Department of Veterans Affairs

INFORMATION AND INSTRUCTIONS FOR COMPLETING VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT- Please read the information below carefully before completing the form. These instructions include questions regarding this form. The answers should help you fill out your form more quickly and accurately. In addition to these instructions, some parts of the form contain notes or specific instructions for completing that part.

Frequently Asked Questions

For what do I use VA Form 21-526?

Use VA Form 21-526 to apply for compensation and/or pension benefits.

Should I apply for compensation or pension benefits?

You should apply for **compensation** benefits if:

- You currently have a disability that is the result of an injury, disease, or an event in military service.

You should apply for **pension** benefits if *all* of the following are true:

- You are age 65 or older or are permanently and totally disabled.
- You served on active duty with at least one day during a period of war.
- Your income and net worth does not exceed certain limits. Visit our website, http://www.vba.va.gov/bln/21/rates for the maximum yearly income we allow.

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

IMPORTANT: If you are a veteran who is age 65 or older, or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are filing for special monthly pension.

What parts of the form should I complete?

You should complete only the parts related to the benefit for which you are applying:

- If you are applying for compensation **ONLY**, skip parts VII, VIII, IX, X.
- If you are applying for pension, complete the **ENTIRE** form.
- If you need more space to answer a question or have a comment about a specific item on this form, please place it in Part XIII, Item 45, "Remarks." Please identify your answer or comment by the part and item number.

Where can I get help?

You can ask VA to help you fill out the form by contacting a regional office or call center. Before you contact us, make sure you gather the necessary materials and complete as much of the form as you can. You can contact VA in the following ways:

- **By internet:**
  https://iris.va.gov
- **In person:**
  You can locate the address of the closest regional office on the website http://www.va.gov/directory or in your telephone book blue pages under **"United States Government, Veterans"**
- **By telephone:**
  Please call one of the following telephone numbers:
  1-800-827-1000
  1-800-829-4833 (Hearing Impaired TDD line)
  1-412-395-6272 (If living outside the U.S.)

You can also contact a county or national veterans' service organization (VSO) representative to help you with your claim. If you want to use a representative to help you, consult your local telephone book to contact a particular VSO or contact the closest VA 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
- VA Form 21-22A, Appointment of Individual as Claimant's Representative

SOCIAL SECURITY BENEFITS - The Social Security And Supplemental Security Income disability programs are the largest of several Federal programs that provide assistance to people with disabilities. While these two programs are different in many ways, both are administered by the Social Security Administration (SSA) and only individuals who have a disability and meet medical criteria may qualify for benefits under either program.

How can I contact SSA if I have questions?

If you have a question, call the SSA toll-free phone number at 1-800-772-1213, Monday through Friday, from 7a.m. to 7p.m. If you have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays. People who are deaf or hard of hearing may call the toll-free TTY number, 1-800-325-0778, between 7a.m. and 7p.m., Monday through Friday. Please have your Social Security number handy when you call. You can also contact SSA in the following ways:

- **By mail:**
  You can locate the address of the closest SSA office in your telephone book blue pages under **"United States Government, Social Security Administration"**
- **By internet:**
  http://www.ssa.gov/

What should I do when I have finished my application?

- You should provide your signature in Part XII, Item 42A. Be sure to sign every form you fill out before you send it to us. If you don't sign the form, VA will return it for you to sign, and it will take longer for us to process.
- Attach any materials that support and explain your claim.
- Mail or take your application to the closest VA regional office.

Do I need to keep a copy of my application?

It is important that you keep a copy of all completed forms and materials you give to VA.

Part II - Nature and History of Disability(ies)

What disabilities should I list?
List the disease(s) or medical condition(s) that a doctor has diagnosed. Be as specific as you can. Indicate the approximate date the disability began with the place of treatment.

Do I have to include any records with this claim form?
If you have records that support your claim, you should attach them to this form. VA will help you obtain records by requesting them from the person, company, or agency that has them. On this form you must tell us the name and address of the person, company or agency that has these records, the approximate time frame covered by them, and the condition for which you were treated. If you received treatment, complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). We will use this form to request these records. Due to Privacy Act regulations, please list only one source of information (Item 7) on each form, as some medical offices will not accept the forms otherwise, which may cause a delay in processing your claim. Additional 21-4142 forms can be downloaded from the VA forms website at www.va.gov/vaforms.

Part III - Active Duty Service Information

Do I need to include my active duty service information?
Please provide the information for each period of active duty (provide a copy of your DD214 or other separation papers for all periods of active duty service).

