VETERAN PREPAREDNESS BOOKLET

A guide for veterans and their families

March 2024

Veteran Preparedness Guide

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Additional Credit and Thanks to:
Al Fitchett, DSO, VFW Pacific Areas
VFW District V for "What My Family Should Know."
VFW Post 9876 "Flow Chart"
JUSMAGTHAI Retired Affairs Office (RAO)
Mrs. Thida Robertin for translating "What My Family Should Know" to Thai

Purpose

The purpose of this booklet is to prepare a “complete package” for veterans and their spouse/family with the “What My Spouse/Family Should Know” as well as other forms and documents that can be prepared to assist the survivors and Veteran Service Officer in filing for benefits.

The history behind this document is based upon our own personal experiences helping widows/families of deceased veterans. Despite our best efforts, many veterans die without preparing the required documents to file benefit claims for their spouse/family.

Our goal is to reduce the stress and financial hardship experienced by the surviving spouse and/or family members who must deal with the death of their loved one.

To make sure that veterans, spouses, and family know what to do, along with how to contact the Post Service Officer. To encourage veterans to prepare these documents as soon as possible and to provide support in completing the documents if the veteran needs assistance.

Additionally, provide the Thai spouse/family materials in Thai to assist in understanding what is required to file these claims. When possible, we have translated many of the instructions to Thai.

This booklet is not intended to replace working with an accredited Veteran Service Officer or the advice of an attorney or legal professional.

ข้างหน้า

วัตถุประสงค์ของหนังสือเล่มนี้คือการเตรียม "แพ็คเกจที่สมบูรณ์"
สำหรับทหารผ่านศึกและคู่สมรส / ครอบครัวของพวกเขาด้วย "สิ่งที่คู่สมรส /
ครอบครัวของฉันควรรู้" รวมถึงแบบฟอร์มและเอกสารอื่น ๆ
ที่สามารถเตรียมเพื่อช่วยเหลือผู้รอดชีวิตและเจ้าหน้าที่บริการทหารผ่านศึกในการยื่นขอผลประโยชน์

ประวัติเบื้องหลังเอกสารนี้ขึ้นอยู่กับประสบการณ์ส่วนตัวของเราเองในการช่วยเหลือหญิงม่าย / ครอบครัวของทหารผ่านศึกที่เสียชีวิต แม้จะมีความพยายามอย่างดีที่สุด
แต่ทหารผ่านศึกจำนวนมากเสียชีวิตโดยไม่ต้องเตรียมเอกสารที่จำเป็นเพื่อยื่นข้อเรียกร้องผลประโยชน์สำหรับคู่สมรส / ครอบครัวของพวกเขา

เป้าหมายของเราคือการลดความเครียดและความยากลำบากทางการเงินที่คู่สมรสและ / หรือสมาชิกในครอบครัวที่รอดชีวิตซึ่งต้องจัดการกับการตายของคนที่คุณรัก

เพื่อให้แน่ใจว่าทหารผ่านศึกคู่สมรสและครอบครัวรู้ว่าต้องทำอย่างไรพร้อมกับวิธีการติดต่อเจ้าหน้าที่ไปรษณีย์
เพื่อส่งเสริมให้ทหารผ่านศึกเตรียมเอกสารเหล่านี้โดยเร็วที่สุดและให้การสนับสนุนในการกรอกเอกสารหากทหารผ่านศึกต้องการความช่วยเหลือ

นอกจากนี้
ให้จัดเตรียมเอกสารคู่สมรส/ครอบครัวไทยเป็นภาษาไทยเพื่อช่วยทำความเข้าใจสิ่งที่จำเป็นในการยื่นข้อเรียกร้องเหล่านี้

หนังสือเล่มนี้ไม่ได้มีวัตถุประสงค์เพื่อแทนที่การทำงานกับเจ้าหน้าที่บริการทหารผ่านศึกที่ได้รับการรับรองหรือคำแนะนำของทนายความหรือผู้เชี่ยวชาญด้านกฎหมาย

VFW Post 12074 VA Claim Checklist

Document/Form	Description	Page
VA 21-22	Appointment of VSO Representative	17
VA 21P-534EZ	Application for DIC/Survivor Benefits	21
VA 21P-530EZ	Application for Burial Benefits	41
VA 21-4142	Authorization to Release Medical Records	49
VA 21-4138 (if needed)	Statement in Support of Claim (use if spouse has no SSN)*	54
VA 10-0137	Advance Directive/Durable Power of Attorney	56
DD-214 (all periods)	All Active-Duty Periods	7
Marriage Certificates (all)	Both Veteran and Spouse	9
Divorce Certificates (all)	Both Veteran and Spouse	10
Copy of Bangkok Bank Book	1st page should name and account number of beneficiary	8
Thai ID Copy (Spouse)	Front and back	8
Death Certificates Thai & English	Thai Death Certificate and US Consulate Certificate	11
Medical Records Thai/English	Any medical reports or documents they have on hand	12
Buddy/Spouse Statements	As needed	13
What My Family Should Know**	Information Package w/ attached documents	62-74
Flow Chart	Survivors Assistance Guide	87
Social Security	How Social Security Can Help When a Family Member Dies	88

**Veteran needs to complete these for his spouse/family.
Available in English and Thai.

Do not send original documents to the VA, only copies.

When signing documents or forms, the Thai spouse or family member should sign in Thai, not print in English.

Many of these documents can be downloaded via computer.

VA Forms: https://www.va.gov/find-forms/

If you require assistance, please contact a VFW Post 12074

VFW Chiang Mai Post 12074: vfw12074.org

VFW Post 12074 VA รายการตรวจสอบการอ้างสิทธิ์

เอกสาร/แบบฟอร์ม	การบรรยาย	หน้า
21-22	การแต่งตั้งตัวแทน VSO	17
VA 21P-534EZ	ใบสมัครสำหรับผลประโยชน์ DIC / Survivor	21
VA 21P-530EZ	การขอรับประโยชน์ในการฝังศพ	41
VA 21-4142	การอนุญาตให้เผยแพร่เวชระเบียน	49
VA 21-4138 (ถ้าจำเป็น)	ข้อความสนับสนุนการเรียกร้องค่าสินไหมทดแทน (ใช้หากคู่สมรสไม่มี SSN)*	54
VA 10-0137**	คำสั่งล่วงหน้า/หนังสือมอบอำนาจที่ทนทาน	56
DD-214 (ทุกช่วงเวลา)	ระยะเวลาการปฏิบัติหน้าที่ทั้งหมด	7
ทะเบียนสมรส (ทั้งหมด)	ทั้งทหารผ่านศึกและคู่สมรส	9
ใบสำคัญการหย่า (ทั้งหมด)	ทั้งทหารผ่านศึกและคู่สมรส	10
สำเนาสมุดบัญชีธนาคารกรุงเทพ	หน้าที่ 1 ควรระบุชื่อและเลขที่บัญชีของผู้รับผลประโยชน์	8
สำเนาบัตรประชาชนไทย (คู่สมรส)	ด้านหน้าและด้านหลัง	8
ใบมรณบัตร ภาษาไทยและภาษาอังกฤษ	ใบมรณบัตรไทย และใบสำคัญประจำสถานกงสุลสหรัฐอเมริกา	11
เวชระเบียน ไทย/อังกฤษ	รายงานทางการแพทย์หรือเอกสารใด ๆ ที่พวกเขามีในมือ	12
ข้อความของเพื่อน/คู่สมรส	ตามความจำเป็น	13
สิ่งที่ครอบครัวของฉันควรรู้**	แพคเกจข้อมูลพร้อมเอกสารแนบ	75-86
ผังงาน	คู่มือช่วยเหลือผู้รอดชีวิต	87
ประกันสังคม	How Social Security Can Help When a Family Member Dies	88

**ทหารผ่านศึกจำเป็นต้องทำสิ่งเหล่านี้ให้สำเร็จสำหรับคู่สมรส/ครอบครัวของเขา

มีให้บริการในภาษาอังกฤษและภาษาไทย

อย่าส่งเอกสารต้นฉบับไปยัง VA เฉพาะสำเนาเท่านั้น

เมื่อลงนามในเอกสารหรือแบบฟอร์มคู่สมรสหรือสมาชิกในครอบครัวชาวไทยควรเซ็นชื่อเป็นภาษาไทยไม่ใช่พิมพ์เป็นภาษาอังกฤษ

เอกสารเหล่านี้จำนวนมากสามารถดาวน์โหลดได้ทางคอมพิวเตอร์

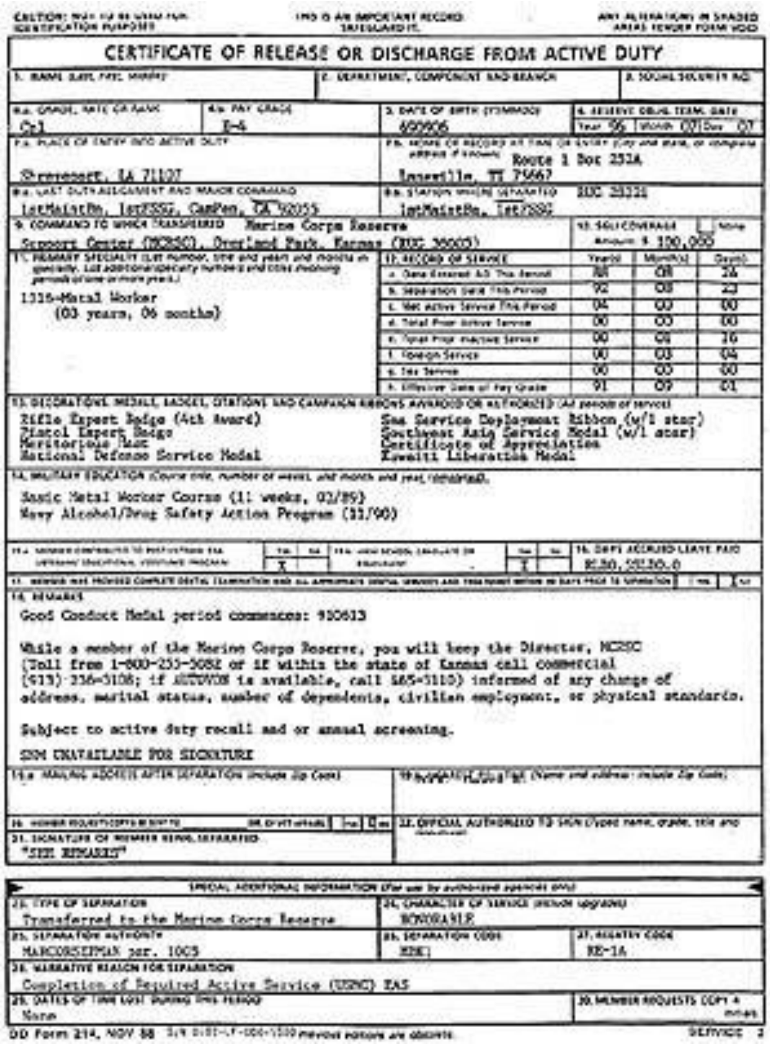
VA Forms: https://www.va.gov/find-forms/

หากคุณต้องการความช่วยเหลือ โปรดติดต่อ VFW Post 12074

VFW Chiang Mai Post 12074: vfw12074.org

DD-214'S FOR ALL ACTIVE-DUTY PERIODS

DD-214 สำหรับทุกช่วงเวลาที่ใช้งาน



CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

4.a. GRADE, RATE OR RANK: Cpl
4.b. PAY GRADE: E-4
5. DATE OF BIRTH (YYMMDD): 690906
6. RESERVE OBLIG. TERM. DATE: Year 96 Month 07 Day 07
7.a. PLACE OF ENTRY INTO ACTIVE DUTY: Shreveport, LA 71107
7.b. HOME OF RECORD AT TIME OF ENTRY: Route 1 Box 253A [illegible], TX 75667
8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND: 1stMaintBn, 1stFSSG, CamPen, CA 92055
8.b. STATION WHERE SEPARATED: RUC 28321 1stMaintBn, 1stFSSG
9. COMMAND TO WHICH TRANSFERRED: Marine Corps Reserve Support Center (MCRSC), Overland Park, Kansas (RUC 30005)
10. SGLI COVERAGE: Amount: $ 100,000
11. PRIMARY SPECIALTY: 1316-Metal Worker (03 years, 06 months)

12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
a. Date Entered AD This Period	88	08	24
b. Separation Date This Period	92	08	23
c. Net Active Service This Period	04	00	00
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	08	16
f. Foreign Service	00	03	04
g. Sea Service	00	00	00
h. Effective Date of Pay Grade	91	09	01

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED:
Rifle Expert Badge (4th Award)
Pistol Expert Badge
Meritorious Mast
National Defense Service Medal
Sea Service Deployment Ribbon (w/1 star)
Southwest Asia Service Medal (w/1 star)
Certificate of Appreciation
Kuwaiti Liberation Medal

14. MILITARY EDUCATION:
Basic Metal Worker Course (11 weeks, 03/89)
Navy Alcohol/Drug Safety Action Program (11/90)

16. DAYS ACCRUED LEAVE PAID: [illegible]

18. REMARKS
Good Conduct Medal period commences: 910613

While a member of the Marine Corps Reserve, you will keep the Director, MCRSC (Toll free 1-800-255-5082 or if within the state of Kansas call commercial (913) 236-3108; if AUTOVON is available, call 465-3110) informed of any change of address, marital status, number of dependents, civilian employment, or physical standards.

