____ Start of Care of Care Date: _____

Address: _____

Telephone Number: _____ Licensed Care Provider: ( ) Yes ( ) No

The following **Nursing Services** are provided on a regular basis *(at least two services must be checked)*:

	Assistance with bathing or showering
	Assistance with personal hygiene (grooming, shaving, brushing teeth, etc.)
	Assistance with dressing
	Assisting with the needs of nature including assistance with incontinence
	Assistance with transfers including standing , sitting, toileting and getting into or out of bed
	Assistance with eating including cues, reminders and direct assistance

The following **Medical Services** are provided on a regular basis:

	Dispensing of medication under the direction of a licensed medical professional
	Physician required monitoring of vital signs such as blood glucose levels, blood pressure and blood density (Coumadin etc.), O2
	Care specific to memory impairment including cues, direction, observation and/or providing a secure, protected environment

The following patient or resident **Maintenance Services** are provided on a regular basis:

	Preparation of meals
	Preparing medically required special diets (low Potassium, low Sodium, low sugar, etc.)
	Housecleaning and/or laundry
	Transportation to medical appointments and other medical appointments

Cost of Services

The monthly cost for these services (including room and board if applicable) is: _____

Medicaid pays for these services: ( ) Yes ( ) No Amount paid from Claimant funds: _____

Certification by Care Provider

I CERTIFY under penalty of law that the above statement is true and correct to the best of my knowledge and belief.

Signature: _____ *Title:* _____

Print Name: _____ Date: _____

Certification by Veteran or Claimant

I CERTIFY under penalty of law that the above information is true and correct, that I do pay the above referenced Care Provider the amount listed for the services indicated and that this expense is unreimbursed from any source public or private is provided on a regular basis and is likely of indefinite duration.

Signature of Veteran or Claimant: _____ *Date:* _____

AFFIDAVIT OF CUSTODIAL CARE

Veteran's Full Name: _____

VA Claim Number or Social Security Number: _____

Claimant's Full Name (if not the Veteran): _____

Veteran or Claimant's Street Address: _____

Veteran or Claimant's City, State and Zip Code: _____

Affidavit of Care Provider

Provider of custodial care is *(check one)* ( ) assisted living facility ( ) third-party care provider ( ) in-home care provider ( ) family member

Care is provided under the direction of an appropriately licensed medical professional: ( ) Yes ( ) No

Name of Care Provider *(individual or company)* : _____ Start of Care of Care Date: _____

Address: _____

Telephone Number: _____ Licensed Care Provider: ( ) Yes ( ) No

The following **Nursing Services** are provided on a regular basis *(at least two services must be checked)*:

	Assistance with bathing or showering
	Assistance with personal hygiene (grooming, shaving, brushing teeth, etc.)
	Assistance with dressing
	Assisting with the needs of nature including assistance with incontinence
	Assistance with transfers including standing , sitting, toileting and getting into or out of bed
	Assistance with eating including cues, reminders and direct assistance

The following **Medical Services** are provided on a regular basis:

	Dispensing of medication under the direction of a licensed medical professional
	Physician required monitoring of vital signs such as blood glucose levels, blood pressure and blood density (Coumadin etc.), O2
	Care specific to memory impairment including cues, direction, observation and/or providing a secure, protected environment

The following patient or resident **Maintenance Services** are provided on a regular basis:

	Preparation of meals
	Preparing medically required special diets (low Potassium, low Sodium, low sugar, etc.)
	Housecleaning and/or laundry
	Transportation to medical appointments and other medical appointments

Cost of Services

The monthly cost for these services (including room and board if applicable) is: _____

Medicaid pays for these services: ( ) Yes ( ) No Amount paid from Claimant funds: _____

Certification by Care Provider

I CERTIFY under penalty of law that the above statement is true and correct to the best of my knowledge and belief.

Signature: _____ *Title:* _____

Print Name: _____ Date: _____

Certification by Veteran or Claimant

I CERTIFY under penalty of law that the above information is true and correct, that I do pay the above referenced Care Provider the amount listed for the services indicated and that this expense is unreimbursed from any source public or private is provided on a regular basis and is likely of indefinite duration.

Signature of Veteran or Claimant: _____ *Date:* _____

SIGNATURE SEPARATION PAGE

The following pages should be signed by the CLAIMANT.

SIGNATURE SEPARATION PAGE

Fee Agreement, Advisement Agreement, Transfer Signature Agreement

Any information provided to CFEVR will be used in the preparation of a claim for disability benefits administered by the Department of Veterans Affairs. Once provided to the VA, the information you have provided above on the preceding pages becomes sworn evidence. There are substantial penalties for providing false or misleading data. By signing below you are attesting that the information provided herein is correct and true to the best of your knowledge and belief.

The law firm of Kristen Vanderkooi operates under the name Center for Elder Veterans Rights, PC (CFEVR). Ms. Vanderkooi is licensed to practice law by the Supreme Court of the State of Tennessee and is accredited to practice before the Department of Veterans Affairs (DVA) nationwide by the General Counsel of the DVA. Legal representation is limited to VA Disability benefits under Title 38 of the U.S. Code. This Agreement constitutes a binding agreement for legal services provided by CFEVR.

Signature:

Occasionally, situations occur where a document is not legible after being faxed or scanned multiple times or a previously signed VA form has to be completed, corrected or amended. If you consent, I will transfer your signature to the legible or completed document from the document that you have previously signed, as to make it unnecessary to send that same document to you for your signature multiple times.

When this is necessary a copy of the document onto which your signature was transferred will be provided to you. Under this provision, my office will not affix your signature to a document that you have not previously signed by your own hand. If you give your informed consent please sign after the statement below.

My signature below provides my informed consent for Kristen Vanderkooi or paralegals working under her direct supervision to transfer my signature where I have already signed a document to a legible or completed document where necessary under the circumstances. I understand that I will be provided a copy of any and all forms to which my signature has been transferred in this manner.

The VA will not accept POA signatures on this or any VA form. The veteran, if still living, or the surviving spouse, if the veteran has passed, MUST sign this and all attached forms, even if illegible.

Signature:

By signing the following blank you are giving your caregivers, family members, and/ or property providing your care the ability to release information pertaining to your care including price, start date, provider, address, etc. You are also giving CFEVR the right to ask for such information from these agencies or individuals.

Signature:

Services: *You are retaining CFEVR to provide you with a pre-filing consultation. This consultation will examine your options concerning potential eligibility for disability benefits administered by the DVA. A pre-filing consultation consists of review of applicable records and official documents, legal and factual research, counseling and other assistance required to advise you regarding potential eligibility. The consultation results in an opinion from Ms. Vanderkooi, including the approximate monetary benefit. CFEVR does not charge a fee when, if in our opinion, potential disability does not pertain. In these cases CFEVR does not reserve representation and does not charge for our consultation. Our fee is not compensation for any form of representation pertaining to a specific benefit claim before the DVA.*

Fee: *Our pre-filing consultation fee is $700.00 which is immediately payable upon receipt of an invoice from CFEVR. Payment may be made by check, money order, or credit/debit card. Your payment will not be processed if it is determined in our opinion that you will not qualify for the benefit. As a matter of CFEVR policy we will not offer pro bono services referenced below until the pre-filing consultation is paid in full.*

Representation: *Should the consultation warrant potential eligibility for the desired benefit and if you so request, CFEVR will represent you as a claimant of the firm before the DVA pro bono- at no charge. Representation includes claim preparation, evidence, and prosecution of claim until a final determination of eligibility is made by the DVA. Pursuant to this agreement and in no accord with federal statues, there is absolutely no fee of any kind charged or anticipated for representation of a client before the DVA.*

HIPPA, the Privacy Act of 1947 and other Confidential Information: *By signing this agreement, you give informed consent for CFEVR to share limited/ necessary information as set forth herein; when someone is assisted you in the preparation of this claim such as you family members, care providers, and Fiduciary; limited information concerning the status of your claim by me communicated to the entity that referred you to our firm. CFEVR will at all times respect your right to privacy and will never share you information with the general public.*

Maintaining Eligibility and Other Issues: *The VA requires all pension recipients to update their unreimbursed medical expenses annually. VA will contact you and provide VA Form 21P-8416 for this purpose. As a courtesy to our clients, CFEVR will review these reports for you each year at no charge. We strongly advise submission to our office prior to DVA. If you submit this form on your own accord, absent of consultation you void attorney/ client privilege.*

Incompetency: *If the DVA determines medical evidence exists that a successful claimant for benefits appears incapable of managing their own finances, award of retroactive benefits will be delayed until an official fiduciary is appointed by the DVA.*

Options: *Be advised that VA accredits attorneys, claims agents, and veteran service officers to represent claimants before the DVA. Choosing legal representation by CFEVR is your option. It is not a requirement to obtain VA benefits.*

Advisement: *You may at some point be contacted by the DVA of other federal agencies. You must refer any inquiry to CFEVR for assistance. We cannot be held responsible for any consequences resulting in these contacts if our advice is not consulted. You may contact CFEVR any time, without limit, to discuss any questions you may have. There is no charge whatsoever for assisting you with any VA-related matter. Your signature below is evidence that you understand and agree to the terms and conditions of this agreement:*

Signature:

Signature of Person Responsible for Fee:

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

Department of Veterans Affai

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

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

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

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records-VA, published in the Federal Register. Your obligation to respond is voluntary. However, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to recognize the individuals appointed by claimants to act on their behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902, 5903, and 5904) and for those individuals to accept appointment. We will also use the information to verify consent for disclosure of VA records to the appointed representative (38 U.S.C. 5701(b) and 7332) Title 38, United States Code, allows us to ask for this information. We estimate that claimants and individuals appointed for purposes of representation will each need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. A Valid OMB control number can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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

6. BRANCH OF SERVICE

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

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

Kristen Vanderkooi - **VA CODE 01F (zero/one/F)**

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

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

☐ SERVICE ORGANIZATION REPRESENTATIVE (*Specify organization below*)

_____

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

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

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

7C. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 7A

7D. SIGNATURE OF CLAIMANT NAMED IN ITEM 2

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

Kristen Vanderkooi, Attorney
533 Church Street
Suite 230
Nashville, Tennessee 37219
615-226-8600

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

Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 7A any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

[X] I authorize the VA facility having custody of my VA claimant records to disclose to the individual named in Item 7A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 7A, either by explicit revocation or the appointment of another representative.

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

None

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

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

[X] I authorize the individual named in Item 7A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual with out my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 7A, either by explicit revocation or the appointment of another representative.

CONDITIONS OF APPOINTMENT

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

None

Signed and accepted subject to the foregoing conditions.

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

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

None

16. SIGNATURE OF REPRESENTATIVE	17. DATE OF SIGNATURE
Kristen Vandecoor	

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

FULLY DEVELOPED CLAIM

CERTIFICATION (DEATH PENSION)

Date: _____

Claimant: _____

Status: SURVIVING SPOUSE

As of the date below, I herby certify that no additional information or evidence is available or needs to be submitted for the claim to be adjudicated.

_____ _____

Claimant's Signature **Date**

DO NOT COMPLETE THIS FORM – REQUIRES CLAIMANT'S SIGNATURE ONLY

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

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

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

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

Account No.:_____ Account No.:_____

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

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

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

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

I certify I have enclosed all information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 44, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

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

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

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

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

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

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

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

DO NOT COMPLETE THIS FORM – REQUIRES CLAIMANT'S SIGNATURE ONLY

MB Approved No. 2900-0736
Respondent Burden: 5 minutes

Department of Veterans Affairs

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

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs permission to release your personal beneficiary or claim information to a third party. This form may not be executed by any beneficiary recognized as incompetent for VA purposes, nor can VA accept this form from any beneficiary recognized as incompetent for VA purposes.

1. FIRST, MIDDLE, LAST NAME OF VETERAN *(Print clearly)*	2. FIRST, MIDDLE, LAST NAME OF BENEFICIARY/CLAIMANT WHO IS NOT THE VETERAN *(Print clearly)*

3. ADDRESS OF BENEFICIARY/CLAIMANT *(No. and Street or rural route, City or P.O., State and ZIP Code)*

4. VA FILE NUMBER	5. SOCIAL SECURITY NUMBER

6. CONTACT INFORMATION

A. DAYTIME PHONE NUMBER	B. CELL PHONE NUMBER	C. E - MAIL ADDRESS *(If applicable)*
	N/A	N/A

7. I (beneficiary/claimant) authorize the Department of Veterans Affairs (VA) to contact the person or organization listed below for the purposes of providing the following information pertaining to my VA record. *(Check only one box below to tell VA the specific benefit or claim information you want disclosed.)*

■ Any Information (Go to Item 9) ☐ Limited Information (Go to Item 8)

8. IF YOU SELECTED "LIMITED INFORMATION", CHECK ALL THAT APPLY

☐ Status of pending claim or appeal ☐ Amount of money owed VA ☐ Other
☐ Current benefit and rate ☐ Request a benefit payment letter _____
☐ Payment history ☐ Change of address or direct deposit _____

9. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

☐ One time only ☐ From the date of signing below until _____
(Specify date - month, day, year)
■ Ongoing until written notice is given to VA to terminate

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION AS SPECIFIED ABOVE TO THE PERSON OR ORGANIZATION LISTED BELOW. NOTE: IF AUTHORIZATION IS FOR AN ORGANIZATION, PLEASE PROVIDE THE FIRST AND LAST NAME OF THE ORGANIZATION'S REPRESENTATIVE. *(Please print clearly)*

A. NAME OF PERSON OR ORGANIZATION	B. ADDRESS OF PERSON OR ORGANIZATION
Kristen Vanderkooi, Attorney **VA Code "01F"**	533 Church Street, Suite 230, Nashville, TN 37219
(zero/one/F)	

11. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ***ONE*** SECURITY QUESTION BOX IN 11A AND PROVIDE THE ANSWER IN 11B.

A. SECURITY QUESTION	B. ANSWER
☐ The city and state your mother was born in	
☐ The name of the high school you attended	
■ Your first pet's name	Marley
☐ Your favorite teacher's name	
☐ Your father's middle name	

12A. SIGNATURE *(Do NOT print)*	12B. DATE SIGNED

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 voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. 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/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

The Center for Elder Veterans Rights, PC

An independent law firm representing the interest and rights of elderly veterans and their Families

Kristen Vanderkooi, Esq.
Tennessee Licensed Attorney-at-Law
Department of Veterans Affairs Accredited Attorney

DO NOT COMPLETE THIS FORM – REQUIRES CLAIMANT'S SIGNATURE ONLY

REQUEST TO ESTABLISH **INFORMAL CLAIM** FOR NON-SERVICE CONNECTION PENSION

Under the provisions of 38 C.F.R. 3.155, please accept this communication as an Informal Claim for Non-Service Connected Pension benefits.

1. Requested Start Date for Claim: _____
2. Claim Number: _____
3. Insurance Number: _____
4. Full Name of Veteran: _____
5. Full Name of Claimant (if not Veteran): _____
6. Social Security Number (Veteran): _____
7. Social Security Number (Claimant or Spouse): _____
8. Service Number: _____
9. Service Branch: _____
10. Date Entered Service: _____
11. Date Separated Service: _____
12. Date of Birth: _____
13. Date of Death (If Veteran is Deceased): _____
14. Signature of Claimant or Representative: _____
    Veteran or Claimant's Full Signature
15. Telephone Number: _____