Part IV - Reserve and National Guard Service Information

What If I have Reserve or National Guard Service?
This section tells us if you were a member of the Reserve or National Guard. Complete information for each period of Reserve and National Guard service. Provide a copy of your DD214 or other separation papers for all periods of active service.

Part V - Military Retired/Severance Pay

What If I have received or will receive military pay?
If you currently receive military retired pay, we may reduce your retired pay by the amount of any compensation that we award. This is to your advantage because VA compensation is not taxable while retired pay is taxable. However, if you wish to receive military retired pay rather than VA compensation, you must check the box in Item 25. Some veterans receive various readjustment, separation, or severance pay from service departments which may be recouped in full or in part from VA benefit payments. This section tells us about your military severance or separation pay, the type, and the amount.

Part VI - Marital and Dependency Information

Who can I count as a dependent spouse?
A spouse is a person of the opposite sex who is married to the veteran (Authority: 38 U.S.C. subsection 101(31)). The marriage must be valid under the law of the place where the parties resided at the time of marriage, or the law of the place where the parties resided when the right to benefits occurred.
Note: It is important that we know the marital history of you and your spouse.

Who can be recognized as a dependent child?
VA recognizes the veteran's biological child, adopted child, and stepchild. However, the child must be unmarried and:

- be under the age of 18, or
- be at least 18 but under 23 and pursuing an approved course of education, or
- have become permanently unable to support themselves before reaching the age of 18.

Part VII - Nonservice-Connected Pension

This section asks you to give us the disabilities that prevent you from working. We also ask you to tell us if you require the regular assistance of another person, if you are housebound, if you are in a nursing home, if you are in receipt of Social Security, or if you have applied for Medicaid.

Part VIII - Income Information

This section asks you to give us specific information about the monthly income you and your dependents receive from all sources. Report the gross amount you receive monthly before deductions are taken out for taxes, insurance, health care, etc. Do not leave any blank boxes in this section! Complete each box with either a dollar figure, "0", or "none." If you expect to receive payment, but you don't know how much it will be, write "Unknown" in the space. If you are not sure about a particular type of income, report it and provide a full explanation of its source. If you are receiving monthly benefits and have a copy of your most recent award letter, please include a copy of the letter with your application.

Part IX - Net Worth

This section asks you to give us specific information about your net worth and the net worth of your dependents. Do not leave any blank boxes in this section! Complete each box with either a dollar figure, "0", or "none." If you and your spouse jointly share assets (such as money in a joint checking account), please clearly indicate this. You must include all assets in your net worth except those items you use everyday. Report farms or buildings that you or a dependent own by reporting its value as "real property."

Net worth is the market value of all interest and rights in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house in which you live or a reasonable area of land on which it sits. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture.

Applicant's applying for VA pension must disclose all financial transactions that involve a transfer of assets, even if the transaction occurred prior to the date of your application for VA pension. A gift of property or sale below the value of property made by you to a relative residing in the same household is not recognized as reducing net worth. A gift of property to someone other than a relative residing in your household is not recognized as reducing net worth unless it is clear that you have relinquished all rights of ownership, including the right of control of the property.

Part X - Medical, Legal or Other Expenses

When determining your eligibility for pension, we may be able to deduct unreimbursed medical expenses from your income for the year in which the expenses are paid. Report the amount of unreimbursed medical expenses, including the Medicare deduction you paid (out-of-pocket) for yourself or relatives you are under an obligation to support. Also, show medical, legal, or other expenses you paid because of a disability for which civilian disability benefits have been awarded. **Do not** report any expenses you did not pay or expenses for which you were or will be reimbursed.

OMB Control No. 2900-0001
Respondent Burden: 1 hour

Department of Veterans Affairs

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT - Read information and instructions carefully before completing the form. Type, print, or write plainly.

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

PART I - VETERAN'S INFORMATION

1. WHAT ARE YOU APPLYING FOR?

☐ COMPENSATION ☐ PENSION ☐ COMPENSATION AND PENSION

2. HAVE YOU PREVIOUSLY APPLIED FOR ANY VA BENEFIT(S)? *(Check applicable box)*

☐ PENSION ☐ COMPENSATION ☐ OTHER (Specify)

3. FIRST, MIDDLE, LAST NAME OF VETERAN

4A. VETERAN'S SOCIAL SECURITY NO.	4B. VA FILE NUMBER *(If applicable)*	4C. SPOUSE'S SOCIAL SECURITY NO.

4D. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.

5. MAILING ADDRESS (*Number and street or rural route, city or P.O., State and ZIP Code)*

6. TELEPHONE NUMBER(S) (Include Area Code)			7. E - MAIL ADDRESS *(If applicable)*
A. DAYTIME	B. EVENING	C. CELL	

8A. DATE OF BIRTH *(Month, day, year)*	8B. PLACE OF BIRTH	9. SEX
		☐ MALE ☐ FEMALE

10A. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? (*Formerly the U.S. Bureau of Employees Compensation)*	10B. WHEN WAS THE CLAIM FILED? *(Mo., day, yr.)*	10C. FOR WHAT DISABILITY ARE YOU RECEIVING BENEFITS?
☐ YES ☐ NO *(If "Yes," complete Items 10B & 10C)*		

PART II - NATURE AND HISTORY OF DISABILITY(IES) - Please use the "Remarks" section for additional disability(ies)

11. PLEASE PROVIDE NATURE OF SICKNESS, DISEASE, OR INJURIES FOR WHICH THIS CLAIM IS MADE; DATE EACH BEGAN; AND PLACE OF TREATMENT

A. LIST DISABILITY(IES)	B. DATE BEGAN	C. PLACE OF TREATMENT

12A. ARE YOU NOW OR HAVE YOU RECEIVED TREATMENT OR DOMICILIARY CARE AT A VA MEDICAL FACILITY?	12B. DATES OF TREATMENT/CARE			12C. NAME AND ADDRESS OF VA MEDICAL FACILITY (If you need more space use Item 45, "Remarks")
	Month	Day	Year	
☐ YES ☐ NO *(If "Yes,"complete Items 12B &12C)*				

13A. HAVE YOU EVER BEEN A PRISONER OF WAR?	13B. NAME OF COUNTRY	13C. DATES OF CONFINEMENT	
		FROM	TO
☐ YES ☐ NO *(If "Yes," complete Items 13B and 13C)*			

14. ARE YOU CLAIMING A DISABILITY RELATED TO AGENT ORANGE OR OTHER HERBICIDE EXPOSURE? *(If "Yes," list disability(ies) below)*

☐ YES ☐ NO _____

15. ARE YOU CLAIMING A DISABILITY RELATED TO ASBESTOS EXPOSURE? *(If "Yes," list disability(ies) below)*

☐ YES ☐ NO _____

16. ARE YOU CLAIMING A DISABILITY RELATED TO MUSTARD GAS EXPOSURE? *(If "Yes," list disability(ies) below)*

☐ YES ☐ NO _____

17. ARE YOU CLAIMING A DISABILITY RELATED TO IONIZING RADIATION EXPOSURE? *(If 'Yes," list disability(ies) below)*

☐ YES ☐ NO _____

18. ARE YOU CLAIMING A DISABILITY RELATED TO AN ENVIRONMENTAL HAZARD EXPOSURE DURING THE GULF WAR? *(If "Yes," list disability(ies) below)*

_____

☐ YES ☐ NO _____

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART III - ACTIVE DUTY SERVICE INFORMATION

NOTE: Please complete the information for each period of active duty. Attach DD214 or other separation papers for all periods of active duty. If you do not have your DD214 form or other separation papers, check the box. ☐

19A. ENTERED INTO SERVICE		19B. SERVICE NUMBER	19C. SEPARATED FROM SERVICE		19D. BRANCH OF SERVICE	19E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

PART IV - RESERVE AND NATIONAL GUARD SERVICE INFORMATION

NOTE: Enter complete information for each period of Reserves and National Guard service. Attach any separation papers you have.

20A. ENTERED INTO SERVICE		20B. SERVICE NUMBER	20C. SEPARATED FROM SERVICE		20D. SERVICE STATUS (Reserve, National Guard)	20E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

21. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE	22A. ARE YOU NOW A MEMBER OF THE RESERVES OR NATIONAL GUARD? IF SO, GIVE THE BRANCH OF SERVICE ☐ YES ☐ NO *BRANCH*_____	22B. RESERVE STATUS ☐ ACTIVE ☐ RESERVE OBLIGATION ☐ INACTIVE

22C. NAME, ADDRESS AND PHONE NO. OF RESERVES OR NATIONAL GUARD UNIT (If additional space is needed, use Item 45 "Remarks")

PART V - MILITARY RETIRED/SEVERANCE PAY

IMPORTANT - Unless you check the box in Item 25 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. If you receive both military retired pay and VA compensation, some of the amount you receive may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

23A. ARE YOU RECEIVING MILITARY RETIRED PAY? *(If "Yes," complete Items 23C & 23D)* ☐ YES ☐ NO	23B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? *(If "Yes," explain, i.e. Future Reserve/National Guard Retirement, Pending MEB/PEB)* ☐ YES ☐ NO _____	23C. BRANCH OF SERVICE	23D. MONTHLY AMOUNT $

24. RETIRED STATUS ☐ RETIRED ☐ TEMPORARY DISABILITY RETIRED LIST ☐ DISABLED RETIRED LIST	25. NO, I DO NOT WANT VA COMPENSATION IN LIEU OF MILITARY RETIRED PAY (Check box, if applicable) ☐

26. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE/SEPARATION PAY, OR ANY OTHER LUMP SUM PAYMENT FROM THE ARMED FORCES? *(If "Yes," list type, amount, date it was received, and the branch of service below)*

☐ YES ☐ NO _____

PART VI - MARITAL AND DEPENDENCY INFORMATION

27A. MARITAL STATUS (If married, complete Items 27B thru 29D) ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NEVER MARRIED *(If never married, skip to Item 30)*			27B. SPOUSE'S BIRTHDATE (Mo., day, yr.)
27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED *(To include current marriage)*	27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED *(To include current marriage)*	27E. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO *(If "Yes,"complete Item 27F)*	27F. SPOUSE'S VA FILE NUMBER (If any) **C-**
27G. DO YOU LIVE TOGETHER? ☐ YES ☐ NO *(If "No,"complete Items 27H thru 27J)*		27H. REASON FOR SEPARATION (For example, *marital problems, job requirements, health, etc.)*	27I. PRESENT ADDRESS OF SPOUSE

27J. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S MONTHLY SUPPORT **$**	27K. HOW WERE YOU MARRIED? ☐ CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL ☐ TRIBAL ☐ OTHER *(Explain)* _____ ☐ COMMON-LAW ☐ PROXY

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VI - MARITAL AND DEPENDENCY INFORMATION - CONTINUED ***(If you need additional space, use Item 45 "Remarks")***

FURNISH THE FOLLOWING INFORMATION ABOUT EACH OF YOUR MARRIAGES (IF NONE, WRITE "N/A")

28A. DATE AND PLACE OF MARRIAGE		28B. TO WHOM MARRIED	28C. TERMINATED (Death, Divorce)	28D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE (IF NONE, WRITE "N/A")

29A. DATE AND PLACE OF MARRIAGE		29B. TO WHOM MARRIED	29C. TERMINATED (Death, Divorce)	29D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

DEPENDENCY - Dependent Children Information *(If you need additional space, use Item 45 "Remarks")*

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN

30A. NAME OF CHILD (First, middle initial, last)	30B. DATE & PLACE OF BIRTH *(City, state or country)*	30C. SOCIAL SECURITY NUMBER	30D. CHECK EACH APPLICABLE CATEGORY					
			BIOLOGICAL	ADOPTED	STEPCHILD	18-23 YRS. OLD AND IN SCHOOL	SERIOUSLY DISABLED BEFORE AGE 18	CHILD PREVIOUSLY MARRIED
	_____ *(Month, day, year)* *Place:*		☐	☐	☐	☐	☐	☐
	_____ *(Month, day, year)* *Place:*		☐	☐	☐	☐	☐	☐
	_____ *(Month, day, year)* *Place:*		☐	☐	☐	☐	☐	☐

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN WHO DO NOT LIVE WITH YOU

31A. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	31B. NAME AND ADDRESS OF PERSON HAVING CUSTODY	31C. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		$
		$

PART VII - NONSERVICE-CONNECTED PENSION ***(If you need additional space, use Item 45 "Remarks")***

32. WHAT DISABILITIES PREVENT YOU FROM WORKING? *(List below)*	33. DO YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON OR ARE YOU HOUSEBOUND?
	☐ YES ☐ NO

NURSING HOME INFORMATION *(If you are in a nursing home provide the following information)*

NOTE: You may submit a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.

34A. ARE YOU NOW IN A NURSING HOME?	34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY	34C. HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☐ NO *(If "YES," complete Items 34B thru 34D)*		☐ YES ☐ NO

34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NO DECISION HAS BEEN MADE?	34E. ARE YOU RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSI BUT NO DECISION HAS BEEN MADE?
☐ YES ☐ NO ☐ APPLIED - NO DECISION	☐ YES ☐ NO ☐ APPLIED - NO DECISION

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VIII - INCOME INFORMATION *(Provide income you have received and you expect to receive from all sources)*

NOTE: Report the total amounts before deductions for taxes, insurance, etc. If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space. If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid. Payments from any source will be counted, unless the law says that they don't need to be counted.

