Department of Veterans Affairs

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

IMPORTANT- Please read the information below carefully to help you complete this form more quickly and accurately. Some parts of the form also 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. Special monthly pension is an allowance that may be paid to individuals who, due to mental or physical disability, require the assistance of another person to perform the basic activities of daily living, or their ability to leave home is very limited.

May I apply electronically?

To file a claim for VA compensation or pension electronically, please complete and submit VA Form 21-526, Veteran's Application for Compensation and/or Pension, using VONAPP. The VONAPP (Veterans On Line Application) website is an official U.S. Department of Veterans Affairs (VA) website that enables service members, veterans and their beneficiaries, and other designated individuals to apply for benefits using the Internet. You can apply online at our website, http://vabenefits.vba.va.gov/vonapp/main.asp.

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 46, "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

What should I do when I have finished my application?

- You should provide your signature in Part XIII, Item 43A. 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. VA regional office addresses are available on the internet at http://www.va.gov/directory

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.

Social Security and Supplemental Security Income Benefits

Social Security and Supplemental Security Income are two Federal programs that help people with disabilities. While these programs are different in many ways, the Social Security Administration (SSA) administers both programs. If you think you have a disabling condition, you may qualify for benefits under one or both of these programs and should contact Social Security.

How can I contact SSA if I have questions?

You can find answers to most questions and file a claim online at www.socialsecurity.gov. Specific information is available for active duty military, veterans, and their families at www.socialsecurity.gov/woundedwarriors.

You can also contact SSA in the following ways:

- **By phone:** (Monday-Friday, 7 a.m. - 7 p.m. EST) at one of the following toll-free numbers:
  1-800-772-1213
  1-800-325-0778 (TTY if you are deaf or hard of hearing)
- **By mail or in person:** You can locate the address of the Social Security office nearest to you in your telephone book blue pages under **"United States Government, Social Security Administration".**

Part II - Nature and History of Service-Related Disability(ies)

What disabilities should I list?
List the disease(s) or medical condition(s) that form the basis of your claim for service connected compensation. Be as specific as you can. Indicate the approximate date the disability began and 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 from a non-VA health care provider 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 use 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 obtained 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?
This section asks about your military severance or separation pay, the type, and the amount. If you currently receive military retired pay, we may reduce your retired pay by the amount of any compensation that we award. It 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.

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 you provide your marital history and that of 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:

- under the age of 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- permanently incapable of self support before reaching the age of 18.

Part VII - Non Service-Connected Pension

This section asks you to provide 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 provide 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, health care, insurance, etc. Do **not** leave any blank boxes in this section! Complete each box with either a dollar figure, "0", or "none." VA will interpret a blank space as "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 from any source 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 provide specific information about your net worth and that of your dependents**. Do not leave any blank boxes in this section! Complete each box with either a dollar figure, "0", or "None". VA will interpret a blank space as "0" or "None".**

Net worth is the market value of all interest and rights in any kind of property, after subtracting any mortgages and other claims against the property. List all assets except the house in which you live, any reasonable area of land on which it sits, and those items you use everyday, such as your vehicle, clothing and furniture.

Clearly indicate if you and your spouse jointly share assets (such as money in a joint checking account). Report the value of farms or buildings that you or a dependent owns as "real property."

Part X - Information About Transferred Assets

VA considers all of your (and your spouse's) assets (net worth) in determining your eligibility for non service-connected pension. Transferring your cash or property to another person, trust, organization, corporation or any other entity does not reduce your net worth in order to qualify for pension unless it is clear that you have permanently given up all rights of ownership, including the right to control the cash or property. In completing this form, you must tell us about all assets you have transferred in the last two (2) years, along with any assets you transferred previously for ***any*** period of time if the value of the asset(s) exceeded a total of $20,000. In Part X, Items 38A and 38B, report all transferred assets. Note the conditions of transfer in Item 46, "Remarks," including any remaining right, privilege of ownership, benefit, or control you have over the asset.

Part XI - 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 deductions 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.

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary; however, no allowance of compensation or pension may be granted unless this form is completed fully as required by law. Giving us you and your dependents' Social Security numbers 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. Information submitted is subject to verification through computer matching programs with other Federal or state 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 your eligibility for compensation and/or pension (38 U.S.C. 5101). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour 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 http://www.reginfo.gov/public/do/PRAMain . If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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. FOR WHAT BENEFIT ARE YOU APPLYING?
☐ COMPENSATION ☐ PENSION ☐ BOTH 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 SERVICE-RELATED DISABILITY(IES) - If you need more space please use Item 46, "Remarks"

11. Please provide nature of sickness, disease, or injuries for which this claim is made; date each began and place of treatment.
If you need more space to list disabilities, please list them in Item 46 "Remarks" or on a separate sheet of paper and attach it to this form.

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

12A. ARE YOU NOW OR HAVE YOU EVER 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 46, "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)*	15. ARE YOU CLAIMING A DISABILITY RELATED TO ASBESTOS EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO	☐ YES ☐ NO
16. ARE YOU CLAIMING A DISABILITY RELATED TO MUSTARD GAS EXPOSURE? *(If "Yes," list disability(ies) below)*	17. ARE YOU CLAIMING A DISABILITY RELATED TO IONIZING RADIATION EXPOSURE? *(If 'Yes," list disability(ies) below)*
☐ YES ☐ NO	☐ 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 43A THRU 43C 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 RESERVE OR NATIONAL GUARD UNIT *(If additional space is needed, use Item 46 "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. SPOUSES'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 43A THRU 43C ON PAGE 10.

PART VI - MARITAL AND DEPENDENCY INFORMATION - CONTINUED *(If you need additional space, use Item 46 "Remarks")*

FURNISH THE FOLLOWING INFORMATION ABOUT EACH OF YOUR MARRIAGES *(IF NOT APPLICABLE, 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 NOT APPLICABLE, 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 46 "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 - NON SERVICE-CONNECTED PENSION *(If you need additional space use Item 46 "Remarks")*

IMPORTANT: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

32. WHAT DISABILITIES PREVENT YOU FROM WORKING? *(List below)*

33. DO YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON OR ARE YOU GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☐ NO

NURSING HOME 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 NOT RECEIVED A DECISION?	34E. ARE YOU RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSI BUT NO DECISION HAS BEEN MADE?
☐ YES ☐ NO ☐ APPLIED - NOT RECEIVED DECISION	☐ YES ☐ NO ☐ APPLIED - NOT RECEIVED DECISION

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON PAGE 10.

PART VIII - INCOME INFORMATION *(Provide the income you received from all sources)*

NOTE: Report the total income 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.	Salary and Wages					
35B.	Social Security					
35C.	U.S. Civil Service					
35D.	U.S. Railroad Retirement					
35E.	Military Retired Pay					
35F.	Black Lung Benefits					
35G.	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 - 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 43A THRU 43C ON PAGE 10.

PART X - INFORMATION ABOUT TRANSFERRED ASSETS

NOTE - Provide the conditions of the transfer in Item 46, "Remarks" including any remaining right, privilege of ownership, benefit, or control you have over the asset.

38A. HAVE YOU TRANSFERRED ANY ASSETS IN THE LAST TWO (2) YEARS?	38B. HAVE YOU TRANSFERRED ASSETS AT ANY TIME IN EXCESS OF $20,000?
☐ YES ☐ NO *(If "Yes," provide the date of transfer_____ and the value $_____*	☐ YES ☐ NO *(If "Yes," provide the date of transfer_____ and the value $_____*

PART XI - MEDICAL, LEGAL, OR OTHER EXPENSES

IMPORTANT - Complete Items 39A through 39E only if you are applying for non service-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 46, "Remarks" or attach a separate sheet.

39A. AMOUNT YOU PAID	39B. DATE PAID (*Month, year*)	39C. PURPOSE *(Doctor's fees, hospital charges, attorney fees, etc.)*	39D. PAID TO *(Name of doctor, hospital, pharmacy, attorney, etc.)*	39E. PERSON FOR WHOM EXPENSE PAID *(Self, spouse, child)*

PART XII - DIRECT DEPOSIT

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 40, 41 and 42 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

40. 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

41. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit to go)*	42. 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 43A THRU 43C ON PAGE 10.

PART XIII - 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 print their names and addresses and sign the form.

43A. VETERAN'S SIGNATURE *(Do not print) (Please sign in ink)*	43B. VETERAN'S PRINTED NAME	43C. DATE SIGNED

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

45A. SIGNATURE OF WITNESS *(Do not print)*	45B. PRINTED NAME AND ADDRESS OF WITNESS

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

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

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)

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 http://reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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. DATE OF BIRTH (MM,DD,YYYY)	3. VETERAN'S VA FILE NUMBER

4. CLAIMANT'S NAME *(If other than veteran)* LAST NAME, FIRST, MIDDLE	5. VETERAN'S SOCIAL SECURITY NUMBER
6. RELATIONSHIP OF CLAIMANT TO VETERAN	7. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF PERTINENT INFORMATION (Please use a separate form for each source)

8A. LIST THE SOURCE OF INFORMATION OR PROVIDER OF MEDICAL TREATMENT FOR YOUR CLAIMED CONDITION(S) *(Include the first and last name, complete address, and telephone number)*	8B. DATE(S) OF TREATMENT: *(Include the time period (month and year) for which the provider in Item 8A treated you for your currently claimed condition(s)*	8C. LIST THE DISABILITY(IES) FOR WHICH YOU FILED YOUR CURRENT CLAIM AND THAT WERE TREATED BY THE PROVIDER IN ITEM 8A
	NOTE - "Treatment" includes office visits, hospitalizations, telephone consultations, etc.	
Source of Information (other than medical treatment provider):		
First Name and Last Name of Medical Treatment Provider:		
Complete Address and Telephone Number of Source of Information or Medical Treatment Provider:		

9. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 10C.

SECTION III - CONSENT TO RELEASE INFORMATION

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

10A. **Privacy Act Notice:** The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, 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.

10B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 8A 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 8A 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 HIPAA 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 8A. 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).

10C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the source shown in Item 8A 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:

11A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	11B. 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)*	11C. DATE

11D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	11E. 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.

12A. SIGNATURE OF WITNESS	12B. DATE

12C. MAILING ADDRESS OF WITNESS