Department of Veterans Affairs

GENERAL INSTRUCTIONS FOR VETERAN'S APPLICATION FOR COMPENSATION VA FORM 21-526

NOTE: Read very carefully, detach, and keep these instructions for your reference.

A. How can I contact VA if I have questions?

If you have questions about VA benefits, this form or how to fill it out, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line 1-800-829-4833). You may also contact VA by Internet at http:// www.vba.va.gov/benefits/address.htm.

B. How can I get information about Social Security Benefits?

Individuals with a disability who meet certain medical criteria may qualify for benefits under the Social Security or Supplemental Security Income disability programs. These programs are administered by the Social Security Administration (SSA). For more information, contact SSA. You can locate the address of the nearest SSA office in the blue pages of your telephone book under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TTY line 1-800-325-0778). You can also contact SSA by Internet at www.ssa.gov.

C. What is the purpose of VA Form 21-526?

Use VA Form 21-526 to apply for compensation for service-connected disabilities.

D. What is disability compensation and how does VA decide what I will or will not receive?

VA pays veterans disability compensation for disability(ies) that are a result of their military service. If VA determines that your disability(ies) are 30% or more disabling, VA can pay additional compensation for your spouse, children, and dependent parents. VA will pay a higher amount of compensation for a spouse when the spouse is a patient in a nursing home or is disabled and requires regular aid and attendance of another person.
If any of the following are true, use VA Form 21-526 to apply for compensation:

- You were injured or seriously ill during service
- You believe you have continuing problems as a result of a service-related condition
- You developed a mental or physical disorder that may be related to your service

E. What evidence should I submit?

If you have records that support your claim you should attach them to this application. Refer to the checklist on page 2 of these instructions for a list of records you should submit. If you know of other records that will support your claim, VA will help you by requesting them from the person, company, or agency that has them.

If you want help obtaining existing non-VA medical records, you must complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). By signing VA Form 21-4142, you authorize any doctors, hospitals or caregivers that have treated you to release information about your treatment to VA. You do not need to complete this form for any treatment you received at a VA facility. Complete a separate VA Form 21-4142 for each medical provider. If you need additional copies of this form, you may contact VA as shown in paragraph A, download the form from our website at http://www.va.gov/vaforms/, or photocopy the attached form.

Note **:** You may complete and submit this application electronically at http://vabenefits.vba.va.gov/vonapp/main.asp.

F. How do I complete my application?

You will find instructions for completing each section of VA Form 21-526 in the checklist below. Your answer to every question is important in assisting us to decide your claim. Print all answers clearly. If an answer is "none" or "0," write that. If you do not know the answer, write "unknown." For additional space, use Item 52 "remarks" or attach a separate sheet of paper to your form, identifying the item number to which your answer applies.

CHECKLIST: THINGS YOU'LL NEED TO PREPARE FOR FILLING OUT YOUR APPLICATION		
When you fill out this VA Form. . .	*You'll need this information ready to answer questions. . .*	*You should attach these documents. . .*
Sections II through IV	☐ Dates and places you entered and left active duty ☐ Date and place your Reserve and/or National Guard service began and ended (If applicable) ☐ Mailing addresses of the Reserve or National Guard units in which you served	☐ Original or certified copies of your DD214 or other separation documents for all periods of service ***Note:*** To obtain a certified copy, you can take the original to your local courthouse and have it copied and signed by an official of the court. A VA employee can also certify a copy of the original for you
Section V	☐ Date(s) and place(s) of your injury while on travel	
Section VI	☐ Type and amount of military benefits you receive	
Section VII	☐ Information about the disabilities you are claiming, including • treatment dates during service • name and address of the medical facilities where you have been treated since service ended ☐ Information about any exposure to toxins or events that caused disabilities you are claiming, including dates and places where the exposure(s) occurred	☐ Original or copies of service medical records in your possession ☐ Medical records you possess showing your disabilities still exist ☐ Medical records you possess indicating that the disabilities were caused by or happened during active duty ☐ Completed VA Form 21-4142 for each non-VA medical care provider whose records you would like us to help you obtain
Section VIII and IX	☐ Information about your current spouse, including: • social security number • date of birth • VA file number if he/she is a veteran ☐ Information about you and your spouse's previous marriages, including: • dates and places of those marriages • dates and places those marriages	☐ A copy of your marriage certificate and all divorce decrees may be required upon request by VA
Section X	☐ Information about your children, including: • social security number • dates and places of birth ☐ Additional information about your children who are not living with you, including: • addresses • amounts that you contribute in child support for them	☐ Copies of the public birth records for each child you claim as a dependent may be required in some cases ☐ Copies of the court records of adoption for each adopted child
Section X	☐ Direct Deposit Information	☐ Voided Check
Section XII	☐ Sign and date your application	☐ If you sign with an "X," two persons must witness it, and you must provide their names and addresses
Section XIII	☐ Any additional information you would like to provide VA as it relates to your claim	

G. What do I do when I have completed my application?

1. Make sure you sign and date this application (Items 48 and 49)

2. Attach any materials that support and explain your claim. Review the checklist on pages 2 and 3 of these instructions to make sure you have attached all supporting material.

3. Make a photocopy of your application and everything that you submit to VA for your records.

4. Mail or take your original application and supporting materials to your nearest VA regional office.

Note **:** If you find you need to change or add information to your application, contact the VA office where you submitted your application immediately.

H. How can I assign someone to act as my representative?

A representative may be an accredited member of an accredited organization that the Secretary of Veterans Affairs recognizes, an agent recognized by VA, or a licensed lawyer. Agents and attorneys may charge you for service they provide only after the Board of Veterans' Appeals (BVA) gives you its final decision about your claim. That means you can use an attorney during any stage of your application for benefits. However, the agent or attorney is prohibited by law from charging you for services unless you are trying to resolve a dispute with VA after BVA has made a decision about your claim.

If you want to use a representative to help you with your application, contact the nearest VA regional office. Depending on the type of representative you want to designate, we will send you one of the following forms:

☐ VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, or

☐ VA Form 21-22a, Appointment of Individual as Claimants Representative.

You may also download these forms at **http://www.va.gov/vaforms/.** If you have already designated a representative, no further action is required on your part.

I. What if I believe VA made an error in processing or deciding my claim?

You may ask for a personal hearing at any time. That means you may ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA regional office and tell them that you want a personal hearing on your case. Someone in that office will arrange a time and a place for your hearing. At this hearing, you may bring witnesses. VA will record whatever you and your witness say during the hearing and include it in the official record. VA will furnish the hearing room and official, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing.

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 the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is voluntary; however, no allowance of compensation may be granted unless this form is completed fully as required by law. Giving us your and your dependents' Social Security number 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 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 under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies. Income and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103 (1)(7)(D) of the Internal Revenue Code of 1986.

Respondent Burden: We need this information to determine eligibility for compensation (38 U.S.C. 5101). Title 38, United States Code, allows us to as for this information. We estimate that you will need an average of 1 hour and 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.html#VA. If

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

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR COMPENSATION
VA Form 21-526

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

SECTION I — Tell us about you

1. What is your name?

First ______ Middle ______ Last ______ Suffix (If applicable) ______

2. What is your social security number? ______

3. What is your sex?
☐ Male ☐ Female

4a. Have you ever filed a claim with VA?
☐ Yes **(If "Yes," provide file number below and complete Item 4b)**
______
(VA File Number)
☐ No **(If "No," go to Item 5)**

4b. I filed a claim with VA for
☐ Compensation
☐ Pension
☐ Other

5a. Did you serve under another name?
☐ Yes Yes **(If "Yes," go to Item 5b)**
☐ No Yes **(If "No," go to Item 6)**

5b. Please list the other name(s) you served under
______
______

Give us your current mailing address in the space provided. If it will change within the next three months, give us that new address in Item 52, "Remarks." Also in Item 52, give us the date you think you will be at the new address.

6. What is your address?

Street address, rural route, or P.O. Box ______ Apt. number ______

City ______ State ______ ZIP Code ______ Country ______

7. What are your telephone numbers?
Daytime ( ) ______
Evening ( ) ______

8. What is your e-mail address? ______

9. What is your date of birth?
___/___/___
month day year

10. Where were you born?
City ______ State ______ Country ______

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

11a. Are you receiving disability benefits from the Office of Workers' Compensation *(OWCP)*?
☐ Yes ☐ No
(If "Yes," answer 11b and 11c also)

11b. When was the claim filed?
___/___
month year

11c. For what disability are you receiving benefits?
______

12a. What is the name of your nearest relative or other person we could contact if necessary?

12b. What is his/her telephone number?
Daytime ( ) ______
Evening ( ) ______

12c. What is this person's address?

12d. How is this person related to you?
______

SECTION II — Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed, use Item 52 "Remarks".

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

The VA has a registry of veterans who served in the Gulf War theater of operations. If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 15b. VA will only share the information in this registry with the Department of Defense and others as permitted by law (such as the National Academy of Sciences). We will keep you informed of significant developments in research on health consequences found to be related to military service in the Gulf War. You may request a VA health examination that will include consultation and counseling covering the results of the examination. You should contact our nearest VA medical facility to request an examination.

13a. I entered active service the **first** time. . . ___/___/___ mo day yr	**13b.** Place:	**13c.** My service number was . . .	
13d. I left this active service. . . ___/___/___ mo day yr	**13e.** Place:	**13f.** Branch of Service	**13g.** Grade, rank, or rating
13h. I entered my **second** period of active service. . . ___/___/___ mo day yr	**13i.** Place:	**13j.** My service number was . . .	
13k. I left this active service. . . ___/___/___ mo day yr	**13l.** Place:	**13m.** Branch of Service	**13n.** Grade, rank, or rating

14a. Did you serve in Vietnam?

☐ Yes ☐ No

(If "Yes," answer Item 15b also)

14b. When were you in Vietnam?

from ___/___/___ mo day yr   to ___/___/___ mo day yr

15a. Were you stationed in the Gulf after August 1, 1990?

☐ Yes ☐ No

(If "Yes," answer Item 15b also)

15b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?"

☐ Yes ☐ No

16a. Have you ever been a prisoner of war?

☐ Yes ☐ No

(If "Yes," answer Items 16b, 16c, and 16d also)

16b. What country or government imprisoned you?

16c. When were you confined?

from ___/___/___ mo day yr   to ___/___/___ mo day yr

16d. What was the name of the camp or sector, and what are the names of the city and country near its location?

SECTION III — Tell us about your reserve duty

17a. Are you currently assigned to an active reserve unit?

☐ Yes ☐ No

(If "Yes," answer Item 17b also)

17b. What is the name, mailing address, and telephone number of your current unit?

17c. Were you previously assigned to an active reserve unit within the last 2 years?

☐ Yes ☐ No

(If "Yes," answer Item 17d also)

17d. What is the name, mailing address, and telephone number of that unit?

SECTION III (Continued) Tell us about your reserve duty

17e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)

☐ Yes ☐ No ☐ Don't know

(If "Yes," answer Item 17f also)

17f. What is your reserve obligation termination date?

___/___/___ mo day yr

Instructions 17g-17k

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

1. Complete 17g-17k for that service only.
2. Attach proof of reserve service

17g. I entered reserve service. . .

___/___/___ mo day yr

Place:

17h. My service number was . . .

17i. I left reserve service. . .

___/___/___ mo day yr

Place:

17j. Branch of service

17k. Grade, rank, or rating

Instructions 17l-17p

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

1. Complete 17l-17p for the period when your disability occurred.
2. Attach proof that your disability occurred during reserve service.

17l. I entered reserve service. . .

___/___/___ mo day yr

Place:

17m. My service number was . . .

17n. I left reserve service. . .

___/___/___ mo day yr

Place:

17o. Branch of service

17p. Grade, rank, or rating

SECTION IV Tell us about your National Guard duty

18a. Are you currently a member of the National Guard?

☐ Yes ☐ No ☐ Not assigned yet

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

18b. What is the name, mailing address, and telephone number of your current unit?

18c. Were you previously assigned to a guard unit within the last 2 years?

☐ Yes ☐ No

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

18d. What is the name, mailing address, and telephone number of that unit?

Instructions 18e-18i

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

1. Complete 18e-18i for that service only
2. Attach proof of this Federal Active Duty.

18e. I entered Federal Active Duty. . .

___/___/___ mo day yr

Place:

18f. My service number was . . .

18g. I left Federal Active Duty. . .

___/___/___ mo day yr

Place:

18h. Branch of service

18i. Grade, rank, or rating

Instructions 18j-18n

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

1. Complete 18j-18n for the period when your disability occurred
2. Attach proof that your disability occurred during National Guard service.

18j. I entered the National Guard. . .

___/___/___ mo day yr

Place:

18k. My service number was . . .

18l. I left National Guard. . .

___/___/___ mo day yr

Place:

18m. Branch of service

18n. Grade, rank, or rating

SECTION V — Tell us about your travel status

19a. Were you injured while traveling to or from your military assignment?

☐ Yes ☐ No

(If "Yes," answer Items 19b thru 19e)

19b. When did your injury happen?

___/___/___
mo day yr

19c. Where did your injury happen? (City,State,Country)

19d. Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)

19e. With what agency did you file an accident report?

SECTION VI — Tell us about your military benefits

Note: If you are receiving or are entitled to receive military retired pay, your military retired pay may be reduced by the amount of any compensation that VA may award you. However, this is to your advantage, because VA compensation is not taxable and most retired pay is taxable. Your signature on this application indicates to us, without separate notice, that you want to get VA compensation instead of military retired pay. Military retired pay in excess of VA compensation will still be awarded to you if VA compensation is granted. In some cases you may be entitled to both VA compensation *and* military retired pay or Combat Related Special Compensation. VA notifies the Military Retired Pay Center of awards of VA benefits and all VA benefit changes. The Department of Defense determines if you are eligible for payments from your service branch.

20a. Are you receiving or will you receive retired pay or retainer pay that is based on your military service?

☐ Yes (If "Yes," answer Items 20b thru 20d)

☐ No (If "No," skip to Item 21)

20b. What branch of service is paying or will pay your retired pay?

20c. What is the monthly amount?

$ ________ . ________
Monthly Amount

20d. What is your retirement based on?

☐ Length of service

☐ Disability

☐ TDRL (Temporary Disability Retired List)

If you received any of these military benefits and VA benefits are awarded, the amount you received may be recouped by VA, or in the case of VSI, by the Department of Defense.

20e. Have you received or will you receive any of the following military benefits?
(Please check the appropriate boxes and tell us the amount)

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

SECTION VII **Tell us about your disability**	In the table below, tell us more about your disability or disabilities. Be sure to: ● List all disabilities you believe are related to military service. Try to list the actual disease and medical condition that a doctor has diagnosed. ● List all the treatments you received for your disabilities, including • treatments you received in a military facility before and after discharge. • treatments you received from civilian and VA physicians before, during, and after your service.

21a. What disability are you claiming?	**21b.** When did your disability begin?	**21c.** When were you treated?	**21d.** What medical facility or doctor treated you?	**21e.** What is the address of that medical facility or doctor?
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		
	__/__/__ mo day yr	from __/__/__ to __/__/__		
	__/__/__ mo day yr	from __/__/__ mo day yr to __/__/__ mo day yr		

SECTION VII **Tell us about your disability** ***(Continued)***

22a. Did you have a separation or retirement physical examination?

☐ Yes ☐ No

(If "Yes," answer Items 22b and 22c also)

22b. When was the exam?

___/___/___
mo day yr

22c. Where did the exam occur?

23. Do you have a medical condition (pregnancy, recent surgery, allergy to contrast media, etc.) that may prevent you from undergoing a VA physical examination?

☐ Yes ☐ No

24a. Did exposure to Agent Orange or other herbicides cause your disability?

☐ Yes ☐ No

(If "Yes," answer Item 24b and 24c also)

24b. What is your disability?

24c. In what country were you exposed?

25a. Did exposure to Asbestos cause your disability?

☐ Yes ☐ No

(If "Yes," answer Items 25b and 25c also)

25b. What is the disability?

25c. When and how were you exposed?

26a. Did exposure to mustard gas cause your disability?

☐ Yes ☐ No

(If "Yes," answer Items 26b and 26c also)

26b. What is the disability?

26c. When and how were you exposed?

27a. Did exposure to ionizing radiation cause your disability?

☐ Yes ☐ No

(If "Yes," answer Items 27b through 27d)

27b. What is the disability?

27c. What are the dates and places of exposure, *OR* what is the operation or test-shot code name?

27d. How were you exposed to radiation?

☐ Atmospheric or oceanic testing
☐ American occupation of Nagasaki or Hiroshima
☐ Military duties (occupational exposure) (Describe circumstances below in Item 29)

28a. Did exposure to an environmental hazard in the Gulf War cause your disability?

☐ Yes ☐ No

(If "Yes," answer Items 28b through 28c)

28b. What is the disability?

28c. What was the hazard?

29. How are the disabilities listed in Item 21a related to your military service?

SECTION VIII — Tell us about your marriage

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

30. What is your marital status?

☐ Married ☐ Surviving spouse ☐ Divorced ☐ Never married

(If your spouse died, you are "divorced," or "never married" skip to Section X)

31. When were you married?

____/____/________
mo day yr

32. Where did you get married?

____
(city/state or country)

33. How were you married?

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

b. ☐ Common law

c. ☐ Tribal

d. ☐ Proxy

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

____
____
____

34. What is your spouse's name?

35. When is your spouse's birthday?

____/____/________
mo day yr

36. What is your spouse's social security number?

37a. Is your spouse also a veteran?

☐ Yes (If "Yes," answer Item 37b also)
☐ No

37b. What is your spouse's VA file number? *(If any)*

____

38a. Do you live with your spouse?

☐ Yes (If "Yes," skip to Section X)
☐ No (If "No," answer Items 38b through 38d)

38b. What is your spouse's address?

____
Street address, rural route, or P.O. Box Apt. number

____
City State ZIP Code Country

38c. Tell us why you are not living with your spouse

38d. How much do you contribute monthly to your spouse's support?

$ ________ . ________

SECTION X	Tell us about any previous marriages	You must furnish complete information about ***all*** of your and your present spouse's previous marriages. If you need additional space, please use Item 52 "Remarks" or attach a separate sheet of paper. NOTE: You should provide copies of divorce decrees or death certificates.

Your previous marriages

39a. How many times have you been married before? ____________

39b. When were you married?	**39c**. Where were you married? (city/state or country)	**39d.** Who were you married to? (first, middle initial, last)	**39e**. When did your marriage end?	**39f**. Why did your marriage end? (death, divorce)	**39g.** Where did your marriage end? (city/state or country)
__/__/__ mo day yr			__/__/__ mo day yr		
__/__/__ mo day yr			__/__/__ mo day yr		

Your spouse's previous marriages

40a. How many times has your current spouse been married before? ____________

40b. When was your spouse married?	**40c**. Where was your spouse married? (city/state or country)	**40d.** To whom was your spouse married? (first, middle initial, last)	**40e**. When did your spouse's marriage end?	**40f**. Why did your spouse's marriage end? (death, divorce)	**40g**. Where did your spouse's marriage end? (city/state or country)
__/__/__ mo day yr			__/__/__ mo day yr		
__/__/__ mo day yr			__/__/__ mo day yr		

SECTION X Tell us about your other dependents

In this section we want to know whether your parents are financially dependent on you and more about your dependent children. VA may recognize a veteran's biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under the age of 18, **or**
- at least 18 but under 23 and pursuing an approved course of education, **or**
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 43h) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment. If you need additional space, please use Item 52 "Remarks" or attach a separate sheet of paper.

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

41. Are your parents financially dependent on you?

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

42. Do you have dependent children?

☐ Yes ☐ No (If "No," Skip to Section XI)

SECTION X Tell us about your dependent children *(Continued)*

43a. Name of child (first, middle initial, last)	43b. Date and place of birth (city/state or country)	43c. Social Security Number	43d. Biological	43e. Adopted	43f. Stepchild	43g. 18-23 yrs. old and in school	43h. Seriously disabled before age 18	43I. Child previously married
	__/__/__ mo day yr Place:		☐	☐	☐	☐	☐	☐
	__/__/__ mo day yr Place:		☐	☐	☐	☐	☐	☐
	__/__/__ mo day yr Place:		☐	☐	☐	☐	☐	☐
	__/__/__ mo day yr Place:		☐	☐	☐	☐	☐	☐

Tell us about the children listed above who *don't live with you*

44a. Name of child (first, middle initial, last)	44b. Child's complete address	44c. Name of person with whom the child lives (If applicable) (first, middle initial, last)	44d. Monthly amount you contribute to child's support
			$.
			$.
			$.

SECTION XI Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All Federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer questions 45-47 to the right.

All Federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT), also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 45, 46 and 47 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the appropriate box below in Item 45. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign up for one of the accounts or continue to receive a paper check. You may also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You may write to: Department of Veterans Affairs, 125 S. Main Street, Suite B, Muskogee OK 74401-7004, and give us a brief explanation of why you do not wish to participate in Direct Deposit.

45. Account number (Please check the appropriate box and provide that account number, if applicable)

☐ Checking

☐ Savings

☐ I certify that **I do not** have an account with a financial institution or certified payment agent

Account number ______________________

46. Name of financial institution

____

47. Routing or transit number

____

SECTION XII

Give us your signature

1. Read the box that starts, "I certify and authorize the release of information."
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have two people witness it. They must then sign the form and print their names and addresses also.

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

48. Your signature	**49.** Today's date ___/___/___ mo day yr
50a. Signature of witness (If claimant signed above using an "X")	**50b.** Printed name and address of witness
51a. Signature of witness (If claimant signed above using an "X")	**51b.** Printed name and address of witness

SECTION XIII

Remarks—Use this space for any additional statements that you would like to make concerning your application for compensation.

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

52. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form, please identify your answer or statement by the section and item number)*

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

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

Respondent Burden: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000
(TDD 1-800-829-4833 FOR HEARING IMPAIRED)

SECTION I —VETERAN/CLAIMANT IDENTIFICATION

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

SECTION II —SOURCE OF INFORMATION

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

8. COMMENTS:

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

SECTION III CONSENT TO RELEASE INFORMATION

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

9A. PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

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

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

____

____

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

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

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

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS