

(DO NOT WRITE IN THIS SPACE)

**VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION,
 VA Form 21-526, Part A: General information**

Please read the attached "General Instructions" before you fill out this form.

SECTION I Tell us what you are applying for Check the box that says what you are applying for. Be sure to complete the other Parts you need.	1. What are you applying for? If you are unsure please refer to the "General Instructions" page 2 Section 1: Preparing your application Compensation ▶ Fill out Part A of VA Form 21-526 and Parts B and C Pension ▶ Fill out Part A of VA Form 21-526 and Parts C and D Compensation and Pension ▶ Fill out Part A of VA Form 21-526 and Parts B, C and D
	2a. Have you ever filed a claim with VA No (If "No," skip Item 2b and go to Item 3) (If "Yes," provide file number below) Yes _____ (Go to 2b)
	2b. I filed a claim for Compensation Pension Other _____

SECTION II Tell us about you We need information about you to process your claim faster. Give us your current mailing address in the space provided. If it will change within the next three months, give us that new address in block 29 "Remarks." Also in block 29, give us the date you think you will be at the new address. OWCP used to be called the U.S. Bureau of Employees Compensation	3. What is your name? _____ First Middle Last Suffix (If applicable)
	4. What is your Social Security number? _____
	5. What is your sex? Male Female
	6a. Did you serve under another name? Yes (If "Yes," go to Item 6b) No (If "No," go to Item 7)
	6b. Please list the other name(s) you served under _____ _____
	7. What is your address? _____ Street address, rural route, or P.O. Box Apt. number _____ City State ZIP Code Country
	8. What are your telephone numbers? Daytime () _____ Evening () _____
	9. What is your e-mail address? _____
	10. What is your date of birth? _____ / _____ / _____
	11. Where were you born? _____ City State Country
	12a. Are you receiving disability benefits from the Office of Workers' Compensation (OWCP)? Yes No (If "Yes," answer 12b and 12c also)
	12b. When was the claim filed? _____ / _____
	12c. What disability are you receiving benefits for? _____
	13a. What is the name of your nearest relative or other person we could contact if necessary? _____
	13b. What is his/her telephone number? Daytime () _____ Evening () _____
	13c. What is this person's address? _____
	13d. How is this person related to you? _____

SECTION III Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed use Item 29 "Remarks".
2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

The VA has a registry of veterans who served in the Gulf War. This area has also been called the "Persian Gulf." If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 16b. For more information about the registry, see page 4 of the General Instructions for VA Form 21-526.

14a. I entered active service the first time. . . _____ mo day yr	14b. Place:	14c. My service number was . . .	
14d. I left this active service. . . _____ mo day yr	14e. Place:	14f. Branch of Service	14g. Grade, rank, or rating
14h. I entered my second period of active service. . . _____ mo day yr	14i. Place:	14j. My service number was . . .	
14k. I left this active service. . . _____ mo day yr	14l. Place:	14m. Branch of Service	14n. Grade, rank, or rating
15a. Did you serve in Vietnam? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 15b also)		15b. When were you in Vietnam? from _____ to _____ mo day yr mo day yr	
16a. Were you stationed in the Gulf after August 1, 1990? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 16b also)		16b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?" <input type="checkbox"/> Yes <input type="checkbox"/> No	
17a. Have you ever been a prisoner of war? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 17b, 17c, and 17d also)		17b. What country or government imprisoned you?	
17c. When were you confined? from _____ to _____ mo day yr mo day yr		17d. What was the name of the camp or sector and what are the names of the city and country near its location	

SECTION IV Tell us about your reserve duty

18a. Are you currently assigned to an active reserve unit? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18b also)	18b. What is the name, mailing address, and telephone number of your current unit?
18c. Were you previously assigned to an active reserve unit within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 18d also)	18d. What is the name, mailing address, and telephone number of that unit?

<p>SECTION (Continued) IV Tell us about your reserve duty</p>	<p>18e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>(If "Yes," answer Item 18f also)</p>	<p>18f. What is your reserve obligation termination date?</p> <p>____/____/____ mo day yr</p>
<p>Instructions 18g-18k</p> <p>If you are currently or have ever been a full time reservist for operational or support duty,</p> <p>1. Complete 18g-18k for that service only.</p> <p>2. Attach proof of reserve service</p>	<p>18g. I entered reserve service. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>18h. My service number was . . .</p>	
<p>Instructions 18l-18p</p> <p>If your disability occurred or was aggravated during any period of reserve duty,</p> <p>1. Complete 18l-18p for the period when your disability occurred.</p> <p>2. Attach proof that your disability occurred during reserve service.</p>	<p>18i. I left reserve service. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>18j. Branch of service 18k. Grade, rank, or rating</p>	
<p>SECTION V Tell us about your National Guard duty</p>	<p>19a. Are you currently a member of the National Guard?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assigned yet</p> <p>(If "Yes," answer Item 19b also)</p>	<p>19b. What is the name, mailing address, and telephone number of your current unit?</p>
<p>19c. Were you previously assigned to a guard unit within the last 2 years?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "Yes," answer Item 19d also)</p>	<p>19d. What is the name, mailing address, and telephone number of that unit?</p>	
<p>Instructions 19e-19i</p> <p>If you were activated to Federal Active Duty under the Authority of Title 10, United States Code,</p> <p>1. Complete 19e-19i for that service only</p> <p>2. Attach proof of this Federal Active Duty.</p>	<p>19e. I entered Federal Active Duty. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19f. My service number was . . .</p>	
<p>Instructions 19j-19n</p> <p>If your disability occurred or was aggravated during any period of guard duty,</p> <p>1. Complete 19j-19n for the period when your disability occurred</p> <p>2. Attach proof that your disability occurred during National Guard Service.</p>	<p>19g. I left Federal Active Duty. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19h. Branch of service 19i. Grade, rank, or rating</p>	
<p>19j. I entered National Guard. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19k. My service number was . . .</p>	<p>19l. I left National Guard. . .</p> <p>____/____/____ Place: _____</p> <p>mo day yr</p> <p>19m. Branch of service 19n. Grade, rank, or rating</p>	

SECTION VI Tell us about your travel status	20a. Were you injured while traveling to or from your military assignment? (If "Yes," answer Items 20b thru 20e and Section I of Part B: Compensation)	20b. When did your injury happen? / / mo day yr	20c. Where did your injury happen? (City, State, Country)	20d. Where were you treated? (Provide name and address of Doctor's office, hospital, etc.)	20e. What agency did you file an accident report with?
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

SECTION VII Tell us about your military benefits When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that 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. You must sign 21e if you want to keep getting military retired pay instead of VA compensation. Please see page 4 of the General Instructions for VA Form 21-526. If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, by the Department of Defense	21a. Are you receiving or will you receive retired or retainer pay that is based on your military service? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 21b thru 21f. If "No," skip to Item 22)	21b. What branch of service is paying or will pay your retired or retainer pay?	21c. What is the monthly amount? \$ _____ . _____
	21d. What is your retirement based on? <input type="checkbox"/> Length of service <input type="checkbox"/> Disability <input type="checkbox"/> TDRL (Temporary Disability Retired List)		
	21e. Sign here if you want to receive military retired pay <i>instead of</i> VA compensation _____		
	21f. Have you received or will you receive any of the following military benefits? (Please check the appropriate boxes and tell us the amount)		

<i>Benefit</i>	<i>Amount</i>
(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____ . _____
(2) <input type="checkbox"/> Separation pay under 10 USC 1174	\$ _____ . _____
(3) <input type="checkbox"/> Special Separation Benefit (SSB)	\$ _____ . _____
(4) <input type="checkbox"/> Voluntary Separation Incentive (VSI)	\$ _____ . _____
(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)	\$ _____ . _____
(6) <input type="checkbox"/> Other (tell us the type of benefit _____)	\$ _____ . _____

SECTION VIII Give us direct deposit information If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, " <i>All federal payments...</i> " and then either: 1. Attach a voided check, or 2. Answer questions 22-24 to the right.	All federal payments beginning January 2, 1999, must 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 22, 23 and 24 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 22. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.
	22. Account number (Please check the appropriate box and provide that account number, if applicable) <input type="checkbox"/> Checking <input type="checkbox"/> I certify that I do not have an account with a financial institution or certified payment agent <input type="checkbox"/> Savings Account number _____
	23. Name of financial institution _____
	24. Routing or transit number _____

SECTION IX Give us your signature

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

I certify and authorize the release of information:
 I certify that the statements in this document are true and complete to the best of my knowledge. 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.

25. Your signature	26. Today's date <div style="text-align: center;"> / / mo day yr </div>
---------------------------	--

27a. Signature of witness (If claimant signed above using an "X")	27b. Printed name and address of witness
--	---

28c. Signature of witness (If claimant signed above using an "X")	28b. Printed name and address of witness
--	---

SECTION X

Remarks— Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension

IMPORTANT
 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, or for the fraudulent acceptance of any payment which you are not entitled to.

29. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form, please identify your answer or statement by the part and item number). (See page 5 "Tips For Filling Out Your VA Form 21-526.")*



VA Form 21-526, Part B: Compensation

Use this form to apply for compensation. Remember that you must also fill out a VA Form 21-526, Part A: General Information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 2.

SECTION I Tell us about your disability

In the table below, tell us more about your disability or disabilities. Be sure to:

- List all disabilities you believe are related to military service.
List all the treatments you received for your disabilities, including treatments you received in a military facility before and after discharge, and treatments you received from civilian and VA sources before, during, and after your service.

Table with 5 columns: 1. What disability are you claiming?, 2. When did your disability begin?, 3b. When were you treated?, 4a. What medical facility or doctor treated you?, 4b. What is the address of that medical facility or doctor? The table contains 10 rows for data entry.

SECTION II

Tell us if any of the disabilities you listed on Page 1 were because of exposures

5a. Were you exposed to Agent Orange or other herbicides?

Yes No

(If "Yes," answer Items 5b and 5c also)

5b. What is your disability?

5c. In what country were you exposed?

6a. Were you exposed to asbestos?

Yes No

(If "Yes," answer Item 6b and 6c also)

6b. What is your disability?

6c. When and how were you exposed?

7a. Were you exposed to mustard gas?

Yes No

(If "Yes," answer Item 7b and 7c also)

7b. What is your disability?

7c. When and how were you exposed?

8a. Were you exposed to ionizing radiation?

Yes No

(If "Yes," answer Items 8b, 8c, and 8d also)

8b. What is your disability?

8c. When was your last exposure?

____ / ____ / ____
mo day yr

8d. How were you exposed to radiation?

- Atmospheric testing
- Nagasaki/Hiroshima
- Other, describe _____

9a. Were you exposed to an environmental hazard in the Gulf War?

Yes No

(If "Yes," answer Items 9b and 9c also)

9b. What is your disability?

9c. What was the hazard?

10a. Did you have a separation or retirement physical examination?

Yes No

(If "Yes," answer Items 10b and 10c also)

10b. When was the exam?

____ / ____ / ____
mo day yr

10c. Where did the exam occur?

SECTION III

Tell us how your disabilities listed on Page 1 are related to your military service

11. Explanation

Your Name

Your Social Security Number

SECTION II Tell us about any previous marriages

NOTE: You should provide copies of divorce decrees or death certificates

In the table below, tell us about:
 ● Your previous marriages, and
 ● Your spouse's previous marriages

Your previous marriages

13a. How many times have you been married before? _____

13b. When were you married?	13c. Where were you married? (city/state or country)	13d. Who were you married to? (first, middle initial, last)	13e. When did your marriage end? mo day yr	13f. Why did your marriage end? (death, divorce)	13g. Where did your marriage end? (city/state or country)
____/____/____ mo day yr			____/____/____ mo day yr		
____/____/____ mo day yr			____/____/____ mo day yr		

Your spouse's previous marriages


14a. How many times has your current spouse been married before? _____

14b. When was your spouse married?	14c. Where was your spouse married? (city/state or country)	14d. Who was your spouse married to? (first, middle initial, last)	14e. When did your spouse's marriage end? mo day yr	14f. Why did your spouse's marriage end? (death, divorce)	14g. Where did your spouse's marriage end? (city/state or country)
____/____/____ mo day yr			____/____/____ mo day yr		
____/____/____ mo day yr			____/____/____ mo day yr		

SECTION III Tell us about your other dependents

In this section we want to know whether your parents are financially dependent on you (Question 15) and more about your **dependent children**. VA may recognize a veteran's biological children, adopted children, and stepchildren as dependent. These children must be unmarried and:

- be under the age of 18, or
- be at least 18 but under 23 and pursuing an approved course of education, or
- have become permanently unable to support themselves before reaching the age of 18.

You should provide: a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child. 

15. Are your parents financially dependent on you?

Yes No (If "Yes," we will request additional information from you later.)

16. Do you have dependent children?

Yes

(If "No," Skip Items 17-21f.) Go to the bottom of page 3 and write your name and Social Security number.)

No

17. How many dependent children do you have?

Give us more information about these children in the tables on the next page (Items 18 through 21f).

SECTION III Tell us about your dependents (continued)

18a. What is the name of your unmarried child(ren)? (first, middle initial, last)	18b. Date and place of birth (city/state or country)	18c. Social Security Number	19a. Biological	19b. Adopted	19c. Stepchild	20a. 18-23 yrs. old and in school	20b. Seriously disabled before age 18	20c. Child previously married
	____/____/____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	____/____/____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	____/____/____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	____/____/____ mo day yr Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tell us about your dependents listed above who *don't* live with you

21a. Do all the children listed above live with you?

Yes (If "Yes," skip Items 21b thru 21f and write your name and Social Security number below.)

No (If "No," complete Item 21b and the table below (Items 21c -21f) and write your name and Social Security number below.)

21b. How many of the children do not live with you?

21c. What is the name of your child? (first, middle initial, last)	21d. What is your child's complete address?	21e. What is the name of the person your child lives with (If applicable)? (first, middle initial, last)	21f. How much do you contribute each month to the support of your child?
			\$.
			\$.
			\$.
			\$.

Your name	Your Social Security Number
------------------	------------------------------------



Department of Veterans Affairs

VA Form 21-526, Part D: Pension

Use this form to apply for pension. Remember that you must also fill out a VA Form 21-526, Part A: General Information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 4.

SECTION I Tell us about your disability and background

Complete this section if you are claiming pension because of permanent and total disability not caused by your military service.

Attach current medical evidence showing that you are permanently and totally disabled.

Note: 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.

<p>1a. What disability(ies) prevent you from working?</p>	<p>1b. When did the disability(ies) begin?</p> <p style="text-align: center;">____/____/____ mo day yr</p>
---	--

<p>2. Are you claiming a special monthly pension because you need the regular assistance of another person, are blind, nearly blind, or having severe visual problems, or are housebound?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>3a. Are you now, or have you recently been hospitalized or given outpatient or home-based care?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 3b and 3c also)</p>
--	---

<p>3b. Tell us the dates of the recent hospitalization or care</p> <p>Began ____/____/____ mo day yr</p> <p>Ended ____/____/____ mo day yr</p>	<p>3c. What is the name and complete mailing address of the facility or doctor?</p>
---	---

<p>4a. Are you now employed?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," answer Item 4b also)</p>	<p>4b. When did you last work?</p> <p style="text-align: center;">____/____/____ mo day yr</p>
--	--

<p>4c. Were you self-employed before becoming totally disabled?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 4d and 4e also)</p>	<p>4d. What kind of work did you do?</p>
---	--

<p>4e. Are you still self-employed?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 4f also)</p>	<p>4f. What kind of work do you do now?</p>
--	---

<p>4g. Have you claimed or are you receiving disability benefits from the Social Security Administration (SSA)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>4h. Circle the highest year of education you completed:</p> <p>Grade school 1 2 3 4 5 6 7 8 9 10 11 12</p> <p>College 1 2 3 4 over 4</p>
--	---

4i. List the other training or experience you have and any certificates that you hold.

SECTION II Tell us your work history

In the table below, tell us about all of your employment, including self-employment, for one year before you became disabled to the present.

5a. What was the name and address of your employer?	5b. What was your job title?	5c. When did your work begin?	5d. When did your work end?	5e. How many days were lost due to disability?	5f. What were your total annual earnings?												
		<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>mo</td><td>day</td><td>yr</td></tr> </table>				mo	day	yr	<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>mo</td><td>day</td><td>yr</td></tr> </table>				mo	day	yr		\$.
mo	day	yr															
mo	day	yr															
		<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>mo</td><td>day</td><td>yr</td></tr> </table>				mo	day	yr	<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>mo</td><td>day</td><td>yr</td></tr> </table>				mo	day	yr		\$.
mo	day	yr															
mo	day	yr															
		<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>mo</td><td>day</td><td>yr</td></tr> </table>				mo	day	yr	<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>mo</td><td>day</td><td>yr</td></tr> </table>				mo	day	yr		\$.
mo	day	yr															
mo	day	yr															

SECTION III Tell us if you are in a nursing home

In this section, tell us if you are in a nursing home. If you are in a nursing home, give us more information about the nursing home.

<p>To get your claim processed faster, provide 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 and tells us the daily charge for your care.</p>	<p>6a. Are you now in a nursing home?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "yes," answer Item 6b also)</p>	<p>6b. What is the name and complete mailing address of the facility or doctor?</p>
	<p>6c. Does Medicaid cover all or part of your nursing home costs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If "no," answer Item 6d also)</p>	<p>6d. Have you applied for Medicaid?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

SECTION IV Tell us the net worth of you and your dependents

In this section, we ask you to give us specific information about your net worth and the net worth of your dependents. You will need to enter this information in the tables on page 3.

You must include all assets in your net worth except those items you use everyday (See definition of net worth below.)
 You should subtract from the market value of your real estate any amounts that you owe on it (such as mortgages, liens, etc.)
 You can subtract mortgages on any property, and the value of the house or part of a building that you live in as your primary residence.
 You can report farms or buildings that you or a dependent own by reporting its value as "real property."

VA cannot pay you pension if your **net worth** is sizeable.

Definitions:
 Net worth is the market value of all interest and rights in any kind of property less 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 things you use everyday like your vehicle, clothing, and furniture.

Go to Page 3 and fill out the table.

SECTION IV
(Continued)

Tell us about your net worth and your dependents' net worth.

For items 7a-h: provide the amounts. If none, write "0" or "None"

Source	Veteran	Spouse	Child(ren)		
			I. Name: <small>(first, middle initial, last)</small>	II. Name: <small>(first, middle initial, last)</small>	III. Name: <small>(first, middle initial, last)</small>
7a. Cash, non-interest bearing bank accounts					
7b. Interest bearing bank accounts, certificates of deposit (CDs)					
7c. IRAs, Keogh Plans, etc.					
7d. Stocks and bonds					
7e. Mutual funds					
7f. Value of business assets					
7g. Real property (not your home)					
7h. All other property					

SECTION V
Tell us about the income you have received and you expect to receive

In this section, we ask you to give us specific information about the income you have received and the income you expect to receive from all sources. You will need to enter this information in the tables on Page 4. In these tables,

Report the total amounts before you take out deductions for taxes, insurance, etc. Do not report the same information in both tables.

If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.

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. VA will determine any amount that does not count.

8. Will you receive any income from rental property or from operation of a business within 12 months of the day you sign this form?

Yes No

9. Will you receive any income from the operation of a farm within 12 months of the day you sign this form?

Yes No

10. Do you expect to receive money from a civilian agency, corporation, or individual, because of personal injury or death within 12 months of the day you sign this form?

Yes No

SECTION V (Continued) Monthly Income—Tell us the income you and your dependents receive every month.

For Items 11a-12f if none write "0" or "None"

Sources of recurring monthly income	Veteran	Spouse	Child(ren)		
			I. Name:	II. Name:	III. Name:
			(first, middle initial, last)	(first, middle initial, last)	(first, middle initial, last)
11a. Social Security					
11b. U.S. Civil Service					
11c. U.S. Railroad Retirement					
11d. Military Retired Pay					
11e. Black Lung Benefits					
11f. Supplemental Security (SSI)/Public Assistance					
11g. Other income received monthly (Please write in the source below:)					

Next 12 months —Tell us about other income for you and your dependents

Sources of income for the next 12 months	Veteran	Spouse	Child(ren)		
			I. Name:	II. Name:	III. Name:
			(first, middle initial, last)	(first, middle initial, last)	(first, middle initial, last)
12a. Gross wages and salary					
12b. Total interest and dividends					
12c. Worker's compensation for injury					
12d. Unemployment compensation					
12e. Other military benefit (Please write in the source below:)					
12f. Other one-time benefit (Please write in the source below:)					

SECTION VI

IMPORTANT—Items 13A through 13E should be completed only if you are applying for nonservice-connected pension.

Tell us any information concerning, Medical, Legal or Other Expenses— Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid 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. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. **Do not** include any expenses for which you were reimbursed. Show the Medicare deduction in line 1. If more space is needed attach a separate sheet.

13A. AMOUNT PAID BY YOU	13B. DATE PAID	13C. PURPOSE <i>(Doctor's fees, hospital charges, Attorney fees, etc)</i>	13D. PAID TO <i>(Name of doctor, hospital, pharmacy, Attorney, etc.)</i>	13E. DISABILITY OR RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID

Your name	Your Social Security Number
------------------	------------------------------------

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

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 <i>(Type or print)</i>	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME <i>(If other than Veteran)</i> LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. <i>(Include ZIP Codes, and also a telephone number, if available)</i>	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. <i>(Include month and year)</i>	7C. CONDITION(S) <i>(Illness, injury, etc.)</i>

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

SECTION III - CONSENT TO RELEASE INFORMATION

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

9A. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Privacy Act of 1974, 5 U.S.C. 552a, 38 U.S.C. 7332, and the Health Insurance Portability and Accountability Act (HIPAA), implemented by 45 Code of Federal Regulations Parts 160 and 164. Your disclosure of the information requested on this form 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. Further, 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.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A 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 7A 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 7A. 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).

9C. I (AUTHORIZE) (DO NOT AUTHORIZE) the source shown in Item 7A 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:**

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. RELATIONSHIP TO VETERAN/CLAIMANT <i>(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)</i>	10C. DATE
--	--	-----------

10D. MAILING ADDRESS <i>(Number and Street or rural route, city, or P.O. State and ZIP Code)</i>	10E. TELEPHONE NUMBER <i>(Include Area Code)</i>
--	--

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.

11A. SIGNATURE OF WITNESS	11B. DATE
---------------------------	-----------

11C. MAILING ADDRESS OF WITNESS
