OMB Control No. 2900-0321
Respondent Burden: 5 Minutes
Expiration Date: XX/XX/20XX

VA | U.S. Department of Veterans Affairs

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden information on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have a VSO assist you with your claim instead of an individual, complete, VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 3.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable check box to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER (SSN) – –

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH (MM/DD/YYYY) – –

5. SERVICE NUMBER (If applicable)

6. BRANCH OF SERVICE
☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD
☐ SPACE FORCE ☐ NOAA ☐ USPHS

7. 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 –

8. TELEPHONE NUMBER (Include Area Code) – –
Enter International Phone Number *(If applicable)*

9. E-MAIL ADDRESS (Optional)

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME (First, Middle Initial, Last)

11. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY) – –

12. RELATIONSHIP TO VETERAN

13. CLAIMANT'S 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. EMAIL ADDRESS (Optional)

SECTION III: APPOINTED REPRESENTATIVE'S INFORMATION

16A. NAME OF INDIVIDUAL APPOINTED AS REPRESENTATIVE (First, Middle Initial, Last)

16B. INDIVIDUAL IS (Check appropriate box)

☐ ATTORNEY ☐ AGENT ☐ INDIVIDUAL PROVIDING REPRESENTATION UNDER SECTION 14.630 (*See required statement below. Signatures are required in Items 17A and 18A)

☐ SERVICE ORGANIZATION REPRESENTATIVE (Specify organization)

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

16C. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE (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 –

16D. TELEPHONE NUMBER OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE (Include Area Code)

– –

Enter International Phone Number *(If applicable)*

16E. EMAIL ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE (Optional)

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

(**Skip to Item 19**, if the box for "Individual Providing Representation Under Section 14.630" was not checked in Item 16B)

NOTE: An individual acting as representative under 38 C.F.R. 14.630 may not represent more than one claimant on a single claim unless an exception to that limitation has been granted by the Department of Veterans Affairs' (VA) General Counsel.

The appointment of the individual named in Item 16A (the representative) authorizes that person to represent the individual named in Item 1 or 10(if other than veteran) is for a particular claim pursuant to the provisions of 38 C.F.R. 14.630. By our signatures below, we, the representative and the claimant, attest that no compensation will be charged by or paid for the individual named in Item 16A.

17A. SIGNATURE OF VETERAN NAMED IN ITEM 1 OR CLAIMANT IN ITEM 10 **(Required only for representation under 14.630)**

17B. DATE SIGNED (MM/DD/YYYY) – –

18A. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 16A **(Required only for representation under 14.630)**

18B. DATE SIGNED (MM/DD/YYYY) – –

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR DISCLOSURE TO AFFILIATED PERSONNEL

☐ a. If the individual in Item 16A is an accredited agent or attorney who has been approved by VA for access to VA information technology (IT) systems in accordance with 38 CFR 1.600 to 1.603, **I AUTHORIZE** VA to disclose all of my records (other than as provided in Items 20 and 21) to the associate attorneys, claims agents, and support staff affiliated with my representative. Provide the name of the firm/organization here:

☐ b. If the individual in Item 16A is an accredited agent or attorney, **I AUTHORIZE** VA to disclose all my records (other than as provided in Items 20 and 21) to the following individuals named as administrative employees of my representative. This applies to disclosures, outside of those made via access to VA electronic IT systems contemplated by 38 CFR 1.600 to 1.603. Provide the names of the individuals here:

20. **AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38 U.S.C.** (**Note:** Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 16A any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I **authorize** the VA facility having custody of my VA claimant records to disclose to the individual named in Item 16A, and the firm/organization/individual(s) named in Item 19 (if approved by VA for affiliated access) all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 16A, either by explicit revocation or the appointment of another representative.

21. LIMITATION OF CONSENT**.** My consent in Item 20 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

22. AUTHORIZATION FOR REPRESENTATIVE TO ACT ON CLAIMANT'S BEHALF TO CHANGE CLAIMANT'S ADDRESS -
Unless I check the box below, I do not authorize the individual named in Item 16A to act on my behalf to change my address in my VA records.

☐ I **authorize** the individual named in Item 16A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 16A, either by explicit revocation or the appointment of another representative.

VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

CONDITIONS OF APPOINTMENT

I, the veteran named in Item 1 or the claimant named in Item 10, hereby **appoint** the individual named in Item 16A as my representative to prepare, present, and prosecute my claims for any and all benefits from VA based on the service of the veteran named in Item 1. If the individual named in Item 16A is an accredited agent or attorney, the scope of representation provided before VA may be limited by the agent or attorney as indicated below in Item 24. I authorize VA to disclose any and all of my records (other than as provided in Items 20 and 21) to that individual appointed as my representative and as indicated in Item 19.

Signed and accepted subject to the foregoing conditions.

23A. SIGNATURE OF VETERAN/CLAIMANT **(Required)**	23B. DATE SIGNED (MM/DD/YYYY) ☐☐ – ☐☐ – ☐☐☐☐

24. LIMITATIONS ON REPRESENTATION - AGENTS OR ATTORNEYS ONLY (Unless limited by an agent or attorney, this power of attorney revokes all previously existing powers of attorney)

25A. SIGNATURE OF REPRESENTATIVE **(Required)**	25B. DATE SIGNED (MM/DD/YYYY) ☐☐ – ☐☐ – ☐☐☐☐

FEES: Section 5904, Title 38, United States Code, contains provisions regarding fees that may be charged, allowed, or paid for services of agents or attorneys in connection with a proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Department.

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.

Documents may be submitted by mail, in person at a VA regional office or electronically. However, VA recommends submitting correspondence electronically as this is the fastest method of receipt.

VA provides several tools to assist in electronic submission. To learn more about how to submit documents and claims electronically, visit www.va.gov/disability/upload-supporting-evidence. You can also go directly to access.va.gov to digitally upload any correspondence using Direct Upload.

By visiting www.va.gov you can also check your claims status and learn about other VA benefits.

If you prefer to mail your correspondence, please use the related mailing address below.

COMPENSATION CLAIMS	PENSION & SURVIVORS BENEFIT CLAIMS
Department of Veterans Affairs **Evidence Intake Center** **PO Box 4444** **Janesville, WI 53547-4444**	**Department of Veterans Affairs** **Pension Intake Center** **PO Box 5365** **Janesville, WI 53547-5365**
FIDUCIARY	**BOARD OF VETERANS' APPEALS**
Department of Veterans Affairs **Fiduciary Intake** **PO Box 95211** **Lakeland, FL 33804-5211**	**Department of Veterans Affairs** **Board of Veterans' Appeals** **PO Box 27063** **Washington, DC 20038**

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 Veteran Readiness and Employment Records-VA, published in the Federal Register. Your obligation to respond is voluntary. However, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0321, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 5 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at **vapra@va.gov**. Please refer to OMB Control No. 2900-0321 in any correspondence. Do not send your completed VA Form 21-22a to this email address.