MONTHLY INCOME - **Provide the income that you and your dependents receive every month. For items 35A -35F, if none, write "0" or "NONE." Do not leave blank spaces.**

ITEM NO.	SOURCES OF RECURRING MONTHLY INCOME	VETERAN	SPOUSE	CHILD(REN) (Provide the first, middle initial, and last name)		
				NAME	NAME	NAME
35A.	Social Security					
35B.	U.S. Civil Service					
35C.	U.S. Railroad Retirement					
35D.	Military Retired Pay					
35E.	Black Lung Benefits					
35F.	Other (Interest, dividends, or one-time payments)					

36A. WILL YOU RECEIVE ANY INCOME FROM RENTAL PROPERTY OR FROM THE OPERATION OF A BUSINESS WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?	36B. WILL YOU RECEIVE ANY INCOME FROM THE OPERATION OF A FARM WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?	36C. DO YOU THINK YOUR INCOME WILL CHANGE IN THE NEXT 12 MONTHS? *(If "Yes," explain below)*
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

PART IX - NET WORTH *(Provide specific information about the net worth of you and your dependents)*

NET WORTH is the market value of all interest and rights in any kind of property after subtracting any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal items such as your vehicle, clothing, and furniture.

NOTE: **For Items 37A-37F provide amounts. If none, write "0" OR "NONE." Do not leave blank spaces.**

ITEM NO.	SOURCE	VETERAN	SPOUSE	CHILD(REN) (Provide the first, middle initial, and last name)		
				NAME	NAME	NAME
37A.	Cash, non-interest bearing bank accounts					
37B.	Interest bearing bank accounts, certificates of deposit (CDs)					
37C.	Retirement accounts (IRAs, Keogh Plans, etc.)					
37D.	Stocks, bonds, and mutual funds					
37E.	Value of business assets					
37F.	Real property (not your home)					

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART X - MEDICAL, LEGAL OR OTHER EXPENSES

IMPORTANT - Complete items 38A through 38E only if you are applying for nonservice-connected pension.

MEDICAL, LEGAL OR OTHER EXPENSES - Family medical expenses you actually paid (out-of-pocket) may be deducted from your income. Show the amount of unreimbursed medical expenses you paid for dependents you are under an obligation to support. Also, show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to increase benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Be sure to include the Medicare deduction. If more space is needed, you may use Item 45, "Remarks" or attach a separate sheet.

38A. AMOUNT YOU PAID	38B. DATE PAID *(Month, year)*	38C. PURPOSE *(Doctor's fees, hospital charges, attorney fees, etc.)*	38D. PAID TO *(Name of doctor, hospital, pharmacy, attorney, etc.)*	38E. PERSON FOR WHOM EXPENSE PAID (Self, spouse, child)

PART XI - DIRECT DEPOSIT

Generally, all Federal payments are required to 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 39, 40, and 41 to enroll in direct deposit. If you do not have a bank account you can receive a waiver from direct deposit, just check the box below in Item 39. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in direct deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in direct deposit.

39. ACCOUNT NUMBER (Please check the appropriate box and provide the account number, if applicable)

☐ CHECKING _____ *(Account Number)*

☐ SAVINGS _____ *(Account Number)*

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

40. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit to go)

41. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check or savings deposit slip)

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART XII - CERTIFICATION, AUTHORIZATION, AND SIGNATURE(S)

I certify that the statements in this document are true and complete to the best of my knowledge and belief. 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.

IMPORTANT - If you sign with an "X", then you must have 2 people witness your signature. They must then sign the form and print their names and addresses.

42A. VETERAN'S SIGNATURE (Do not print) (Please sign in ink)	42B. VETERAN'S PRINTED NAME	42C. DATE SIGNED

43A. SIGNATURE OF WITNESS (Do not print)	43B. PRINTED NAME AND ADDRESS OF WITNESS

44A. SIGNATURE OF WITNESS (Do not print)	44B. PRINTED NAME AND ADDRESS OF WITNESS

PART XIII - REMARKS *(Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension)*

45. REMARKS *(If you need more space you may attach a separate sheet of paper)*

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 to which you are not entitled.

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON THIS PAGE.

OMB Control No. 2900-0001
Respondent Burden: 5 Minutes

Department of Veterans Affairs

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

Important Notice About Information: 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) *(List illness, injury, etc. pertinent to your claim)*

8. COMMENTS

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

SECTION III - CONSENT TO RELEASE INFORMATION

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

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

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 7A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the 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 you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

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

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

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

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

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS