Department of Veterans Affairs

PRIORITY PROCESSING REQUEST INSTRUCTIONS

Please complete the attached form to submit a request for priority processing of a claim due to certain circumstances or status as described below along with any supporting information or evidence.

If you are…	Then submit the following evidence if available or not already on file with VA…
• Experiencing extreme financial hardship	Documentation to support the assertion of extreme financial hardship, including but not limited to: • Copy of an eviction notice or statement of foreclosure • Copy of notices of past-due utilities bills • Copy of collection notices from creditors
• Terminally ill	• Copy of medical evidence showing illness that is terminal in nature, and/or • If you want VA to obtain private treatment records on your behalf, submit a completed VA Form 21-4142, and VA Form 21-4142a **Note**: Additional VA forms are available, here: **www.va.gov/vaforms.**
• Diagnosed with Amyotrophic Lateral Sclerosis (ALS) also known as Lou Gehrig's disease	· Copy of medical evidence showing diagnosis of ALS, and/or · If you want VA to obtain private treatment records on your behalf, submit a completed VA Form 21-4142 and VA Form 21-4142a
• Very Seriously Injured/Ill or Seriously Injured/Ill during military operations (Defined as a disability resulting from a military operation that will likely result in discharge from military service.)	• Copy of military personnel records such as a determination from the Department of Defense • Medical evidence showing severe disability or injury, and/or • If you want VA to obtain private treatment records on your behalf, submit a completed VA Form 21-4142 and VA Form 21-4142a
• Age 85 or older	• Date of birth
• Former Prisoner of War	• Copy of military personnel records such as DD Form 214, *Certificate of Release or Discharge from Active Duty*, or • Information such as service number, branch and dates of service, dates and location of internment, detaining power, or any other information relevant to the detainment
• Medal of Honor or Purple Heart Award recipient	• Copy of military personnel records such as DD Form 214, or • Information showing receipt of Medal of Honor or Purple Heart Award

WHERE TO SEND INFORMATION AND EVIDENCE:

The time it takes your response to reach VA affects how long it takes us to process your request. We recommend calling our National Call Center at 1-800-827-1000 for immediate assistance whenever possible. If you are not a claimant or representative, we recommend faxing rather than mailing the information to expedite processing.

Note: You may designate one person or organization as a third-party representative to act on your behalf. A third-party may be a family member or other designated person who is not a Power of Attorney (POA), agent, or fiduciary. If you designate a third-party to represent you, a VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, must be attached or of record.

The **fastest** way to respond to VA is to contact us at 1-800-827-1000.

If you need to fax or mail your correspondence, identify the benefit type; then, use the corresponding fax number or mailing address below:

FAXING:	
Compensation Claims Toll Free: 1-844-531-7818	**Pension & Survivors Benefit Claims** Toll Free: 1-844-655-1604
Board of Veterans' Appeals Toll Free: 1-844-678-8979	**Fiduciary** Toll Free: 1-888-581-6826
MAILING ADDRESSES	
Compensation Claims Department of Veterans Affairs Compensation Intake Center P.O. Box 4444 Janesville, WI 53547-4444	**Pension & Survivors Benefit Claims** Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, WI 53547-5365
Board of Veterans' Appeals Department of Veterans Affairs Board of Veterans' Appeals P.O. Box 27063 Washington, DC 20038	**Fiduciary** Department of Veterans Affairs Fiduciary Intake Center P.O. Box 5211 Janesville, WI 53547-5211
These addresses serve **all United States and foreign locations**.	

Attention: If you are currently receiving GI Bill Education benefits and are experiencing any of the reasons listed within Section III: Reason(s) for Request, please call the 1-888-GIBILL1 (1-888-442-4551) or send an email through Ask A Question at **www.gibill.va.gov** for immediate assistance.

IMPORTANT

If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1,

or visit **https://www.VeteransCrisis/line.net/** to chat online, or send a text message to 838255

to receive confidential support 24 hours a day, 7 days a week, 365 days a year.

Support for deaf and hard of hearing individuals is available.

OMB Approved No. 2900-XXXX
Respondent Burden: 7 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

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

PRIORITY PROCESSING REQUEST

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 5. Use this form to request priority processing of a claim due to certain status or circumstances. For more information, visit our website at <placeholder website>, contact us at **https://iris.custhelp**.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at **www.va.gov/vaforms**.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

(This information is required to process your request)

NOTE: You can *either* complete the form on-line or by hand. If completed by hand, print the information requested in ink, neatly, and legibly and completely fill in each circle to expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER – –

3. DATE OF BIRTH (MM-DD-YYYY) – –

4. VA FILE NUMBER (If applicable)

5. INSURANCE NUMBER (If applicable)

6. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

7. TELEPHONE NUMBER (Include Area Code) – –

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION

(If other than Veteran)

9. CLAIMANTS NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER – –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH (MM-DD-YYYY) – –

13. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

14. TELEPHONE NUMBER (Include Area Code) – –

Enter International Phone Number (If applicable)

15. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III - REASON(S) FOR REQUEST

(This information is required in order to complete your request)

16. HOMELESS INFORMATION (Check all that apply)

16A. ARE YOU CURRENTLY HOMELESS?

◯ YES (If "YES," complete item 16B regarding your living situation)

◯ NO (If "NO," skip to item 16C)

16B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION

◯ LIVING IN A HOMELESS SHELTER

◯ STAYING WITH ANOTHER PERSON

◯ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g. living in a car or tent)

◯ 16A. ARE YOU CURRENTLY HOMELESS? Radio button. YES

◯ OTHER (Specify)

VETERAN'S SSN

16C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

YES (If "YES," complete item 16D regarding your living situation)

NO (If "NO," skip to item 17)

16D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION

HOUSING WILL BE LOST IN 30 DAYS

LEAVING PUBLICLY FUNDED SYSTEM OF CARE IN 30 DAYS OR LESS (e.g. homeless shelter)

OTHER (Specify)

17. OTHER REASON(S)/CIRCUMSTANCES FOR REQUEST (Check all that apply)

EXPERIENCING EXTREME FINANCIAL HARDSHIP

TERMINALLY ILL

MEDAL OF HONOR/PURPLE HEART RECIPIENT

DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS) ALSO KNOWN AS LOU GEHRIG'S DISEASE

85 YEARS OF AGE OR OLDER

VERY SERIOUSLY INJURED/ILL OR SERIOUSLY ILL/INJURED (VSI/SI) DURING MILITARY SERVICE

FORMER PRISONER OF WAR (Provide date(s) of confinement) (MM-DD-YYYY)

TO – –	FROM – –
TO – –	FROM – –

SECTION IV - REPORT OF MEDICAL TREATMENT (If applicable)

18. LIST VA MEDICAL CENTERS (VAMC), DEPARTMENT OF DEFENSE (DoD) MILITARY TREATMENT FACILITIES (MTF), OR PRIVATE MEDICAL FACILITIES WHERE YOU WERE TREATED FOR THE CIRCUMSTANCE YOU IDENTIFIED IN ITEM 17 AND PROVIDE APPROXIMATE BEGINNING DATE OF TREATMENT:

NAME/LOCATION OF TREATMENT FACILITY	DATE OF TREATMENT (MM-DD-YYYY)
City State/Province Country	– –
NAME/LOCATION OF TREATMENT FACILITY	DATE OF TREATMENT (MM-DD-YYYY)
City State/Province Country	– –
NAME/LOCATION OF TREATMENT FACILITY	DATE OF TREATMENT (MM-DD-YYYY)
City State/Province Country	– –
NAME/LOCATION OF TREATMENT FACILITY	DATE OF TREATMENT (MM-DD-YYYY)
City State/Province Country	– –

VETERAN'S SSN ___ – ___ – ____

SECTION V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT I have completed this form and it is true and correct to the best of my knowledge and belief.

18A.SIGNATURE OF REQUESTER ***(REQUIRED)*** (Note: During COVID-19 ink and electronic signatures are accepted)	14B. DATE SIGNED (MM-DD-YYYY)
	__ – __ – ____

SECTION VI - THIRD PARTY SIGNATURE
(Only required if requester has an authorized third party)

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

NOTE: A third-party signature ***will not*** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, is of record or attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

19A. THIRD-PARTY SIGNATURE (Note: During COVID-19 ink and electronic signatures are accepted)	19B. DATE SIGNED (MM-DD-YYYY)
	__ – __ – ____

SECTION VII - POWER OF ATTORNEY (POA) SIGNATURE
(Required only if requester has an authorized POA representation)

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual as Claimant's Representative,* is of record or attached to this request.

20A. POWER OF ATTORNEY (POA) SIGNATURE (Note: During COVID-19 ink and electronic signatures are accepted)	20B. DATE SIGNED (MM-DD-YYYY)
	__ – __ – ____

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

PRIVACY ACT NOTICE: 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.

RESPONDENT BURDEN: This information will let us help you in support of or response to your claim. Title 38, United States Code, allows us to ask for this information. It should take you about 7 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid Office of Management and Budget (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.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.