Attention Veterans & Surviving Spouses

Are you aware of the Tax Free Long Term Care Pension available for Veterans and their Surviving Spouses?

The Veterans Administration Non-Service Connected Disability Pension is designed to provide qualified veterans and their surviving spouses with a tax free pension. This benefit which was established in 1952 under Title 38USC, provides a monthly pension to help defray the cost of Long Term Care.

Gabriel Lenhart and the team from US Senior Vets, which is comprised of Veteran Service Officers and VA Accredited attorneys are helping veterans and their surviving spouses navigate through the complicated and often exasperating process of applying for and maintaining their Non-Service Connected Benefits for Long Term Care.

2014 Maximum Aid & Attendance Benefit			
	Monthly		**Yearly**
Two Veterans / Spouses	**$2,789**	Two Veterans / Spouses	**$33,468**
Married Veteran *	**$2,085**	Married Veteran	**$25,020**
Single Veteran	**$1,758**	Single Veteran	**$21,096**
Surviving Spouse	**$1,130**	Surviving Spouse	**$13,560**

f only the spouse of a healthy veteran needs care, a married veteran could qualify for up to $1,380 a month.

So what does this mean to you, the Veteran or Veteran's surviving spouse?

- Access of your benefit through this system provides you with access to care. With a pension in hand, you are able to afford the care you need.
- You have a choice and the power to select the services you need, as well as the provider that meets those needs.
- Like Social Security this pension is paid directly to you by the U.S. Treasury Department. It is dependable and will always be there for the qualified applicant.

For more information about this benefit please contact:

Your Local Volunteer:
Gabriel Lenhart Phone: 530-268-5485
Email: lenhart.legal@gmail.com

Your local U.S.S.V volunteer
Senior Veteran Advocate
We're here to help - Free of charge
www.usseniorvets.com

Rev. 01-2014

Qualifications for The Non Service Connected Disability Pension with Aid & Attendance

There is 1 requirement & 4 criteria that must be met to qualify for Aid & Attendance benefits.

Age/Unemployable

- Veteran must be over the age of 65 and/or unemployable.
- Un-remarried surviving spouse has no age requirement. (A surviving spouse must have been married to the veteran at the time of the veteran's death and the marriage must have been for at least one year.

Qualifying Military Service

- Must have an honorable or general discharge (any discharge other than dishonorable).
- Must have served at least 90 days of active duty with at least one day during an official period of conflict.

Official Periods of Conflict

WWI	**04/06/1917**	**-**	**11/11/1918**
WWII	**12/07/1941**	**-**	**12/31/1946**
Korea	**06/27/1950**	**-**	**01/31/1955**
Vietnam	**08/05/1964**	**-**	**05/07/1975**
Gulf War	**08/02/1990**	**-**	**Date TBD**

For all other dates please visit www.usseniorvets.com

Medical Necessity

- Must have a medical diagnosis or condition that requires the applicant to need assistance with Activities of Daily Living (ADL's).
- Doctor is able to document this need with a qualifying Physicians Report.

Cost of Care and Monthly Income

- The VA has an income test, certain medical expenses can be deducted from income to help qualify. Your Volunteer Veteran Advocate or U.S.S.V. can review allowable deductions.

Net Worth and Liquid Assets

- The VA's asset and net worth limit can vary depending on many factors like life expectancy, medical expenses etc.. Please consult your Volunteer Veteran Advocate or U.S.S.V. for a personal assessment.

Other Pertinent Information

Service in the **Merchant Marines** during War World II must have 90 days of ocean-going service between 12/7/1941 and 8/15/1945 (the 90 days do not have to be consecutive).

Reserves and **National Guard** do not qualify unless they served 90 days Active Duty Federal duty with 1 day during a period of Conflict. Training does not count as active duty.

A **DD214** was implemented by the VA in 1950 and is the only document required for a veteran that served in the Korean conflict as long as it meets the Qualifying Military Service stated above.

Prior to 1950 you will need to provide **Military Discharge Paper (s)** that state Date of Entry Into Active Duty, Date of Discharge, Character of Separation and must meet the Qualifying Military Service stated above.

For more information about this benefit please contact:

Your Local Volunteer:
Gabriel Lenhart Phone: 530-268-5485
Email: lenhart.legal@gmail.com

Your local U.S.S.V.
Volunteer Veteran Advocate
We're here to help - Free of charge

Dear Family,

It is our pleasure to assist you and your family through the process of collecting all of the necessary forms and documentation needed to be able to submit a Fully Developed Claim to the Department of Veterans Affairs.

Please review the checklist below and print the attached forms initially required for us to do a proper assessment. Once you have collected and completed the forms, please fax, mail or email back to my attention. Upon our review we will call and/or email you to discuss the next possible step and/or schedule a meeting.

Checklist of Required Information;

- ✓ **Part 1- Demographics Information**
- ✓ **Part 2- Asset Planning Worksheet**
- ✓ **Physicians Report**; Please follow the "Recommendations for MD Report".
- ✓ **Copies of the Financial Powers of Attorney** (Only needed if Dementia or Alzheimer's diagnosis)
- ✓ **Veterans Discharge Papers;**
  Make sure the document(s) include the following;

1. Date of Entry into Active Duty (refer to the Qualifying Criteria page for dates)
2. Date of Discharge (refer to the Qualifying Criteria page for dates)
3. Character of Discharge (any discharge other than dishonorable)
   If you need to order discharge papers please go to;
   https://vetrecs.archives.gov/VeteranRequest/home.html Follow the 4 step process. After you "send" the request you will print out a signature page. You will get 2 copies, keep one for your records and have the claimant sign the other so you can fax or mail it to the address provided. Normally, you should hear from them in about 4 weeks but your copy will have a number to call if you need to follow up.

***About Gabriel Lenhart and Our Team of Professionals*;**

We specialize in Asset Preservation, Retirement Planning and two Long Term Care government programs (The Non-Service Connected Disability Pension with Aid and Attendance and Medi-Cal LTC). We work in conjunction with U.S. Senior Vets, Medi-Cal Specialists and VA Accredited Legal Council. U.S. Senior Vets is a 501(c)3 non-profit organization comprised of Veteran Service Officers and VA Accredited attorneys. Medi-Cal LTC is a government entitlement program that helps to defray the cost of a skilled nursing facility. We work with our legal council that specializes in VA Law, Medi-Cal LTC and Elder Law to ensure that any planning solutions we recommend are within the current laws of the VA and Medi-Cal.

Our services are always free of charge.

No one other than the Department of Veterans Affairs can approve or deny a claim therefore, we cannot make any guarantees. We can, however, educate, guide and help you collect all of the necessary evidence and documentation needed to be able to submit the most well documented claim for the VA with the support of our entire team of professionals working together to assist you.

Please take a few minutes to learn more about U.S. Senior Vets by clicking on the link below.
http://youtu.be/DNnOdns670s

Part One:

Veterans or Surviving Spouse Demographic Information

For

Non Service Connected Disability Pension Benefits

Date ____/____/____ **Please Print Clearly**

Veterans Information Check if deceased [ ]

Veterans Name: _____ **Date of Birth:**_____ **Age** _____

Place of birth:_____

Veterans Spouse (If applicable)

Complete Name:_____ **Date of Birth:**_____ **Age** _____

Claimant (person applying for the benefit) **is a: Married Veteran [ ] Single Veteran [ ] Surviving Spouse [ ]**

Telephone Number for Claimant: (____)_____

Contact Person (Next of Kin)

Name:_____ **Relationship to Veteran; Child[ ] Spouse[ ] Other** _____

Telephone Numbers: Home: (___)_____**Work:** (___)_____**Cell**:(___)_____

Address : _____ **Email:** _____

Children (Other than contact person)

Name:_____ **City:**_____ **Name:**_____ **City:**_____

Name:_____ **City:**_____ **Name:**_____ **City:**_____

Assisted Living Community or In Home Care Provider Information

Name of Community or Provider:_____

Contact at Senior Care Facility:_____ **Phone Number: (____)_____**

Current resident since : _____ **Date planning on moving in:** _____

Has the claimant been diagnosed with: **Cognitive Impairment ___ Dementia ___ Alzheimer's ___**

Have funeral / final expenses been pre funded **Yes [ ] No [ ]** **Trust in Place** **Yes [ ] No [ ]**

Financial Powers of Attorney in place **Yes [ ] No [ ]**

Name of POA and their relationship to the claimant: _____

Your Local Volunteer Veteran Advocate

Gabriel Lenhart

P.O. Box 2596 Grass Valley, CA 95949

Phone: 530-268-5485

Email: lenhart.legal@gmail.com

Part Two:

Asset Planning Worksheet

A. Cost of Care and Fixed Monthly Medical Expenses

Monthly Bill from Assisted Living Facility or Home Care Provider $_____
Health Insurance Premium $_____ Dental Insurance Premium $_____
LTC Insurance Premium $_____ Medicare Deductions Part B $_____ Part D $_____
A. Total $_____

Additional Variable Monthly Medical Expenses (Estimated figures OK); Pharmacy-Veteran $_____
Pharmacy-Spouse $_____ Incontinent Supplies $_____ Other $_____ **Total $_____**

B. Gross Monthly Income Veteran Spouse

Social Security	$_____	$_____	(Before Medicare deduction)
Long Term Care Insurance	$_____	$_____	Source _____
Retirement or Pension Income	$_____	$_____	Source _____
Retirement or Pension Income	$_____	$_____	Source _____
RMD from IRA/401K	$_____	$_____	
Interest Income (Estimate OK)	$_____	$_____	
Rental Income (Net)	$_____	$_____	Mortgage on Property $_____
VA or Military Income	$_____	$_____	Disability ___ Retirement___
Other	$_____	$_____	Source _____

B. Total $_____

C. Combined Net Worth Excl. Real Estate (Please provide proof and or copies of statements if requested)

Checking $ _____ Savings $ _____ CD's $ _____
Mutual Funds $ _____ Stocks $ _____ Annuities $ _____
Bonds $ _____ Life Insurance $ _____ (Cash Value - estimate OK)
IRA/401K's $ _____ (Applicant) RMD taken for the year $ _____
IRA/401K's $ _____ (Spouse) RMD taken for the year $ _____
Other Assets $ _____ Details: _____

C. Total $_____

D. Real Estate

Own a Primary Residence? [ ] Yes [ ] No (Exempt for VA purposes under specific conditions)
Estimated Value $ _____ Mortgage if any $ _____ Monthly Payment $ _____
If claimant or spouse is not living in the property plans are to; [ ] Sell [ ] Rent [ ] Leave unoccupied
Other Real Estate [ ] Yes [ ] No Details: _____

Important Note! The Veterans Administration has immediate access to an applicant's Internal Revenue tax records as well as Social Security Records. Please be accurate as to the information you provide.

RECOMMENDATIONS ON HOW TO COMPLETE THE PHYSICIANS REPORT - SPOUSE

This form must be completed and signed by the Spouses examining physician (does not have to be a VA doctor). This may be the only medical information the VA will use to determine medical eligibility. Incomplete or inaccurate forms could result in a denial of benefits.

The Spouse must have a "Diagnosis" or medical necessity requiring them to live in an Assisted Living Facility or requiring assistance in the home with at least 2 of the 5 specific ADL's listed in Blocks 16 through 21.

The Spouse must require a need for Aid and Attendance of another person, and this form must show:

1. The patient requires the aid of another person in order to perform 2 of these 5 personal functions required in everyday living: Eating/Feeding (not meal preparation), Bathing or Showering, Dressing, Transferring or Toileting.

OR

2. The patient's eyesight is limited to a corrected 5/200 visual acuity or less in both eyes or, The patient's eyesight is limited to a concentric contraction of the visual field to 5 degrees or less.

The following are some questions that need special attention and/or clarification. If the question requires an explanation do not leave blank.

BLOCK 8: COMPLETE DIAGNOSIS: This cannot be left blank and the examining physician must be VERY thorough in documenting major and minor conditions and problems. It will also help if the report characterizes the diagnoses as being very severe, far advanced, etc. The DIAGNOSIS MUST BE WELL SUBSTANTIATED IN THE REMAINDER OF THE QUESTIONS. A problem list from the doctor may also be used.

BLOCKS 19-23: The patient would require a "YES" on at least 2 of these questions in order to have it support the medical eligibility requirements.

BLOCKS 24: Medication Management is NOT an ADL recognized by the VA.

BLOCKS 25: This is a question of mental capacity. "YES" should be marked if there is a diagnosis like Dementia or other Cognitive Impairment that affects mental capacity. This is NOT a question of the patient's physical ability to write a check or balance a checkbook.

BLOCK 29-30: If the patient meets the VA standards listed in either of these two blocks, this form must be completed by an Ophthalmologist.

SIGNATURE AND TITLE OF PHYSICIAN: Make sure that only the doctor signs this form and they put MD or DO after their signature. PA or FNP signatures are not acceptable to the VA for purposes of this benefit.

PHYSICIANS REPORT FOR AID & ATTENDANCE –SPOUSE

1. FIRST – MIDDLE – LAST NAME OF VETERAN	2. VETERAN SOCIAL SECURITY NUMBER	3. CLAIM NUMBER

4. NAME OF SPOUSE	5. SPOUSE SOCIAL SECURITY NUMBER
6. DATE OF EXAMINATION	7. HOME ADDRESS

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 himself/herself; to attend to the wants of nature; or keep himself/herself ordinarily clean and presentable.
Findings should be recorded to show whether the claimant is blind or bedridden.
Whether the claimant needs 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.

8. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 17 through 36)*

9. AGE	10. SEX	11. WEIGHT ACTUAL: LBS ESTIMATED: LBS	12. HEIGHT FEET INCHES

13. NUTRITION

14. BLOOD PRESSURE	15. PULSE RATE	16. RESPIRATORY RATE	17. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

18. IS THE PATIENT CONFINED TO BED? *(If 'YES' INDICATE THE NUMBER OF HOURS IN BED)*

☐ YES ☐ NO FROM 9PM to 9AM: FROM 9AM TO 9 PM

19. DOES THE PATIENT NEED ASSISTANCE WITH EATING/FEEDING? *(If 'YES' provide explanation)*

☐ YES ☐ NO

20. DOES THE PATIENT NEED ASSISTANCE WITH BATHING OR SHOWERING? *(If 'YES' provide explanation)*

☐ YES ☐ NO

21. DOES THE PATIENT NEED ASSISTANCE WITH DRESSING? *(If 'YES' provide explanation)*

☐ YES ☐ NO

22. DOES THE PATIENT NEED ASSISTANCE WITH GETTING IN OR OUT OF BED OR A CHAIR? *(If 'YES' provide explanation)*

☐ YES ☐ NO

23. DOES THE PATIENT NEED ASSISTANCE WITH USING THE TOILET? *(If 'YES' provide explanation)*

☐ YES ☐ NO

24. DOES THE PATIENT NEED MEDICATION MANAGEMENT? *(If 'YES' provide explanation)*

☐ YES ☐ NO

25. DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If 'NO' provide explanation)*

☐ YES ☐ NO

26. DOES THE PATIENT NEED TO LIVE IN A PROTECTED ENVIRONMENT DUE TO A MENTAL OR PHYSICAL CONDITION*? (If 'YES' circle diagnosis or explain physical condition)*

☐ YES ☐ NO MENTAL DIAGNOSIS: DEMENTIA ALZHEIMER'S OTHER _____

27. CAN THE PATIENT ADEQUATELY PROTECT THEMSELVES FROM THE HAZARDS OF THEIR ENVIRONMENT? IF 'NO' EXPLAIN WHY AND INCLUDE A MEDICAL DIAGNOSIS FOR THE INABILITY.

☐ YES ☐ NO

28. IS THE PATIENTS EYESITE LIMITED TO CONCENTRIC CONTRACTION OF THE VISUAL FIELD TO 5 DEGREES OR LESS? *(If "YES" provide explanation)*

☐ YES ☐ NO

29. IS THE PATIENTS EYESITE LIMITED TO A CORRECTED 5/200 VISUAL ACUITY OR LESS IN BOTH EYES? *(IF 'YES' enter corrected vision in #30)* ☐ YES ☐ NO ☐ NA	30. CORRECTED VISION	
	LEFT EYE	RIGHT EYE

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

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, 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)*

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

34. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK.

35. 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 CLAIMANTS 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.

36. IS PATIENT ABLE TO LIVE AT HOME WITHOUT ASSISTANCE? (If 'NO' complete #37 below)

☐ YES ☐ NO

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

38. 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 #37 above)*

☐ YES ☐ NO (If 'YES' give distance) ☐ 1 BLOCK ☐ 5 OR 6 BLOCKS ☐ 1 MILE ☐ OTHER *(Specify distance)*

PRINTED NAME OF EXAMINING PHYSICIAN *(Must be an MD or DO)*	ADDRESS OF PHYSICIAN	TELEPHONE NUMBER OF PHYSICIAN *(Include Area Code)*

SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	DATE SIGNED

Acknowledgement of Services Offered by Gabriel Lenhart

- I understand that Gabriel Lenhart is not a government agency and is not affiliated with the Department of Veterans Affairs (VA).

- I understand that Gabriel Lenhart in conjunction with Veteran Service Officers and VA Accredited attorneys can educate me with up to date information, so that I can submit a properly prepared and well documented Aid & Attendance claim to the VA.

- I understand that only the VA can approve or deny a claim. Therefore, Gabriel Lenhart CANNOT make any guarantees in regards to an approval or the total amount of benefit awarded by the VA.
- I understand that Gabriel Lenhart does **NOT** receive any compensation from the VA, any government agencies or any other sources for their assistance. Our services are always free of charge.

- I understand that Gabriel Lenhart generates income only from the estate planning services he offers.

By offering this invaluable service to our veterans, surviving spouses and their families, Gabriel Lenhart hopes that you will find our assistance to be helpful and our team to be professional, knowledgeable and courteous.

All applications are filed by a Veterans Service Officer, VA Accredited Claims Agent or Attorney!

We appreciate the opportunity to earn your future business and hope you think of us if you, any member of your family or a friend needs any of the services we offer. This is what enables us to continue to offer free services to all of the families we assist.

Signature of Veteran, Surviving Spouse and/or their representative:

Name of Veteran / Spouse: _____ Signature: _____

Name of representative: _____ Signature: _____

Date: _____

Instructions for STANDARD FORM 180

REQUEST PERTAINING TO MILITARY RECORDS

To initiate this process only send us a **COPY** of the veteran's Discharge Papers with the initial documentation and forms requested in this email. Once you return the completed paperwork to us we will then submit everything to US Senior Vets;

1. US Senior Vets will then email you the "Final signature Pages"
2. You will be instructed to print the forms, have the applicant sign the Signature Pages and mail them back to USSV along with a "Certified/Original" Military Discharge Paper(s).

We do not recommend sending the VA the only originals you have as the VA does not always return them so please;

1. Order additional copies of the Discharge Papers by filling out the following page named " REQUEST PERTAINING TO MILITARY RECORDS"
2. Fax to the National Archives: Fax (314)801-9195 (Alternate fax number (314)801-9049

It typically takes 3-5 weeks to receive the certified originals in the mail. Make sure to add a cover page and we recommend requesting additional copies.

REQUEST PERTAINING TO MILITARY RECORDS

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

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

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

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

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

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

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☑ **DD Form 214 or equivalent.** When was the DD Form(s) 214 issued? YEAR(S): _____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214 . ☐.

The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

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

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

☐ **Other** (Specify): _____

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☑ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) No signature required for Archival records.*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran: _____ ***(Relationship)***
☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) _____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

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

Name

Street Apt.

City State Zip Code

3. AUTHORIZATION SIGNATURE WHEN REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct. No signature required for Archival records.

Signature Required - Do not print **Date**

( ) Daytime phone ( ) Fax Number

Email address

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