OMB Number 2900-XXXX
Burden Hours: 30 minutes
OMB EXP Date: XX/XX/XXXX

Department of Veterans Affairs

Camp Lejeune Family Member Program Application

Important! *For expedited processing, please submit your application online at:* ***https://clfamilymembers.fsc.va.gov*** or for standard processing, mail the completed form to: Department of Veterans Affairs, Financial Services Center PO Box 149200 Austin, TX 78714-9200

1. Applicant Information

Last Name	First Name	MI

Social Security Number	Date of Birth (MMDDYYYY)

Mailing Address	City	State	Zip Code

If you reside outside the United States enter address below

Email Address	Gender ☐ Male ☐ Female

Please indicate if you would like to receive correspondence via ☐ email ☐ regular mail

Phone Number (include area code)	Alt Phone Number (include area code)

Relationship to the Veteran during the period January 1, 1957 through December 31, 1987:

☐ Spouse (provide a copy of marriage certificate)
☐ Child (provide a copy of birth certificate)
☐ Stepchild (provide a copy of birth certificate)
☐ Legal Dependent State your relationship (provide documentation of relationship):

2. Residency Information

Did you reside on Camp Lejeune for 30 days or more between January 1, 1957 and December 31, 1987? ☐ Yes ☐ No

Dates resided on Camp Lejeune:

From (MM/YYYY) To (MM/YYYY)

Address (if known) on Camp Lejeune:

Do you have documentation verifying your residency on Camp Lejeune? ☐ Yes ☐ No

If yes, please enclose a copy of the documentation with your application. **Documentation may include a utility bill, pay stub, tax forms, or similar documentation.**

3. Conditions/Illnesses

Have you been diagnosed with any of the following conditions?
The following conditions/illnesses may be related to your exposure to contaminated water at Camp Lejeune while living there for at least thirty days between 1957-1987. Please check the box for any condition for which you have received a diagnosis (you do not need to have been previously diagnosed to be eligible).

☐ Bladder cancer
☐ Breast cancer
☐ Esophageal cancer
☐ Kidney cancer
☐ Lung cancer
☐ Leukemia
☐ Multiple myeloma
☐ Myelodysplastic syndrome
☐ Non-Hodgkin's lymphoma
☐ Scleroderma
☐ Renal toxicity
☐ Hepatic steatosis
☐ Neurobehavioral effects
☐ Female infertility* Dates _____
☐ Miscarriage* Dates _____

*Please indicate the dates of Miscarriage and Female Infertility.

4. Health Care Coverage

Do you have health care coverage? ☐ Yes ☐ No

Note: This includes coverage you may have through an employer, spouse, significant other or federal/state health care benefit plan. Health care coverage may also be referred to as health care insurance.

☐ Medicare Part A Effective Date (MMDDYYYY) _____

☐ Medicare Part B Effective Date (MMDDYYYY) _____

☐ Medicare Advantage Effective Date (MMDDYYYY) _____

☐ Medicare Part D Effective Date (MMDDYYYY) _____

☐ Medicaid/State Assistance Effective Date (MMDDYYYY) _____

☐ TRICARE Effective Date (MMDDYYYY) _____

☐ CHAMPVA Effective Date (MMDDYYYY) _____

Please complete the following if you have other health care coverage not identified above.

Name of Primary Insurance:	Effective Date (MMDDYYYY)	☐ HMO ☐ PPO
Name of Secondary Insurance:	Effective Date (MMDDYYYY)	☐ HMO ☐ PPO

Does your health care coverage provide Pharmacy benefits? Yes ☐ No ☐

5 Veteran Information

Last Name	First Name	MI
Social Security Number (if known)	Phone Number (include area code)	
Date of Birth (MMDDYYYY)	Is Veteran deceased? ☐ Yes ☐ No	Gender ☐ Male ☐ Female
Dates Stationed at Camp Lejeune (If Known): From (MM/YYYY) _____ To: (MM/YYYY) _____	List Unit(s) and Rank(s) while assigned to Camp Lejeune Unit(s) Rank(s)	

6. Certification

I hereby apply to the Camp Lejeune Family Member (CLFM) Program and give permission for my personal information to be used by appropriate Federal Government agencies, Federal Government contractors and other Government entities to determine if I am eligible for the CLFM Program.

By my signature I attest that I have answered the questions truthfully and that I understand the following: Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to gain enrollment in the CLFM Program to which that person is not entitled is subject to civil and/or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I certify that the above information is correct and true to the best of my knowledge and belief. (Sign and date on below.)

Signature	Date

If certification is signed by a person other than an applicant, complete the following:

Last Name	First Name
Mailing Address	

City	State	Zip Code	Phone Number (include area code)

Should you apply for the Camp Lejeune Family Member Program?

If the Veteran	And	And	Then
Was on active duty and served at Camp Lejeune for 30 days or more between January 1, 1957 and December 31, 1987;	You were the spouse or dependent of the Veteran or were in utero of the Veteran, spouse, or a dependent during that same period;	You lived or were in utero on Camp Lejeune for 30 days or more between January 1, 1957 and December 31, 1987;	You may meet the criteria for VA's Camp Lejeune Family Member Program.

NOTE TO APPLICANT: You're applying to the Department of Veterans Affairs (VA). VA will consider the information you provide on this questionnaire as part of their eligibility determination for this program. This program's eligibility criteria will be determined through the VA. **Submission of this application does not guarantee acceptance into this program.**

Getting Started: Directions for Applicant, representative or Power of Attorney (POA), please answer all questions**.**

Applicant Information: Please complete and provide copy of legal documents.

Residency Information: Please answer all questions. If possible, provide copies of documents verifying your residency.

Conditions/Illnesses: Please answer all questions. If you mark the box for Yes, check all the conditions you have been diagnosed with. A Treating Physician Report form is enclosed for your physician to complete and return with this application. If you mark the box for No, you may go to the next section.

Health Care Coverage: Please answer all questions and provide your health care coverage, if applicable**. (Note:** Health care coverage may also be referred to as health care insurance).

Veteran Information: Please answer all questions, if known.

Certification: Please sign, and date.

For more information go to: www.publichealth.va.gov/exposures/camp-lejeune/index.asp

Customer Service Center: 1-866-372-1144, Fax 512-460-5536

Camp Lejeune Family Member Program
Department of Veterans Affairs, Financial Services Center
PO Box 149200, Austin, TX 78714-9200

The Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to determine eligibility for benefits.

Privacy Act Information: The authority for collection of the requested information on this form is 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement of health care related to conditions determined to result from contaminated water while you resided at Camp Lejeune, North Carolina, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Department of Defense (DoD), Defense Enrollment Eligibility Reporting System (DEERS), Centers for Medicare & Medicaid Services (CMS) or any other applicable authoritative source at any time. You are requested to provide your social security number as your VA record is filed and retrieved by this number. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for Camp Lejeune Family Member Program benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered private and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 23VA16. For example, information including your social security number may be disclosed to the Department of Defense, contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services.