



Department of Veterans Affairs

DESIGNEE FOR PATIENT PERSONAL PROPERTY

This designee form is an official document where you can designate an individual to whom VA will deliver your personal funds and effects in the event of your death in a VA medical facility. The designee may not be a VA employee unless such employee is a member of your family. You may change or revoke in writing such designation at any time. The delivery of your personal funds and effects to the designee is only a delivery of possession. Such delivery of possession does not affect in any manner: (1) The title to such funds or effects; or (2) The person legally entitled to ownership of such funds or effects.

PART I: PATIENT INFORMATION

NAME (<i>Last, First, Middle</i>):	LAST 4 OF SSN:
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STREET ADDRESS:

CITY, STATE, ZIP:

HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:
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PART II: DESIGNEE INFORMATION

NAME OF DESIGNEE (<i>Last, First, Middle</i>):	DATE OF ADMISSION:
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STREET ADDRESS:

CITY, STATE, ZIP:

HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:
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PART III: PATIENT SIGNATURE

By signing below you are designated the person listed above as a recipient of your personal effects.

<i>Signature of Patient</i>	<i>Date</i>
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Privacy Act Information and Paperwork Reduction Act Notice

The information requested on this form is solicited under the authority of 38 C.F.R. §12.1. It is being collected to document your preferences in the event that you can't speak for yourself anymore. The information you provide may be disclosed outside the VA as permitted by law. Possible disclosures include those that are described in the "routine uses" identified in the VA system of records 24VA19, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances at <http://www.gpoaccess.gov/privacyact/index.html>. You may choose to fill out this form or not. But without this information, VA may not understand your preferences. If you don't fill out this form, there won't be any effect on the benefits you are entitled to receive. The Paperwork Reduction Act of 1995 requires us to let you know that this information collection follows the clearance requirements of section 3507 of this Act. We estimate that it will take you about 3 minutes to fill out this form, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information you write down. A Federal agency may not conduct or sponsor, and a person is not required to respond to a collection of information, unless it displays a current valid OMB control number. The OMB Control No. for this information collection is 2900-XXXX