Subject to active duty recall and or annual screening.

SNM UNAVAILABLE FOR SIGNATURE

21. SIGNATURE OF MEMBER BEING SEPARATED: "SEE REMARKS"

SPECIAL ADDITIONAL INFORMATION

23. TYPE OF SEPARATION: Transferred to the Marine Corps Reserve
24. CHARACTER OF SERVICE: HONORABLE
25. SEPARATION AUTHORITY: MARCORSEPMAN par. 1005
26. SEPARATION CODE: [illegible]
27. REENTRY CODE: RE-1A
28. NARRATIVE REASON FOR SEPARATION: Completion of Required Active Service (USMC) EAS
29. DATES OF TIME LOST DURING THIS PERIOD: None

DD Form 214, NOV 88

COPY OF THE FIRST PAGE SHOWING ACCOUNT NUMBER AND NAME OF ACCOUNT OWNER (BENEFICIARY)

สำเนาหน้าแรกที่แสดงหมายเลขบัญชีและชื่อเจ้าของบัญชี (ผู้รับผลประโยชน์)

COPY OF SPOUSES THAI ID CARD, FRONT AND BACK

สำเนาบัตรประจำตัวประชาชนของคู่สมรสทั้งด้านหน้าและด้านหลัง

MARRIAGE CERTIFICATES FOR BOTH VETERAN AND SPOUSE
FOR ALL MARRIAGES (CURRENT AND PAST)

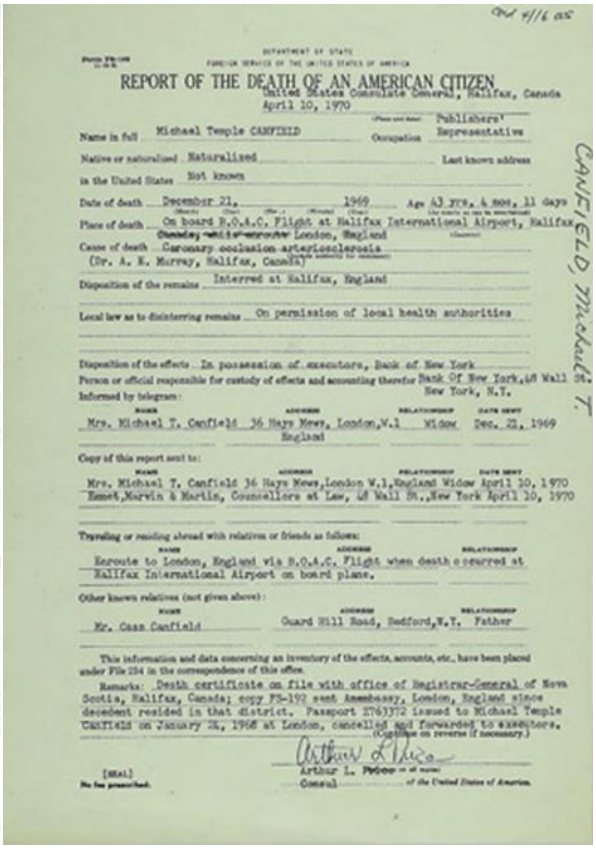
ทะเบียนสมรสสำหรับทั้งทหารผ่านศึกและคู่สมรส
สำหรับการแต่งงานทั้งหมด (ปัจจุบันและอดีต)

DIVORCE DOCUMENTS FOR BOTH THE VETERAN AND SPOUSE FOR ALL DIVORCES

เอกสารการหย่าร้างสำหรับทั้งทหารผ่านศึกและคู่สมรสสำหรับการหย่าร้างทั้งหมด

DEATH CERTIFICATES FROM BOTH THAILAND AND THE U.S. EMBASSY/CONSULATE

ใบมรณบัตรจากทั้งไทยและสถานทูต/สถานกงสุลสหรัฐฯ



REPORT OF THE DEATH OF AN AMERICAN CITIZEN

United States Consulate General, Halifax, Canada
April 10, 1970

Name in full: Michael Temple CANFIELD — Occupation: Publishers' Representative

Native or naturalized: Naturalized — Last known address in the United States: Not known

Date of death: December 21, 1969 — Age: 43 yrs, 4 mos, 11 days

Place of death: On board B.O.A.C. Flight at Halifax International Airport, Halifax

Cause of death: Coronary occlusion arteriosclerosis (Dr. A. E. Murray, Halifax, Canada)

Disposition of the remains: Interred at Halifax, England

Local law as to disinterring remains: On permission of local health authorities

Disposition of the effects: In possession of executors, Bank of New York

Person or official responsible for custody of effects and accounting therefor: Bank Of New York, 48 Wall St., New York, N.Y.

Informed by telegram:

Name	Address	Relationship	Date sent
Mrs. Michael T. Canfield	36 Hays Mews, London, W.1 England	Widow	Dec. 22, 1969

Copy of this report sent to:

Name	Address	Relationship	Date sent
Mrs. Michael T. Canfield	36 Hays Mews, London W.1, England	Widow	April 10, 1970
Emmet, Marvin & Martin, Counsellors at Law	48 Wall St., New York		April 10, 1970

Traveling or residing abroad with relatives or friends as follows:

Enroute to London, England via B.O.A.C. Flight when death occurred at Halifax International Airport on board plane.

Other known relatives (not given above):

Name	Address	Relationship
Mr. Cass Canfield	Guard Hill Road, Bedford, N.Y.	Father

This information and data concerning an inventory of the effects, accounts, etc., have been placed under File 234 in the correspondence of this office.

Remarks: Death certificate on file with office of Registrar-General of Nova Scotia, Halifax, Canada; copy FS-192 sent Embassy, London, England since decedent resided in that district. Passport 2761372 issued to Michael Temple CANFIELD on January 24, 1968 at London, cancelled and forwarded to executors.

Arthur L. Price
Consul of the United States of America

CANFIELD, Michael T.

MEDICAL RECORDS AS NEEDED

เวชระเบียนตามความจำเป็น

'BUDDY' AND/OR SPOUSE STATEMENT

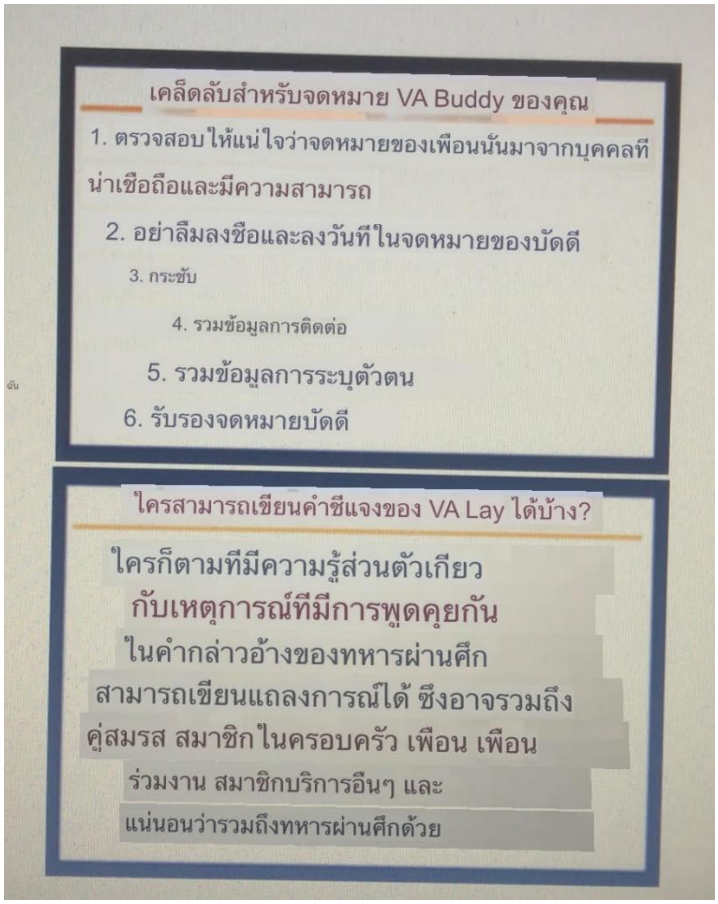
คำแถลงของเพื่อนและ/หรือคู่สมรส

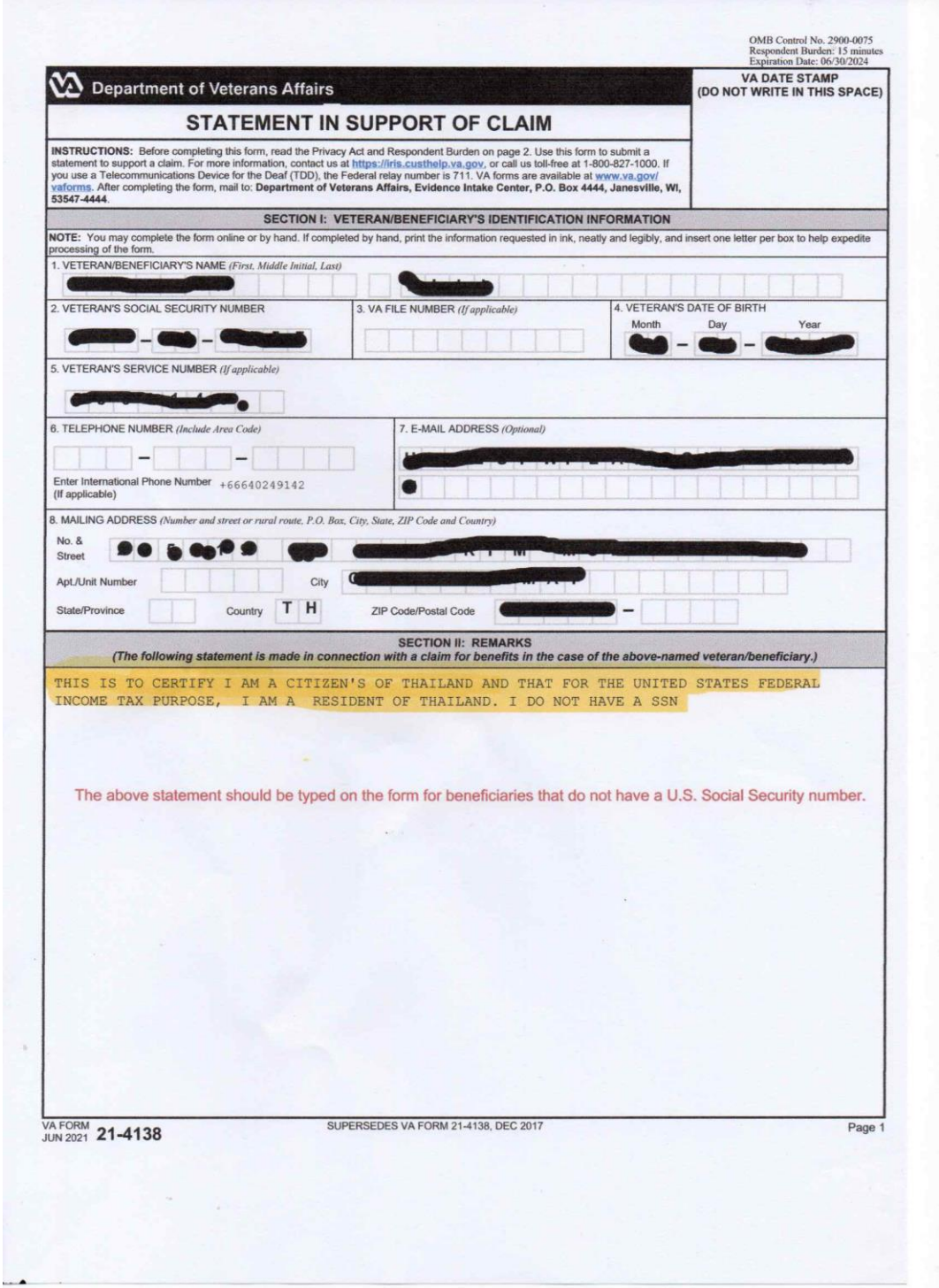
Tips for Your VA Buddy Letter

1. Ensure that the buddy letter is from someone credible and competent
2. Be sure to sign and date the buddy letter
3. Be concise
4. Include contact information
5. Include identifying information
6. Certify the buddy letter

Who Can Write a VA Lay Statement?

Anyone with personal knowledge of the events being discussed in a veteran's claim can write a lay statement. This can include spouses, family members, friends, coworkers, other service members, and, of course, the veteran themselves.





OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a statement to support a claim. For more information, 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. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547-4444.**

SECTION I: VETERAN/BENEFICIARY'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, and insert one letter per box to help expedite processing of the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH
Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)*

Enter International Phone Number (If applicable) +66640249142

7. E-MAIL ADDRESS *(Optional)*

8. 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 T H

ZIP Code/Postal Code –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

THIS IS TO CERTIFY I AM A CITIZEN'S OF THAILAND AND THAT FOR THE UNITED STATES FEDERAL INCOME TAX PURPOSE, I AM A RESIDENT OF THAILAND. I DO NOT HAVE A SSN

The above statement should be typed on the form for beneficiaries that do not have a U.S. Social Security number.

VA FORM JUN 2021 **21-4138**

SUPERSEDES VA FORM 21-4138, DEC 2017

Page 1

"นี่คือการรับรองว่าฉันเป็นพลเมืองของประเทศไทยและเพื่อวัตถุประสงค์ด้านภาษีของรัฐบาลกลางสหรัฐอเมริกาฉันเป็นผู้มีถิ่นที่อยู่ในประเทศไทย ฉันไม่มีหมายเลขประกันสังคม"

สิ่งนี้เขียนไว้ในแบบฟอร์มเพื่อให้ VA ทราบว่าคุณไม่มีหมายเลขประกันสังคม

Veterans Administration Forms

VA Form 21-22

vba.va.gov/pubs/forms/vba-21p-530ez-are.pdf

vba.va.gov/pubs/forms/vba-21p-534ez-are.pdf

vba.va.gov/pubs/forms/vba-21-4142-are.pdf

VA Form 10-0137

vba.va.gov/pubs/forms/vba-21-4138-are.pdf

Standard Form 180 (Rev (va.gov)

What My Family Should Know English.

What My Family Should Know Thai.pdf

This page reserved for notes:

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. See Page 4 for information on how to submit the completed form, either by mail, in person at a VA regional office or electronically. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)* – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'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 –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

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

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

11. 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 –

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form 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 service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized 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 service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☐ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	**23B. DATE SIGNED** *(MM/DD/YYYY)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
AMVETS
American Ex-Prisoners of War, Inc.
American GI Forum, National Veterans Outreach Program
Armed Forces Services Corporation
Army and Navy Union, USA
Associates of Vietnam Veterans of America
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc,
National Association for Black Veterans, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
The Veterans Assistance Foundation, Inc.
The Veterans of the Vietnam War, Inc. & The Veterans Coalition
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America
West Virginia Department of Veterans Assistance
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims:

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

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. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. 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. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. 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: We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid 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.

WHERE TO SEND YOUR WRITTEN CORRESPONDENCE

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 need assistance, you can find a local, accredited representative at https://www.benefits.va.gov/vso/.

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

These addresses serve **all United States** and **foreign locations**.

Department of Veterans Affairs

NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

This notice provides information regarding evidence necessary to substantiate a claim for:

- Survivors Pension
- Dependency Indemnity Compensation (DIC)
- DIC under 38 U.S.C. 1151
- DIC re-evaluation based on PL 117-16 (PACT ACT)
- Increased Survivor Benefits Based on Need for Special Monthly Pension or Special Monthly DIC
- Accrued Benefits
- Benefits Based on a Veteran's Seriously Disabled Child.

If you are making a claim for:

- Parent's DIC and/or accrued benefits for parents use - VA Form 21P-535, *Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation when Applicable)*
- Veteran's disability compensation use - VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*
- Veteran's pension benefits use - VA Form 21P-527EZ, *Application for Veterans Pension*
- Accrued benefits only use - VA Form 21P-601, *Application for Accrued Benefits Due a Deceased Beneficiary*

If you are ***not*** ready to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*, to protect your date of claim. If you complete the VA Form 21P-534EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date of receipt of the VA Form 21-0966.

VA Forms are available at www.va.gov/vaforms.

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veteran Service Officer to assist you with your application. For a list of accredited veteran's service organizations go to https://www.va.gov/vso/. You may also contact your state office of Veterans Affairs at https://www.va.gov/statedva.htm, should you need further assistance with the application process. To assign a VSO as your power of attorney for the claims process please submit VA Form 21-22, *Appointment of Veteran Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veterans Affairs go to: https://www.va.gov/ogc/apps/accreditation/index.asp. To assign a private attorney or claims agent as your power of attorney for the claims process please submit a VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims: Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

WHEN TO USE THIS FORM

The attached application and the worksheets are needed to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. This notice details the evidence necessary to substantiate your claim.

The Application is comprised of 14 sections. Be sure to answer the question(s) in each section as required.	
Section I: Veteran's Identification Information	Section VIII: Nursing Home or Increased Survivors Entitlement Based on a Claim For Special Monthly Pension
Section II: Claimant's Contact Information	Section IX: Income and Assets
Section III: Veteran's Service Information	Section X: Information about Your Medical or Other Expenses
Section IV: Marital Information	Section XI: Direct Deposit Information
Section V: Marital History	Section XII: Claim Certification and Signature
Section VI: Child of the Veteran Information	Section XIII: Witness to Signature
Section VII: DIC	Section XIV: Alternate Signer Certification and Signature

WANT TO GET YOUR CLAIM PROCESSED FASTER?

Participation in the FDC Program is:

- An Optional Expedited process (enrollment is automatic unless you opt-out).
- Will not affect the quality of care you receive or the benefits to which you are entitled.

You will be removed from the FDC program if :

- It is determined that other non-federal records exist, and VA needs the records to decide your claim.

See below for more information.

- If you wish to file your own claim in the FDC Program, see FDC Program.
- If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

FDC Program Criteria

To qualify for the FDC Program you must:

1. Submit your claim on a completed, signed and dated VA Form 21P-534EZ, *Application for DIC, Survivors Pension, and/or Accrued Benefits* (Attached).

2. Submit simultaneously with your claim:
   - A copy of the veteran's death certificate (unless the veteran died on active duty); AND

If claiming Survivor's Pension:
- All necessary income and asset information; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

If claiming DIC:
- All, if any, of the veteran's relevant, private medical treatment records and an identification of any of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA;
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s) if applicable; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

3. Report for any VA examinations VA determines are necessary to decide your claim.

For more information on the FDC Program, visit our website at https://www.choose.va.gov/pensions. For more information on VA benefits, visit our website at www.va.gov, contact us at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.

SPECIAL CIRCUMSTANCES: Additional forms may be needed to remain eligible for the FDC Program.
This includes VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, which may be required if you:
- Have multiple income sources
- Have more than $25,000 in assets
- Additional forms as noted on the VA Form 21P-0969 may be required

If claiming Special Monthly Pension or Special Monthly DIC:
- Please have a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinic Nurse Specialist (CNS) complete VA Form 21-2680, *Examination for Household Status or Permanent Need for Regular Aid and Attendance*, **OR**
- If you are a patient in a nursing home complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

If claiming benefits for a child of the veteran:
- And they are in school between the ages of 18 and 23, a completed VA Form 21-674, *Request for Approval of School Attendance*
- If the child was adopted, please submit the adoption papers or amended birth certificate
- If claiming benefits for a child of the veteran who became seriously disabled prior to reaching the age of 18, submit all, if any, relevant private medical treatment records for the child's pertinent disabilities

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service. A substantially complete claim must contain: (1) The claimant's name; (2) Their relationship to the veteran (3) Sufficient service information for VA to verify the claimed service, if applicable; (4) The benefit sought and any medical condition(s) on which it is based; (5) The claimant's signature; (6) A statement of income, if applicable.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Submit your claim in accordance with the "FDC Program Criteria" (see page 2)	You must: • If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it **NOTE**: If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. **It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.**

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

VA will retrieve evidence on your behalf in some circumstances. If VA is unable to retrieve the necessary evidence, we will notify you and provide you with an opportunity to submit the information or evidence. It is your responsibility to make sure we receive all requested records that are not in the possession of a federal department or agency.

FDC Program (Optional Expedited Process)	Standard Claim Process
VA will: • Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain • Get a medical opinion if we determine it is necessary to decide your claim	VA will: • Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain • Get a medical opinion if we determine it is necessary to decide your claim • Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from state or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records or records from current or former employers

WHEN YOU SHOULD SEND WHAT WE NEED

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Send the information and evidence simultaneously with your claim **NOTE**: If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program expedited process and process it in the Standard Claim process. If we decide your claim before one year from the date we received the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.	You are strongly encouraged to: • Send any information or evidence as soon as you can **NOTE**: You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we received the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See Evidence Tables titled...
Survivor's Pension (a needs based benefit based on the the veteran's wartime service)	• Military Service Verification • Survivor's Pension
• DIC because the veteran's death was related to the veteran's service, OR • DIC because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling	• Dependency and Indemnity Compensation (DIC)
• DIC because the veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy	• DIC under 38 U.S.C. 1151
DIC re-evaluation of a previously denied claim based on eligibility under PL 117-168 (PACT Act)	• DIC re-evaluation based on PL 117-168 (PACT Act)
DIC that was previously denied by VA	• Supplemental DIC
Special Monthly Pension or Special Monthly DIC based on the need for aid and attendance or housebound benefits	• Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC
Benefits that were due to the veteran at the time of the veteran's death	• Accrued Benefits
Benefits because the child of the veteran is severely disabled	• Child incapable of self-support

EVIDENCE TABLES

Military Service Verification

To support your claim for **Survivors benefits**, the veteran's military service must be verified. The following evidence can be submitted to verify the veteran's military service:

- A photocopy of the veteran's DD 214 (or equivalent) for all periods of military service. You may request a copy of the DD 214 through the National Archives' National Personnel Records Center (NPRC) using Standard Form 180 (SF-180, 09/2021 version), *Request Pertaining to Military Records*, (available at **https://www.gsa.gov/forms**) or through your local public custodian of records.

Fire Related Military Records.
As you may know, there was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately

- 80 percent of the records NPRC held for veterans who were discharged from the Army between November 1, 1912 and January 1, 1960 and
- 75 percent of the records NPRC held for veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947 and January 1, 1964.

If the veteran's military records were stored there on that date, they may have been destroyed in the fire. If you believe the veteran's military records may have been destroyed in the fire, NA Form 13075, *Questionnaire About Military Service*, should be completed to avoid delays in processing your claim. NA Form 13075 is available at: https://www.archives.gov/files/st-louis/military-personnel/**na-13075-questionnaire-aboutmilitary-service.pdf**

NOTE: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please ***do not*** submit original documents to VA since they ***will not*** be returned to you.

Survivors Pension

To support your claim for **Survivors Pension**, the evidence must show:
1. The veteran met certain minimum active service requirements during a period of war.
   Generally, those requirements are:
   - 90 days of service during a period of war; **OR**
   - 90 days of consecutive service at least one day of which was during a period of war; **OR**
   - 90 days of combined service during more than one period of war
   (**Note**: If the veteran's service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligations.); **OR**
   - any length of active service during a period of war when:
     - at the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
     - the veteran was discharged from active service due to a service-connected disability.
2. Your income and assets do not exceed certain requirements.
Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area that does not exceed 2 acres, unless the additional acreage is not marketable) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

EVIDENCE TABLES (Continued)

Dependency and Indemnity Compensation (DIC)

To support a claim for **Dependency and Indemnity Compensation (DIC) based on a service-connected disability**:

- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non-service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - For at least 10 years immediately before death; **OR**
  - For at least 5 years after the veteran's release from active duty preceding death; **OR**
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **DIC based on a disability that was not service-connected** or for which the veteran did not file a claim during their lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

To support your claim for **DIC based upon the service person's active duty for training**, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty, and the disease or injury caused or contributed to the service person's death.

NOTE: If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC based on a disability that was not service-connected or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **DIC based upon the service person's inactive duty training**, the evidence must show:

- The service person died during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

NOTE: If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **DIC based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

DIC under 38 U.S.C. 1151:

In order to support your claim for **DIC under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**

- The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program

EVIDENCE TABLES (Continued)

DIC Re-evaluation Based on PL 117-168 (PACT Act)

Public Law 117-168 (PACT ACT) was signed into law on August 10, 2022. This resulted in a substantial expansion of a veteran's military service that qualifies for presumptive toxic exposure and new presumptive conditions linked to that exposure. The law allows prior claimants for DIC to request a re-evaluation based on the expanded eligibility within the PACT Act. More information about the PACT Act can be found at https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

In order to support your claim for **DIC re-evaluation based on PL 117-168 (PACT Act)** the evidence must show:
- A claim was submitted and denied prior to August 10, 2022, the date the PACT Act went into effect; **AND**
- The claimant has elected re-evaluation of the previously denied claim.

Supplemental DIC:

In order to reopen a **claim previously denied by VA**, we need:
- The prescribed supplemental claim form, VA Form 20-0995, *Decision Review Request: Supplemental Claim*; **AND**
- New and relevant evidence. New and relevant evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.
  - To qualify as new, the evidence must currently exist and be submitted to VA for the first time
  - In order to be considered relevant, the additional existing evidence must pertain to the reason your claim was previously denied

Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:
- you have corrected vision of 5/200 or less in both eyes; **OR**
- you have concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulations 3.352(a)); **OR**
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulations 3.352(a)); **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:
- you are substantially confined to your immediate premises because of permanent disability

Accrued Benefits

To support a claim for **accrued benefits**, the evidence must show:
- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority:
1. Spouse 2. Children of the veteran (in equal shares) 3. Dependent parents (in equal shares)

NOTE: Child means an unmarried child of the veteran who is under 18 years of age, or at least 18 but under 23 years of age and pursuing an approved course of education or became incapable of self-support prior to reaching age 18.
If there are no living persons who are entitled on the basis of relationship, accrued benefits may be used to reimburse the person or persons who paid for or are responsible to pay the expenses of last illness and burial of a beneficiary. The claim should be filed by the person or persons whose funds were or will be used to pay such expenses using VA Form 21P-601, *Application for Accrued Amounts Due a Deceased Beneficiary*.

Child Incapable of Self-Support

To support a **claim for benefits based on a veteran's child being incapable of self-support**, the evidence must show that the child, before their 18th birthday became permanently incapable of self-support due to mental or physical disability. The information necessary to establish the extent of the child's disability includes:
- the extent to which the child is and was, prior to reaching their 18th birthday, physically or mentally deficient as evidenced by factors such as their ability to perform self-care functions, and ordinary tasks expected of a child of that age
- whether or not the child attended school and, if so, the maximum grade attended
- if any material improvement in the child's condition has occurred
- if the child has ever been employed and, if so, the nature and dates of such employment, and amount of pay received
- whether or not the child has ever been married, and
- a description of the child's present condition

Presumptive Service Connection

To support a claim for presumptive service connection the evidence must show:

- The veteran served in a recognized location that qualifies for the presumption of exposure; **AND/OR**
- The veteran died of a disability that qualifies for the presumption of service connection. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable.

Under certain circumstances, VA may presume that certain current diseases were caused by service, even if there is no specific evidence proving this in your particular claim. Service connection is presumed for certain diseases for the following veterans:

- Former prisoners of war;
- Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
- Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
- Veterans who were exposed to certain herbicides, such as by service in/on:
  - Vietnam or qualifying offshore waters, from January 9, 1962, through May 7, 1975;
  - a unit determined by VA or the Department of Defense to have operated in the Korean DMZ, from September 1, 1967, through August 31, 1971;
  - individuals who performed service in the Air Force or Air Force Reserve and regularly and repeatedly operated, maintained, or served onboard C-123 aircraft known to have used to spray an herbicide agent during the Vietnam era;
  - Thailand at any United States or Royal Thai base, from January 9, 1962, through June 30, 1976;
  - Laos, from December 1, 1965, through September 30, 1969;
  - Cambodia at Mimot or Krek, Kampong Cham Province, from April 16, 1969, through April 30, 1969;
  - Guam or American Samoa, or in the territorial waters thereof, from January 9, 1962, through July 31, 1980;
  - Johnston Atoll or on a ship that called at Johnston Atoll, from January 1, 1972, through September 30, 1977.
- Veterans who served at Camp Lejeune for no less than 30 days (consecutive or nonconsecutive) between August 1, 1953 and December 31, 1987; **OR**
- Veterans who served in the Gulf War:
  - On or after August 2, 1990, and served in:
    - Bahrain; Iraq; the neutral zone between Iraq and Saudi Arabia; Kuwait; Oman; Qatar; Saudi Arabia; Somalia; United Arab Emirates; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; the Red Sea; Afghanistan; Israel; Egypt; Turkey; Syria; or Jordan; **OR**
  - On or after September 11, 2001, and served in:
    - Afghanistan; Djibouti; Egypt; Jordan; Lebanon; Syria; Yemen; or Uzbekistan.

IMPORTANT INFORMATION REGARDING MARRIAGE:

If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for Survivors benefits, the beginning date of your entitlement will generally be the date we received your claim. However, if VA receives your claim within one year after the date of the veteran's death, entitlement will be from the first day of the month in which the veteran died. The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Special monthly pension may be available for a veteran's surviving spouse who is unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit online or mail it to the Pension Intake Center listed below. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and any evidence you send to VA before submitting.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center PO Box 5365 Janesville, WI 53547-5365	VA gov: www.va.gov Direct Upload via access.va.gov

TERMS AND CALCULATIONS FOR SURVIVOR'S PENSION

Maximum Annual Pension Rate (MAPR)
This is the maximum payable amount of the benefit. Your MAPR is based on how many dependents you have and if your disabilities qualify you for Housebound or Aid and Attendance benefits. The MAPR is reviewed each year for cost of-living adjustments.

Medical Deductible
The unreimbursed expenses must exceed 5 percent of the applicable MAPR. The deductible increases based on the number of dependents but is not adjusted for aid and attendance (A&A) or housebound.

Countable Medical Expenses
Your countable unreimbursed medical expenses are only those expenses that exceed the medical deductible. Medical expenses are typically considered on a calendar year basis.

- Recurring Medical Expenses
  Examples may include Medicare Part B, Medical Insurance, In-Home Care Provider, or care provided by a care facility
- One-time Medical Expenses
  Examples include Medical Co-Payments, Prescription Medications, and Durable Medical Equipment.

Countable Income
We count the income you report or the income we discover from data matching programs with other federal sources. If our data match shows a significant discrepancy, you will be removed from the FDC program and asked to clarify the discrepancy. We count incomes in three ways:

- One-time income is income that you receive once, and the VA will count it for one year from the receipt date.
  Examples include Lottery winnings, gifts, capital gains from property sales, irregular IRA or stock disbursements
- Irregular-income is income that you receive at different time or in irregular amounts throughout the year and VA will count it for one year from the receipt date.
  Examples include odd job or contract work and interest income from fluctuating rates.
- Recurring income is counted continuously until we are informed that you are no longer in receipt of it.
  Examples include wages from employment, retirement payments, required minimal distributions from an IRA.

Income for VA Purposes (IVAP)
The VA counts all your income and considers any unreimbursed medical expenses reported when determining your IVAP. The following calculation is a way for you to estimate your IVAP.

Countable Yearly Income – Countable Medical Expenses (less medical deductible) = Income for VA Purposes

Pension Rate
Your maximum annual benefit is the difference of the current MAPR and what the VA calculates as your IVAP. To convert into a monthly benefit, take this amount and divide by 12 then rounded down to the nearest dollar.

Maximum Annual Pension Rate - Income for VA purposes = Annual Pension Rate.

Net Worth
The net worth limit is increased by the same percentage as the Social Security increase when there is a cost-of-living adjustment. For purposes of entitlement to VA pension, net worth includes your assets and your and your dependent's annual income. If your child has net worth that exceeds the limit, VA won't consider them to be a dependent when determining your pension entitlement.

Additional information about how VA calculates net worth, income, and benefit rates can be found at:
https://www.va.gov/pension/survivors-pension-rates/

SURVIVORS BENEFITS APPLICATION CHECKLIST

In addition to your application, VA may require some of the evidence described in this checklist. Failure to provide needed evidence, may delay the decision on your claim. This checklist does not apply to claims for Accrued benefits. Please carefully read pages 5 and 6 of the Instructions if you are claiming service-connected death (Dependency and Indemnity Compensation (DIC) only. Please note, the items marked with an asterisk (*) are required.

VERIFICATION OF VETERANS DEATH* *(Requested on page 2 of Instructions)*

- ☐ A Death certificate for the veteran, clearly showing the primary cause(s) of death and any contributing factors or conditions *(If the veteran's death certificate lists the cause of death as "Pending," please have the medical examiner submit evidence that shows the cause of death)*.

SERVICE VERIFICATION* *(Requested on page 4 of Instructions and Section III of the form)*

- ☐ Copy of the veteran's DD Form 214 (or equivalent) for all periods of military service. Must demonstrate military service dates, type of service and character of discharge.

INCOME AND NET WORTH *(Requested on page 2 of Instructions and Section IX of the form)*

- ☐ VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, is required if instructed in Section IX of this application form.
  NOTE: If you have specific types of income or assets the VA Form 21P-0969 requires additional evidence:
- ☐ Farm - VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*
- ☐ Business - VA Form 21P-4185, *Report of Income from Property or Business*
- ☐ Rental Property - VA Form 21P-4185, *Report of Income from Property or Business*
- ☐ Royalties - VA Form 21-4138, *Statement in Support of Claim,* (provide details, such as Royalty source, joint owners, etc.)
- ☐ Trust - submit complete trust documents to include the Schedule of Assets
- ☐ Interest, Dividends or Financial Investments - Current account statements from financial institutions (Bank, Investment, Annuity, etc.)

SPECIAL CIRCUMSTANCES REGARDING YOUR MEDICAL CARE *(Requested on page 2 of Instructions and in Sections VIII and X of the form)*

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Housebound Status

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Claim for Medicare Nursing Home and/or $90.00 Rate Reduction Request

- ☐ VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

Claim for Fiduciary Assistance

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Statement of Medical Care

- ☐ Care worksheets (found on pages 19 and 20 of the form).
- ☐ Proof of Payment from care provided (canceled checks, bank statements, etc.).
- ☐ Signed verification from care service provider.

Dependent Children* *(Requested on page 2 of Instructions and Section VI of the form)*

- ☐ A birth certificate must be included clearly showing the veteran as the parent if you do not reside within the U.S. or its territories. (A state includes the District of Columbia, Puerto Rico and other territories and possessions of the U.S.)
- ☐ If child(ren) is/are adopted the adoption decree or a revised birth certificate is required.
- ☐ If your child is between the ages of 18 and 23 please submit VA Form 21-674, *Request for Approval of School Attendance*.
- ☐ Medical records for each seriously disabled child.

Medical Expenses *(Requested in Section X of the form)*

- ☐ If additional space is needed, submit VA Form 21P-8416, *Medical Expense Report.*

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at **https://www.va.gov/contact-us** or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at **www.va.gov/vaforms**. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

NOTE: You may *either* complete the form by typing the information in on the computer or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

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

1B. VETERAN'S SOCIAL SECURITY NUMBER — – –

1C. VETERAN'S DATE OF BIRTH (MM/DD/YYYY) / /

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known)

1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ☐ YES ☐ NO

1G. VETERAN'S SERVICE NUMBER

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY) / /

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last)

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

☐ SURVIVING SPOUSE ☐ CHILD 18-23 IN SCHOOL ☐ CUSTODIAN FILING FOR CHILD UNDER 18 ☐ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER — – –

2D. YOUR DATE OF BIRTH (MM/DD/YYYY) / /

2E. ARE YOU A VETERAN? ☐ YES ☐ NO

2F. 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 –

2G. YOUR TELEPHONE NUMBER (Include Area Code) – –

Enter International Phone Number (If applicable)

2H. E-MAIL ADDRESS (Optional)

2I. WHAT ARE YOU CLAIMING? (Check all that apply)

☐ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

NOTE: Please refer to instructions page 4, Military Service Verification for more information pertaining to service information and relevant documents.

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

☐ YES ☐ NO (If "YES," list other names the veteran served under below)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY)

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY)

3D. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS

☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS

3E. PLACE OF LAST SEPARATION

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)

☐ YES ☐ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY)

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

___ – ___ – ____

3J. WAS THE VETERAN EVER A PRISONER OF WAR?

☐ YES ☐ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)

START:

END:

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

☐ YES ☐ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THE VETERAN'S DEATH?

☐ YES ☐ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?

☐ DEATH ☐ DIVORCE ☐ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)

START:

END:

4E. PLACE OF MARRIAGE (City/State or Country)

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)

☐ CEREMONIAL ☐ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

☐ YES ☐ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

☐ YES ☐ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THE VETERAN'S DEATH?

☐ YES ☐ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS?

☐ YES ☐ NO (If "YES," provide explanation in space provided)

NOTE: Give, the reason, date(s), and duration of the separation *(If the separation was by court order, attach a copy of the order)*

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

☐ YES ☐ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)

START:

END:

4N. HOW DID YOUR REMARRIAGE END?

☐ DEATH ☐ DIVORCE ☐ DID NOT END ☐ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?

☐ YES ☐ NO (If "YES," please submit a VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for each marriage)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: ___/___/____
END: ___/___/____

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: ___/___/____
END: ___/___/____

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: ___/___/____
END: ___/___/____

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: ___/___/____
END: ___/___/____

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VI: CHILD OF THE VETERAN INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.

6A. HOW MANY DEPENDENT CHILDREN DO YOU HAVE?

(**NOTE**: Please complete a VA Form 21-686c, *Application Request to Add and/or Remove Dependents*, if you need more space for additional dependents)

6B. CHILD'S NAME (First, Middle Initial, Last)

6C. CHILD'S DATE OF BIRTH (MM/DD/YYYY) / /

6D. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6E. PLACE OF BIRTH (City/State or Country)

6F. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___ , ___ .00

6G. CHILD'S NAME (First, Middle Initial, Last)

6H. CHILD'S DATE OF BIRTH (MM/DD/YYYY) / /

6I. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6J. PLACE OF BIRTH (City/State or Country)

6K. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___ , ___ .00

6L. CHILD'S NAME (First, Middle Initial, Last)

6M. CHILD'S DATE OF BIRTH (MM/DD/YYYY) / /

6N. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6O. PLACE OF BIRTH (City/State or Country)

6P. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___ , ___ .00

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU (If listed above) RESIDE AT THE SAME ADDRESS?

☐ YES ☐ NO (If "YES," please complete Item 6R) (If "NO," please complete a VA Form 21-4138, *Statement in Support of Claim*, with the following information. Name of person the child is currently living with, and the full address where the child resides)

6R. PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:

Custodian's Name (First, Middle Initial, Last)

Custodian'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 ___ – ____

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

☐ DIC ☐ DIC under 38 U.S.C. 1151 (**Note**: DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151)

☐ DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (**Note**: Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: __/__/____ END: __/__/____
	START: __/__/____ END: __/__/____
	START: __/__/____ END: __/__/____

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☐ NO (If "YES," please complete a VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA)*, Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))

8B. ARE YOU NOW IN A NURSING HOME?

☐ YES ☐ NO (If "YES," complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC") (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

NOTE: **Assets** are all the money and property you or your dependents own. Assets **do not** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS? (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

(If "No," provide an estimate of the total value of your assets below)

$ ___,___.__

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

☐ YES ☐ NO (If "NO," skip to Item 9G)

9D. IS THE VALUE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

☐ YES ☐ NO (If "NO," skip to Item 9G)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF THE LAND OVER 2 ACRES? (Do **NOT** include the value of the residence or the first 2 acres)

$ ___,___,___.__

9F. IS THE LAND OVER 2 ACRES (87,120 SQ FT) MARKETABLE?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION IX: INCOME AND ASSETS (CONTINUED)
(Skip to Section X if you are not claiming survivors pension benefits)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME $ ___,___.___
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	**9J(2) SPECIFY THE TYPE OF INCOME**	**9J(3) SPECIFY INCOME PAYER** *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME $ ___,___.___
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	**9K(2) SPECIFY THE TYPE OF INCOME**	**9K(3) SPECIFY INCOME PAYER** *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9K(4) CURRENT GROSS MONTHLY INCOME $ ___,___.___
9L(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	**9L(2) SPECIFY THE TYPE OF INCOME**	**9L(3) SPECIFY INCOME PAYER** *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9L(4) CURRENT GROSS MONTHLY INCOME $ ___,___.___

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

☐ YES ☐ NO (If "NO," skip to Section XI)

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?	10B (2). NAME OF PROVIDER AND TYPE OF CARE	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ ___.00 Hours Worked (Per Week) ___

10B (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10B (5). PAYMENT FREQUENCY	10B (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10B (5))
START: ___/___/____ END: ___/___/____ ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	$ ___,___.___

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?	10C (2). NAME OF PROVIDER AND TYPE OF CARE	10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ ___ .00 Hours Worked (Per Week) ___

10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10C (5). PAYMENT FREQUENCY	10C (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10C (5))
START: ___/___/____ END: ___/___/____ ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	$ ___,___.___

10D (1). WHOSE EXPENSES WERE PAID?	10D (2). NAME OF PROVIDER AND TYPE OF CARE	10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ ___ .00 Hours Worked (Per Week) ___

10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10D (5). PAYMENT FREQUENCY	10D (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10D (5))
START: ___/___/____ END: ___/___/____ ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	$ ___,___.___

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)	10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☐ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: Purpose:

10E (3). DATE COSTS PAID (MM/DD/YYYY)	10E (4). PAYMENT FREQUENCY	10E (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10E (4))
___/___/____	☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	$ ___,___.___

10F (1). WHOSE EXPENSES WERE PAID? (Check one)	10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☐ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: Purpose:

10F (3). DATE COSTS PAID (MM/DD/YYYY)	10F (4). PAYMENT FREQUENCY	10F (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10F (4))
___/___/____	☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	$ ___,___.___

10G (1). WHOSE EXPENSES WERE PAID? (Check one)	10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☐ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: Purpose:

10G (3). DATE COSTS PAID (MM/DD/YYYY)	10G (4). PAYMENT FREQUENCY	10G (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10G (4))
___/___/____	☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	$ ___,___.___

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES (Continued)

10H (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10H (3). DATE COSTS PAID (MM/DD/YYYY) ___/___/____

10H (4). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10H (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10H (4))
$ ___,___.___

10I (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10I (3). DATE COSTS PAID (MM/DD/YYYY) ___/___/____

10I (4). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10I (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10F (4))
$ ___,___.___

10J (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10J (3). DATE COSTS PAID (MM/DD/YYYY) ___/___/____

10J (4). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10J (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10J (4))
$ ___,___.___

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and** attach either a voided personal check **or** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

11C. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☐ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

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.

I certify I have received the notice attached to this application titled ***Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 12A, indicating that I **DO NOT** want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for paid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE) (Continued)

12B. CLAIMANT'S SIGNATURE **OR** MARK WITH AN "X" IF UNABLE TO SIGN (**REQUIRED**)	12C. DATE SIGNED (MM/DD/YYYY)
	/ /

SECTION XIII: WITNESSES TO SIGNATURE
(TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12B IS SIGNED WITH AN "X")

13A. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED (MM/DD/YYYY)
	/ /

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid 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.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR

☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

☐ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED

☐ THE FACILITY IS LICENSED

☐ THE FACILITY IS RESIDENTIAL

☐ THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

☐ YES ☐ NO, Care is being provided by a third-party provider. ☐ NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY)

/ /

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

/ / ☐ INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$, . PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)

15. DATE SIGNED (MM/DD/YYYY)

/ /

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

☐ YES ☐ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

☐ YES ☐ NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR

☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

☐ A. SHOPPING ☐ B. FOOD PREPARATION ☐ C. NON-MEDICAL TRANSPORTATION

☐ D. LAUNDERING ☐ E. USING TELEPHONE ☐ F. MANAGING FINANCES

☐ G. HOUSEKEEPING ☐ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

☐ YES ☐ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)

/ /

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

/ / ☐ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

$. PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

/ /

Department of Veterans Affairs

NOTICE OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR BURIAL BENEFITS (UNDER 38 U.S.C., CHAPTER 23)

This notice provides information regarding the evidence necessary to substantiate a claim for:

- Non-service-connected Burial Allowance
- Service-connected Burial Allowance
- Plot or Interment Allowance
- Transportation Benefit
- Unclaimed Remains of Veteran

When to Use this Form

Use this notice and the attached application to submit a claim for any of the above named burial allowances and related burial benefits. This notice informs you of the evidence necessary to decide your claim. After you submit your claim on the attached application, you *will not* receive an initial letter regarding your claim. You *do not* need to submit another application.

If you are filing a claim for new burial benefits or disagree with an evaluation decided more than one year ago...	Please complete and submit VA Form 21P-530EZ, *Application for Burial Benefits*
If you disagree with a burial decided within the past year and have new and relevant evidence ***OR*** If you are filing a supplemental claim (a claim after an initial claim for the same burial benefit(s) previously decided)...	Please complete and submit VA Form 20-0995, *Decision Review Request: Supplemental Claim***

**You may also file a request for a higher-level review or an appeal to the Board of Veterans' Appeals. For additional information on all these different options, please visit https://benefits.va.gov/benefits/appeals.asp.

Want to apply electronically?

You can apply for VA burial benefits online at https://www.va.gov/. You can also upload all supporting evidence you may have and make your claim a Fully Developed Claim (FDC).

NOTE: You may wish to contact an accredited Veterans Service Officer (VSO) to assist you with your application. For a list of accredited Veterans Service Organizations go to **https://www.va.gov/vso/**. You may also contact your state office of Veterans Affairs at **https://www.va.gov/statedva.htm** should you need further assistance with the application process.

Want your claim processed faster?

The FDC Program is the **fastest** way to get your claim processed without any risk to participate! To participate, submit your claim in accordance with the "FDC Criteria" shown on page 3. If you are making a claim for survivor benefits, use VA Form 21P-534EZ, *Application for DIC, Survivors Pension, and/or Accrued Benefits.* VA forms are available at www.va.gov/vaforms.

NOTE: Participation in the FDC program is optional and will not affect the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program and process it in the Standard Claim Process. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process) on page 3. If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process on page 3.

FEES for claims: Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

GENERAL INFORMATION

ELIGIBLE CLAIMANTS (Who Should File A Claim):

Check the appropriate box on the form (Item 13) regarding your relationship to the veteran to certify your correct claimant eligibility.

VA may grant a claim that any eligible person files. Upon death of the veteran, VA will pay the first living person to file a claim of those listed below:

- The veteran's surviving spouse; **OR**
- The survivor of a legal union between the deceased veteran and the survivor; **OR**
- The veteran's children, regardless of age (biological, step and adopted); **OR**
- The veteran's parents or the surviving parent; **OR**
- The executor or administrator of the deceased veteran's estate, or person acting for the deceased veteran's estate (a person is considered acting for the estate when no executor or administrator has been appointed).
- For purposes of this application, legal union means a formal relationship between the veteran and the survivor that existed on the date of the veteran's death, was recognized under the law of the State in which the couple formalized to relationship and was evidenced by the State's issuance of documentation memorializing the relationship.

If the veteran's remains are unclaimed, VA will pay the person or entity that provided burial services for the remains of an unclaimed veteran.

NOTE: Claimant Social Security Number and date of birth are not required when claiming unclaimed remains, or if the claimant is a firm, corporation, or state agency.

TIME LIMIT FOR FILING A CLAIM: Claim for non-service-connected burial allowance must be filed with VA within 2 years after the date of the veteran's permanent burial or cremation. If a veteran's discharge was corrected after death to "Under Conditions Other Than Dishonorable," the claim must be filed within 2 years after the date of correction. There is no time limit for the service-connected burial allowance, plot or interment allowance, non-service-connected burial allowance based upon VA hospitalization death, or reimbursement of transportation expenses.

BURIAL ALLOWANCE: A one-time benefit payment payable toward the expenses of the funeral and burial of the veteran's remains. Burial includes all legal methods of disposing of the veteran's remains including, but not limited to, cremation, burial at sea and medical school donation. (See evidence table for more information.)

PLOT OR INTERMENT ALLOWANCE: A one-time benefit payment payable toward:

(1) Expenses incurred for the plot or interment of a Veteran who was eligible for burial in a national cemetery if the actual burial was not in a national cemetery under the jurisdiction of the United States and non-service-connected burial allowance is granted; **OR**
(2) Expenses are payable if non-service-connected burial allowance is granted and veteran was buried in a State-owned cemetery or sub-section used solely for the remains of such persons or other individuals as authorized within 38 U.S.C. 2303(b)(1) and meets eligibility for burial in a national cemetery.

"Plot" means the final disposition site of the remains, whether it is a grave, mausoleum vault, columbarium niche, or similar place.
"Interment" means the burial of casketed remains in the ground or the placement of cremated remains into a columbarium niche.

TRANSPORTATION BENEFIT: When the transportation benefit is allowable, VA may pay for expenses relating to the transportation of the veteran's remains. This includes the pickup and transportation of the veteran's remains to their final resting place. Claims for transportation benefits must include a statement of account showing itemized transportation charges.

VA may pay transportation benefits only when one of the following eligibility requirements are met:

- VA hospitalization death; **OR**
- the veteran was in receipt of disability compensation at the time of death; **OR**
- the veteran was in receipt of military retirement in lieu of disability compensation at the time of death; **OR**
- the veteran was in receipt of pension at the time of death; **OR**
- the veteran's remains are unclaimed; **OR**
- Service-connected burial allowance granted and burial was in a national or covered Veteran's cemetery.

NOTE: a covered Veterans' cemetery is defined as a Veterans' cemetery in which a deceased veteran is eligible to be buried that is owned by a State or is on trust land owned by, or held in trust for, a tribal organization, and for which the Secretary has made a grant under 38 U.S.C. 2408.

PROOF OF DEATH TO ACCOMPANY CLAIM: Death in a government institution does not need to be proven. In other cases, the claimant must forward a copy of the public record of death. If the proof of death has previously been furnished to VA, it does not need to be submitted again.

Claims for service-connected burial allowance must include the veteran's cause of death.

RESPONSIBLE FOR (LEGALLY INCURRED) EXPENSES: The claimant (you) have already paid or owe the burial expenses for the benefit being claimed and is legally the responsible party for the debt. By checking "Yes" in Item 22A on the form, you are certifying that this statement is true. If filing as an executor of the veteran's estate, by checking "Yes," in Item 22A you certify that the veteran paid the burial prior to his or her death or funds from the estate were used as payment.

SERVICE RECORD: A photocopy of the veteran's DD Form 214, Report of Separation (or equivalent) for all periods of military service will permit prompt processing. You may request a copy of the DD Form 214 through the National Archives' National Personnel Records Center (NPRC) using SF 180 (09/2021 version), Request Pertaining to Military Records, (available at https://www.archives.gov/) or through your local public custodian of records. Service documents **will not** be returned. If the veteran was receiving VA benefits, this is not required with your application.

SUBMITTING A CLAIM

When submitting a claim(s) for **Burial Benefits** the following information tells you what you need to do and what VA will do during the FDC Program (Optional Expedited Process) or the Standard Claim Process:

HOW TO SUBMIT A CLAIM: Submit your claim on a VA Form 21P-530EZ, *Application for Burial Benefits* (attached). Make sure you complete and sign your application.

WHAT YOU NEED TO DO: The tables beginning on page 3 describe the information and evidence you need to submit based on if you wish to have your claim considered in the FDC Program (Optional Expedited Process) or in the Standard Claim Process. You will need to indicate how you want your claim to be processed by checking the appropriate box in Section VII on page 7 of this form.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must submit: • A signed and FULLY COMPLETED VA Form 21P-530EZ, *Application for Burial Benefits* • Required evidence for each burial benefit claimed (see tables below) • Complete veteran and claimant information • Proof of veteran's death, including the cause of death, if claiming service-connected burial allowance. If the veteran was seen outside of the VA, you must include copies of any medical records from a private medical provider or provide a completed VA Form 21-4142, *Authorization to Disclose Information to the Department of Veterans Affairs (VA)* and VA Form 21-4142a, *General Release for Medical Provider Information to the Department of Veterans Affairs (VA),* with your application for VA to request the records on your behalf • An itemized statement of account, if claiming transportation benefit. **NOTE:** If you decide to submit your claim through the FDC Program, please indicate FDC in Section VII of the application on page 7.	Please submit a complete signed VA Form 21P-530EZ, *Application for Burial Benefits,* that includes any required evidence listed in the tables below. If you know of any evidence not in your possession and want VA to try to get it for you; **You must:** • Complete and sign VA Form 21-4142 and VA Form 21-4142a, identifying any private medical records you wish VA to request for you • Give VA enough information about other relevant evidence so that we can request it from the person or agency that has it If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. ***It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.***
You must: • Send the above information and any specific evidence listed below for the burial benefit(s) claimed *along* with your claim form If you submit additional information or evidence ***after*** you submit your "fully developed" claim, then VA will remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. If we decide your claim before one year from the date we receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.	**You are strongly encouraged to:** • Send any information or evidence as soon as you can **You have up to *one*** year from the date we receive the claim to submit the information and evidence necessary to support your claim. If within ***30*** days, you do not provide any evidence or do not provide us with the information requested to assist you with obtaining evidence, we may decide your claim prior to the expiration of the one year period. If we decide the claim before one year from the date we receive the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM: The table below describes the information and evidence VA will assist you in obtaining based on whether you wish to have your claim considered in the FDC Program (Optional Expedited Process) or in the Standard Claim Process.

FDC Program (Optional Expedited Process)	Standard Claim Process
VA will: • Retrieve relevant records from a Federal facility, such as a VA Medical Center, that you adequately identify and authorized VA to obtain. • Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim.	**VA will:** • Retrieve relevant records from a Federal facility, such as a VA Medical Center, that you adequately identify and authorized VA to obtain. • Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim. • Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as a private doctor or hospital records from current or former employers.

WHERE TO SEND INFORMATION AND EVIDENCE: You may send your application and any evidence in support of your claim by using any of the following methods shown in the table below.

MAIL TO	ONLINE
Department of Veterans Affairs Pension Claims Intake Center P.O. Box 5365 Janesville, WI 53547-5365	https://www.va.gov/

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM: The tables below show what evidence you must provide and eligibility information to support your claim for burial benefits.

EVIDENCE TABLES

Non-Service-Connected Burial Allowance

To support a claim for **non-service-connected burial allowance,** the evidence must show:

- VA received a burial claim for non-service-connected burial allowance no later than two years after the burial or cremation of the veteran; **AND**
- You are an eligible claimant authorized burial benefits; **AND**
- Proof of veteran's death; **AND**
- Statement certifying that the claimant incurred the burial expenses of the deceased veteran, or claimant is the executor of the estate and is applying on behalf of the veteran who incurred the expenses; **AND**
- Verification of veteran's military service (only if veteran was not in receipt of VA benefits at time of death; **AND**
- At the time of death, the veteran:
  - Was in receipt of VA disability compensation or VA pension; **OR**
  - Had a claim pending which would have resulted in entitlement to VA disability compensation or VA pension; **OR**
  - Was entitled to receive VA disability compensation or VA pension but decided to receive military retirement or disability pay in place of VA disability compensation check; **OR**
  - Was hospitalized by VA. For VA hospitalization, for the purpose of this burial benefit, VA hospitalization is met, if at the time of death, the veteran:
    - Was properly admitted to a VA facility; **OR**
    - Was transferred or admitted to a non-VA facility for hospital care under VA contract; **OR**
    - Was transferred or admitted to a nursing home for nursing home care at the expense of the VA contract; **OR**
    - Was traveling under proper prior authorization to or from a specified place for purpose of examination treatment or care, at VA expense; **OR**
    - Was transferred or admitted to a State nursing home at the expense of the VA, under VA contract; **OR**
    - Was a patient in a State Veteran's home

Service-Connected Burial Allowance

To support a claim for **service-connected burial allowance,** the evidence must show:

- VA received a burial claim for service-connected burial allowance; **AND**
- You are an eligible claimant authorized burial benefits; **AND**
- Proof of veteran's death including the cause of death; **AND**
- Statement certifying that the claimant incurred the burial expenses of the deceased veteran, or claimant is the executor of the estate and is applying on behalf of the veteran who incurred the expenses; **AND**
- Verification of the veteran's military service (only if the veteran was not in receipt of VA benefits at the time of death; **AND**
- If your claim is based on a service-connected disability established during the veteran's lifetime, the evidence must show:
  The veteran had a service-connected disability(ies) that was/were either the principal or contributory cause of the veteran's death; **OR**
  - If your claim is based on a disability that was not established as service-connected during the veteran's lifetime or for which the veteran did not file a claim during his or her lifetime, the evidence must show:
    - An injury or disease that was incurred or aggravated during active military service, or an event in service that caused an injury or disease;
      AND
    - A physical or mental disability that was either the principle and contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of a disability that were visible or observable; **AND**
    - A relationship between the disability associated with the cause of death and an injury, disease, or event in military service. Medical records or medical opinions are generally required to establish this relationship.

Unclaimed Remains

In order to support a claim for **unclaimed remains,** the evidence must show:

- VA received a burial claim for veteran's unclaimed remains no later than two years after the burial or cremation of the veteran; **AND**
- You are an eligible claimant authorized burial benefits; **AND**
- Proof of veteran's death; **AND**
- Statement certifying that the claimant incurred burial expenses of the deceased veteran; **AND**
- The remains of the deceased veteran have not been claimed by relatives or friends; **AND**
- There are not sufficient resources available in the veteran's estate to cover the burial and funeral expenses.

NOTE: Funeral homes and/or entities in care and custody of remains who incurred costs for burial of unclaimed veteran remains may file a claim for burial benefits as the claimant responsible for the expense. When filing a claim, check "Yes" in Item 22A as the responsible party for the burial expense if you incurred costs due to the service you provided in burial or cremation of the remains. By checking "Yes", you are certifying that you incurred the costs and no one other than you is responsible for the expense.

EVIDENCE TABLES (Continued)

Plot or Interment Allowances
In order to support a claim for **plot or interment allowance,** the evidence must show: • VA received a burial claim for plot or interment allowance; **AND** • You are an eligible claimant authorized burial benefits; **AND** • Veterans burial or interment was not in a National cemetery, State Veterans cemetery or other State-owned cemetery. • Proof of veteran's death; **AND** • Statement certifying that the claimant incurred plot or interment expenses, or claimant is the executor of the estate and is applying on behalf of the veteran who incurred the expenses; **AND** • Veterans burial or interment was not in a National cemetery, State Veterans cemetery or other cemetery as listed in 38 U.S.C. 2303(b)(1).

Transportation Benefit

To support your claim for **transportation benefit,** the evidence must show:
• VA received a burial claim for transportation benefit; **AND**
• You are an eligible claimant authorized burial benefits; **AND**
• Proof of veteran's death; **AND**
• Statement certifying that the claimant incurred transportation expenses of the deceased veteran, or claimant is the executor of the estate and is applying on behalf of the veteran who incurred the expenses; **AND**
• An itemized receipt or statement, preferably on letterhead that includes the:
  • Name of the deceased veteran; **AND**
  • Specific transportation costs incurred; **AND**
  • Date of the services rendered; **AND**
  • Name of the individual who paid the costs.

HOW VA DETERMINES THE EFFECTIVE DATE

Burial benefits are based on the date of the veteran's death and the death date we receive your claim. The veteran's death certificate is relevant evidence used in determining the effective date of any benefits we award.

OMB Approved No. 2900-0003
Respondent Burden: 30 Minutes
Expiration Date: 08/31/2025

Department of Veterans Affairs

APPLICATION FOR BURIAL BENEFITS
(Under 38 U.S.C. Chapter 23)

IMPORTANT - Please read the Privacy Act and Respondent Burden on page 8 before completing the form. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS IN SECTION VII, PAGE 7 OF THE FORM. *(Check the appropriate box) (See Instructions page 3)*

NOTE: You can ***either*** complete the form online or by hand. If you complete the form online, you may submit it at **https://www.va.gov/** to expedite processing. If you complete the form by hand, please print the information requested in ink, neatly, and legibly to help process the form.

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

SECTION I - VETERAN'S INFORMATION

1. NAME OF THE DECEASED VETERAN *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* – –

5. VETERAN'S DATE OF DEATH *(MM/DD/YYYY)* – –

6. VETERAN'S DATE OF BURIAL *(MM/DD/YYYY)* – –

SECTION II - CLAIMANT'S INFORMATION

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

8. CLAIMANT'S SOCIAL SECURITY NUMBER *(See instructions for exceptions.)* – –

9. CLAIMANT'S DATE OF BIRTH *(MM/DD/YYYY) (See instructions for exceptions)* – –

10. 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 –

11. TELEPHONE NUMBER *(Include Area Code)* – –

12. E-MAIL ADDRESS

13. RELATIONSHIP OF CLAIMANT TO DECEASED VETERAN *(Check one)*

- ☐ SPOUSE OR SURVIVOR OF LEGAL UNION
- ☐ CHILD
- ☐ PARENT
- ☐ EXECUTOR/ADMINISTRATOR OF ESTATE OR PERSON ACTING FOR THE ESTATE
- ☐ FUNERAL HOME OR OTHER THIRD PARTY
- ☐ OTHER RELATIVE OR FRIEND OF THE DECEASED (Non-Executor)

SECTION III - VETERAN'S SERVICE INFORMATION

The following information should be furnished for the periods of the VETERAN'S ACTIVE SERVICE

14A. ENTERED SERVICE		14B. SERVICE NUMBER	14C. SEPARATED FROM SERVICE		14D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE *(MM/DD/YYYY)*	PLACE		DATE *(MM/DD/YYYY)*	PLACE	

15. IF VETERAN SERVED UNDER NAME OTHER THAN THAT SHOWN IN ITEM 1, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME

VETERAN'S SSN *(Pre-populated from Page 6)* ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - INFORMATION REGARDING FINAL RESTING PLACE

16. PLACE OF BURIAL PLOT, INTERMENT SITE, OR FINAL RESTING PLACE OF DECEASED VETERAN'S REMAINS

☐ CEMETERY/GRAVEYARD ☐ PRIVATE RESIDENCE

☐ MAUSOLEUM/VAULT/TOMB/CRYPT ☐ OTHER *(SPECIFY)*

17. WAS THE VETERAN BURIED IN A NATIONAL CEMETERY, OR ONE OWNED BY THE FEDERAL GOVERNMENT?

☐ YES ☐ NO *(If "Yes," provide name of cemetery)*

18. WAS THE VETERAN BURIED IN A CEMETERY OWNED BY THE STATE OR TRIBAL TRUST LAND?

☐ YES, State Cemetery ☐ YES, Tribal Trust Land ☐ NO *(If "Yes," provide name and zip code of cemetery or Tribal Trust Land below)*

Name: Zip Code:

19A. DID A FEDERAL/STATE GOVERNMENT OR THE VETERAN'S EMPLOYER CONTRIBUTE TO THE BURIAL?

☐ YES ☐ NO *(If "Yes," complete Item 19B)*

19B. AMOUNT OF GOVERNMENT OR EMPLOYER CONTRIBUTION

$ ☐☐☐☐☐.00

SECTION V - CLAIM FOR BURIAL ALLOWANCE

20A. SELECT TYPE OF BURIAL ALLOWANCE YOU ARE CLAIMING *(May apply for more than one)*

☐ NON-SERVICE-CONNECTED BURIAL ALLOWANCE

☐ SERVICE-CONNECTED BURIAL ALLOWANCE

☐ UNCLAIMED REMAINS OF THE VETERAN *(If claimed, you must answer question 20B)*

20B. WHERE DID THE VETERAN'S DEATH OCCUR? *(Check One)*

☐ NURSING HOME/FACILITY (NOT PAID BY VA) OR VETERAN'S RESIDENCE

☐ NURSING HOME/FACILITY (PAID BY VA)*

☐ VA MEDICAL CENTER*

☐ STATE VETERANS FACILITY*

☐ OTHER (Specify place of death)*

*Please provide veteran's specific place of death including the name and location of the nursing home, VA Medical Center or State veteran facility

21. IF YOU ARE THE DECEASED VETERAN'S SPOUSE, DID YOU PREVIOUSLY RECEIVE A VA BURIAL ALLOWANCE? ☐ YES ☐ NO

22A. ARE YOU RESPONSIBLE FOR THE VETERAN'S BURIAL EXPENSES? ☐ YES ☐ NO

22B. DO YOU CERTIFY THE REMAINS OF THE DECEASED VETERAN HAVE NOT BEEN CLAIMED BY RELATIVES OR FRIENDS AND THERE ARE NOT SUFFICENT RESOURCES AVAILABLE IN THE VETERAN'S ESTATE TO COVER THE BURIAL AND FUNERAL EXPENSES? *(Required only if claiming unclaimed remains of veteran)* ☐ YES ☐ NO

SECTION VI - CLAIM FOR PLOT AND/OR TRANSPORTATION ALLOWANCE

23. ARE YOU RESPONSIBLE FOR THE VETERAN'S PLOT OR INTERMENT EXPENSES? ☐ YES ☐ NO

24. ARE YOU RESPONSIBLE FOR THE VETERAN'S TRANSPORTATION EXPENSES FROM THE PLACE OF DEATH TO THE FINAL RESTING PLACE? *(You must include an itemized receipt.)* ☐ YES ☐ NO

SECTION VII - CLAIM CERTIFICATION AND SIGNATURES (MUST COMPLETE)

CLAIMANT CERTIFICATION AND SIGNATURE

☐ I WANT my claim processed under the FDC program. 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 and the veteran, and I WAIVE any privilege which makes the information confidential. I CERTIFY I have received the notice attached to this application titled, ***Application for Burial Benefits,*** and, I CERTIFY I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; or, I have no additional information or evidence to give VA to support my claim.

☐ I do not want my claim processed under the FDC program. I am indicating I want my claim processed under the standard claim process because I plan to submit further evidence in support of my claim.

25A. SIGNATURE OF CLAIMANT **(REQUIRED)** *(Physical Signature OR E-Signature) (If signed using an "X", complete Items 27A through 28B) (If signing for a firm, corporation, or State agency, complete Items 26A through 26B)*

25B. PRINTED NAME OF CLAIMANT

26A. FULL PRINTED NAME AND ADDRESS OF PERSON, FIRM, CORPORATION, OR STATE AGENCY SIGNING AS CLAIMANT *(If different from Item 7)*

26B. OFFICIAL POSITION OF PERSON SIGNING ON BEHALF OF FIRM, CORPORATION OR STATE AGENCY

VETERAN'S SSN *(Pre-populated from Page 6)* ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION VIII: WITNESSES TO SIGNATURE

NOTE - If the claimant signed above using an "X", a signature must be witnessed by two persons to whom the person making the statement and the signatures and addresses of such witnesses must be shown below.

27A. SIGNATURE OF WITNESS *(Physical Signature) (Only sign if the signature in Item 25A used an "X")*	27B. PRINTED NAME AND ADDRESS OF WITNESS
28A. SIGNATURE OF WITNESS *(Physical Signature) (Only sign if the signature in Item 25A used an "X")*	28B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION IX: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (REQUIRED ONLY IF ITEM 25A IS BLANK)

I CERTIFY THAT by signing on behalf of the claimant, I am a court-appointed representative; **OR,** an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR,** a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR,** a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND,** that the claimant is under the age of 18; **OR,** is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR,** is physically unable to sign this form.

I UNDERSTAND that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

29A. ALTERNATE SIGNER SIGNATURE **(REQUIRED only if 25A is blank)** *(Physical Signature)*	29B. DATE SIGNED *(MM/DD/YYYY)*

PRIVACY ACT INFORMATION: The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses 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. The requested information is considered relevant and necessary to determine maximum benefits under the law and is required to obtain benefits. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for burial benefits. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain.

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.

DEPARTMENT OF VETERANS AFFAIRS HEADSTONES AND MARKERS

The Department of Veterans Affairs will furnish, upon request, a Government headstone or marker at the expense of the United States for the unmarked graves of certain individuals eligible for burial in a national cemetery, but not buried there. These individuals may include any veterans with an other than dishonorable discharge who dies after service or any servicemember who dies on active duty. Certain other individuals may also be eligible for the headstone or marker. Headstones or Markers for all individuals in a national or post cemetery are furnished automatically without a request from the family. For additional information on burial benefits go to the web site, https://www.cem.va.gov/burial_benefits/index.asp. To obtain VA Form 40-1330, *Application for Standard Government Headstone or Marker* go to www.va.gov/vaforms or contact your local VA regional office. The address of that office can be found at www.va.gov/directory.

OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 07/31/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to provide your written authorization to obtain your treatment records, so the VA can get the information required to process your claim. For more information, you can contact us online through Ask VA: https://ask.va.gov/ or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. For mailing information see page 3.

SECTION I - VETERAN 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, and insert one letter per box, to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)* — —

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. 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 *(Optional)* ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING *(If other than veteran)*

9. PATIENT'S NAME *(First, Middle Initial, Last)*

10. SOCIAL SECURITY NUMBER — —

11. VA FILE NUMBER *(If applicable)*

SECTION III - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

- **ALL** medical sources *(hospitals, clinics, labs, physicians, psychologists, etc.)* including mental health, correctional, addiction treatment, and VA health care facilities,
- Social workers/rehabilitation counselors,
- Consulting examiners used by VA,
- Employers, insurance companies, workers' compensation programs, and
- Others who may know about my condition *(family, neighbors, friends, public officials).*

SECTION IV - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: ***All* my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, but not limited to:
   a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
   b. Drug abuse, alcoholism, or other substance abuse,
   c. Sickle cell anemia,
   d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
   e. Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months *after* the date this authorization is signed in Item 13, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME. THIS FORM IS NOT NEEDED TO REQUEST VA MEDICAL RECORDS.

IMPORTANT: In accordance with 38 C.F.R. §3.159(c), **"VA will not pay any fees charged by a custodian to provide records requested."**

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

SECTION V- AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

12. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE *(If this space is left blank, there is no limitation to records)*:

TO WHOM: The Department of Veterans Affairs (VA).

PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.

EXPIRES: This authorization is good for 12 months from the date shown in Item 14.

- I authorize the use of a copy *(including electronic copy)* of this form for the disclosure of the information described above in Section I.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties *(See page 2 for details).*
- I may write to VA and my source(s) to revoke this authorization at any time *(See page 2 for details).*
- VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgment below.**

13. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE ***(Required)***

14. DATE SIGNED *(MM/DD/YYYY)* ***(Required)*** ☐☐ – ☐☐ – ☐☐☐☐

15. PRINTED NAME OF PERSON SIGNING *(First, Middle Initial, Last)*

16. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, street, city, State, and ZIP code. All court appointments must include docket number, county, and State)*

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of material fact knowing it to be false.

If you do not revoke this authorization, it will automatically expire in 12 months from the date you sign and date the form. Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by VA without your consent if authorized by Federal laws such as the Privacy Act.

Under the Government Paperwork Elimination Act (GPEA) (Public Law 105-277), the Office of Management and Budget (OMB) ensures that agencies, when practicable, provide for the option of electronic maintenance, submission of disclosure of information and for the use and acceptance of electronic signatures. GPEA states that electronic records submitted or maintained in accordance with the procedures developed by OMB, or electronic signature or other forms of electronic authentication used in accordance with such procedures, "shall not be denied legal effect, validity, or enforceability merely because such records are in electronic form" (Public Law 105-277, section 1707).

PATIENT ACKNOWLEDGMENT: I HEREBY AUTHORIZE the sources listed in Section IV, 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 source being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it provides me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my source 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 in writing, at any time except to the extent a source of information has already relied on it to take an action. To revoke, I must send a written statement to the VA Regional Office handling my claim or the Board of Veterans' Appeals (if my claim is related to an appeal) and also send a copy directly to any of my sources that I no longer wish to disclose information about me. I understand that VA may use information disclosed prior to revocation to decide my claim.

NOTE: For additional information regarding VA Form 21-4142, refer to the following website: https://www.benefits.va.gov/privateproviders/.

PRIVACY ACT INFORMATION: The 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, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the source to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. 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. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975 and still in effect.

RESPONDENT BURDEN: We need this information and your written authorization to obtain your treatment records to help us get the information required to process your claim. Title 38, United States Code, allows us to ask for this information. You can provide this authorization by signing VA Form 21-4142. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form. If you use the Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

WHERE TO SEND YOUR WRITTEN CORRESPONDENCE

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 need assistance, you can find a local, accredited representative at https://www.benefits.va.gov/vso/.

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**

These addresses serve all United States and foreign locations.

OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 07/31/2024

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to provide the name of the provider or facility you have received treatment from to the VA. For more information, 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. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

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, and insert one letter per box, to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER — –

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — –

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING *(If other than veteran)*

6. PATIENT'S NAME *(First, Middle Initial, Last)*

7. SOCIAL SECURITY NUMBER — –

8. VA FILE NUMBER

SECTION III - MEDICAL PROVIDER INFORMATION

9A. PROVIDER OR FACILITY NAME	9B. CONDITIONS YOU ARE BEING TREATED FOR	9C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)*
		From: — – To: — –

9D. PROVIDER/FACILITY STREET 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 –

10A. PROVIDER OR FACILITY NAME	10B. CONDITIONS YOU ARE BEING TREATED FOR	10C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 10A)*
		From: — – To: — –

10D. PROVIDER/FACILITY STREET 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 –

VETERAN'S SOCIAL SECURITY NO. [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

11A. PROVIDER OR FACILITY NAME	11B. CONDITIONS YOU ARE BEING TREATED FOR	11C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 11A)*
		From: – – To: – –

11D. PROVIDER/FACILITY STREET 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 –

12A. PROVIDER OR FACILITY NAME	12B. CONDITIONS YOU ARE BEING TREATED FOR	12C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 12A)*
		From: – – To: – –

12D. PROVIDER/FACILITY STREET 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 –

13A. PROVIDER OR FACILITY NAME	13B. CONDITIONS YOU ARE BEING TREATED FOR	13C. DATE(S) OF TREATMENT: *(Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 13A)*
		From: – – To: – –

13D. PROVIDER/FACILITY STREET 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 –

PRIVACY ACT INFORMATION: The 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, 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. 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. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975 and still in effect.

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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.

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a statement to support a claim. 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, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN/BENEFICIARY'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, and insert one letter per box to help expedite processing of the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year – –

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)* – –

Enter International Phone Number *(If applicable)*

7. E-MAIL ADDRESS *(Optional)*

8. 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 –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

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

SECTION II: REMARKS *(Continued)*
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

SECTION III: DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

9. SIGNATURE OF VETERAN/BENEFICIARY ***(Required)***	10. DATE SIGNED *(MM/DD/YYYY)* Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

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.

PRIVACY ACT INFORMATION: The 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 required to obtain or retain benefits. 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. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. 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: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid 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

OMB Approval Number 2900-0556
Estimated Burden Avg: 30 minutes
Expiration Date: 04/30/2024

Department of Veterans Affairs

VA ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

INSTRUCTIONS

This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, mental health care, long-term care, or other types of health care

You may complete some, none, or all sections of this form. If you need more space for any part of the form, you may attach extra pages. Be sure to initial and date every page that you attach. You also must initial the sections you complete and sign the form. If you are unable to initial or sign the form because of a physical impairment, you can place an "X", thumbprint, or stamp on the form instead of your initials and signature. If a physical impairment prevents you from doing any of these things, you can ask someone else who is with you to sign, place an "X", thumbprint, or stamp on the form.

When you complete this form, it's important that you also talk to a member of your health care team, family, and other loved ones to explain what you meant when you filled out the form. A member of your health care team can help you with this form and can answer any questions that you have.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

STREET ADDRESS:

CITY, STATE, ZIP:

HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:

Privacy Act Information and Paperwork Reduction Act Notice

The information requested on this form is solicited under the authority of 38 C.F.R. §17.32. It is being collected to document your preferences for your health care 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 24VA10P2, Patient Medical Records-VA, published in the Federal Register inaccordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances. You may choose to fill out this form or not.But without this information, VA health care providers may not understand your preferences as well. 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 30 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 2900-0556.

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you in case you can't make decisions for yourself anymore. This person will be called your Health Care Agent.

Your Health Care Agent should be someone:

- You trust
- Who knows you well
- Who is familiar with your values and beliefs

If you get too sick to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you. This includes decisions to admit and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to start or stop any type of health care treatment. He or she can access your personal health information, and medical records, including information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism.

NOTE: If you wish to give general permission for VA to share your medical records or health information with others, you can complete VA Form 10-5345 (Request for and Authorization to Release Medical Records or Health Information). You can get VA Form 10-5345 from your VA health care provider or you can get it using a computer from this website **http://www4.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf**.

A - HEALTH CARE AGENT

Place your initials in the box next to your choice. Choose only one.

Initials	
	I don't wish to appoint a Health Care Agent right now. (Skip this section and go to Part III, Living Will.)
	I appoint the person named below to make decisions about my health care if I can't decide for myself anymore.

Name *(Last, First, Middle)*:	Relationship to Me:
Street Address:	
City, State, Zip:	

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

B - ALTERNATE HEALTH CARE AGENT

Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't available.

Initials	
	If the person named above can't or doesn't want to make decisions for me, I appoint the person named below to act as my Health Care Agent.

Name *(Last, First, Middle)*:	Relationship to Me:
Street Address:	
City, State, Zip:	

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

PART III: LIVING WILL

This section of the advance directive form is called a Living Will. This section of it lets you write down how you want to be treated in case you aren't able to decide for yourself anymore. Its purpose is to help others decide about your care.

A - SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- a breathing machine (mechanical ventilation)
- kidney dialysis
- a feeding tube (artificial nutrition and hydration)

Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-sustaining treatments?" Place your initials in the box that best describes your treatment preference. You may complete some, all, or none of this section. Choose only one box for each statement.

	Yes. I would want life-sustaining treatments.	I'm not sure. It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.	Initials	Initials	Initials
If I have permanent, severe brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials	Initials
If I need to use a breathing machine and be in bed for the rest of my life.	Initials	Initials	Initials
If I have pain or other severe symptoms that cause suffering and can't be relieved.	Initials	Initials	Initials
If I have a condition that will make me die very soon, even with life-sustaining treatments.	Initials	Initials	Initials
Other:	Initials	Initials	Initials

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

B - MENTAL HEALTH PREFERENCES

This section is optional. You may skip this section if you do not have a serious mental health problem or if you do not want to write down your preferences for mental health care. If you have a serious mental health condition, you might want to write down medications that have worked for you in the past and that you would want again, or you might want to write down the mental health facilities or hospitals that you like and those that you don't like. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

C - ADDITIONAL PREFERENCES

This section is optional. In this space, you can write other important preferences for your health care that aren't described somewhere else in this document. For example, these might be social, cultural, or faith-based preferences for care, or preferences about treatments such as feeding tubes, blood transfusions, or pain medications. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:

D - HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Place your initials in the box next to the statement that reflects how strictly you want others to follow your preferences. Choose only one.

Initials	
	I want my preferences, as expressed in this Living Will, to serve as a general guide. I understand that in some situations, the person making decisions for me may decide something different from the preferences I express above, if they think it's in my best interests.
	I want my preferences, as expressed in this Living Will, to be followed strictly, even if the person making decisions for me thinks that this isn't in my best interests.

PART IV: SIGNATURES

A - YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

B - WITNESSES' SIGNATURES

Two people must witness your signature. Witnesses to the patient's signing of an advance directive are attesting by their signatures only to the fact that they saw the patient or designated third party sign the VA Advance Directive form. Neither witness may, to the witness' knowledge, be named as a beneficiary in the patient's estate, appointed as health care agent in the advance directive, or financially responsible for the patient's care. Nor may a witness be the designated third party who has signed the VA Advance Directive form at the direction of the patient and in the patient's presence.

Witness #1

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient's estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed)*:

Street Address:

City, State, Zip:

Witness #2

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient's estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed)*:

Street Address:

City, State, Zip:

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

PART V: SIGNATURE AND SEAL OF NOTARY PUBLIC *(Optional)*

This VA Advance Directive form is valid in VA facilities without being notarized. However, you may need to have it notarized to be legally binding outside the VA health care setting. Space for a Notary's signature and seal is included below.

On this _____ day of _____ , in the year of _____ , personally appeared before me

_____ ,

known by me to be the person who completed this document and acknowledged it as their free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____ ,

State of _____ , on the date written above.

Notary Public: _____ Commission Expires: _____

[SEAL]

What My Family Should Know

Name:

Last Updated:

My Information Sheet

Name: _____ Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Current Address: _____

Phone Number: _____ Email Address: _____

U.S. Citizen ☐ Yes ☐ No Naturalized ☐ Yes ☐ No

Date Naturalized: _____ Location: _____

Certificate Number: _____ Application Number: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed

Date of Marriage: _____ Place of Marriage: _____

Former Spouse

Name (First-Middle-Maiden): _____

Date of Birth: _____ Place of Birth: _____

Date of Marriage: _____ Place of Marriage: _____

Date of Divorce: _____ Place of Divorce: _____

Still Alive ? ☐ Yes ☐ No Date if Marriage Ended in Death: _____

Military Service

Branch of Service: N/A Date of Inlistment: _____

Place of Inlistment: _____ Retirement Date: _____

Last Unit: _____ Location: _____

Date of Death: _____ Place of Death: _____

Cause of Death: _____

Date of Funeral/Cremation: _____ Location: _____

Fathers Name: _____ Still Alive ? ☐ Yes ☐ No

Date of Birth: _____ Place of Birth: _____

Mothers Name: _____ Still Alive ? ☐ Yes ☐ No

Date of Birth: _____ Place of Birth: _____

My Spouse's Information Sheet

Name: _____ Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Current Address: _____

Phone Number: _____ Email Address: _____

U.S. Citizen ☐ Yes ☐ No Naturalized ☐ Yes ☐ No

Date Naturalized: _____ Location: _____

Certificate Number: _____ Application Number: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed

Date of Marriage: _____ Place of Marriage: _____

Former Spouse

Name (First-Middle-Maiden): _____

Date of Birth: _____ Place of Birth: _____

Date of Marriage: _____ Place of Marriage: _____

Date of Divorce: _____ Place of Divorce: _____

Still Alive ? ☐ Yes ☐ No Date if Marriage Ended in Death: _____

Military Service

Branch of Service: _____ Date of Inlistment: _____

Place of Inlistment: _____ Retirement Date: _____

Last Unit: _____ Location: _____

Date of Death: _____ Place of Death: _____

Cause of Death: _____

Date of Funeral/Cremation: _____ Location: _____

Fathers Name: _____ Still Alive ? ☐ Yes ☐ No

Date of Birth: _____ Place of Birth: _____

Mothers Name: _____ Still Alive ? ☐ Yes ☐ No

Date of Birth: _____ Place of Birth: _____

Our Children's Information Sheet

Name: SSN: Status: Natural

Date of Birth: Place of Birth: Gender:

Current Address:

Phone Numbers: Email Address:

U.S. Citizen ◯ Yes ◯ No Naturalized ◯ Yes ◯ No

Date Naturalized: Location:

Certificate Number: Application Number:

Name: SSN: Status: Natural

Date of Birth: Place of Birth: Gender:

Current Address:

Phone Numbers: Email Address:

U.S. Citizen ◯ Yes ◯ No Naturalized ◯ Yes ◯ No

Date Naturalized: Location:

Certificate Number: Application Number:

Name: SSN: Status: Natural

Date of Birth: Place of Birth: Gender:

Current Address:

Phone Numbers: Email Address:

U.S. Citizen ◯ Yes ◯ No Naturalized ◯ Yes ◯ No

Date Naturalized: Location:

Certificate Number: Application Number:

Name: SSN: Status:

Date of Birth: Place of Birth: Gender:

Current Address:

Phone Numbers: Email Address:

U.S. Citizen ◯ Yes ◯ No Naturalized ◯ Yes ◯ No

Date Naturalized: Location:

Certificate Number: Application Number:

· Documents List ·

☐ DD-214s
แบบฟอร์มDD-214s

☐ U.S. Military ID Card
บัตรประจำตัวข้าราชการทหารอเมริกัน

☐ U.S. Naturalization Certificate
ใบรับรองสัญชาติอเมริกัน

☐ U.S. Green Card
เอกสารอนุญาติให้อาศัยในสหรัฐอเมริกา

☐ U.S. Social Security Card
บัตรประกันสังคมอเมริกัน

☐ Thai ID Card
บัตรประจำตัวประชาชน

☐ Thai Passport (+ U.S. Passport)
หนังสือเดินทางของประเทศไทยและสหรัฐอเมริกา

☐ Marriage Certificate (+ English)
ใบทะเบียนสมรส(ภาษาอังกฤษ)

☐ Divorce Certificate (+ English) (Both)
กรณีหย่านำมาทั้งทะเบียนสมรสและใบหย่า(ภาษาอังกฤษ)

☐ Birth Certificate - Wife (+ English)
ใบเกิดของภรรยา(ภาษาอังกฤษ)

☐ Birth Certificate - Children (+ English)
ใบเกิดของบุตร(ภาษาอังกฤษ)

☐ Adoption Papers
เอกสารการบริจาคให้แก่มูลนิธิต่าง ๆ

☐ Insurance Documents
เอกสารประกันภัย

☐ Bank Statements / Documents
รายการเงินฝากถอนในบัญชีเงินฝาก

☐ Stocks & Bonds Statements
ใบหุ้นทุนหุ้นกู้หรือพันธบัตร

☐ Retiree Account Statement
รายการเงินฝากถอนในบัญชีเกษียณอายุ

☐ Veterans Affairs (VA) Documents
เอกสารทหารผ่านศึก

☐ Wills / Powers of Attorney
พินัยกรรม/หนังสือมอบอำนาจ

☐ Income Tax Records
เอกสารบันทึกการเสียภาษีเงินได้

☐ Safe Deposit Box
ตู้นิรภัยของธนาคาร

☐ Copies of Deeds / Mortgages
เอกสารโฉนดหรือเอกสารจำนองอสังหาริมทรัพย์

☐ Outstanding Debts
หนี้คงค้างที่ยังต้องชำระ

☐ Association Membership(s)
เป็นสมาชิกของสมาคม

Miscellaneous Information:

Make at least 8 copies of Death Certificate with translation
Make necessary changes to your DEERS Program, Tricare, etc.
Change Social Security & Military retirement payments
Check with VA for entitlements (Grave Marker, Payments, Presidential Memorial Certificate)
Check with VFW abour Memorial Service & Casket Flag
Survivor should update appropriate will
Contact Bank(s) as appropriate
Extra Credit/ATM Cards should be destroyed or canceled
Appropriate changes should be made to all joint ownerships
Contact Insurance companies as appropriate
Turn in Militarty and Dependent ID Card's (Where and when required)

* MAKE EVERY EFFORT TO RETAIN "ORIGINAL" DOCUMENTS
PROVIDE CERTIFIED COPIES WHENEVER POSSIBLE

Bank and Finance Information

Bank #1

Address

Phone No's Fax

Web Site Routing No./Swift Code:

Account No. Owner: Type of Account:

Account No. Owner: Type of Account:

Bank Card: Card No. Pin No.

Bank Card: Card No. Pin No.

Remarks:

Bank #2

Address

Phone No's Fax

Web Site Routing No./Swift Code:

Account No. Owner: Type of Account:

Account No. Owner: Type of Account:

Bank Card: Card No. Pin No.

Bank Card: Card No. Pin No.

Remarks:

Bank #3

Address

Phone No's Fax

Web Site Routing No./Swift Code:

Account No. Owner: Type of Account:

Account No. Owner: Type of Account:

Bank Card: Card No. Pin No.

Bank Card: Card No. Pin No.

Remarks:

Bank and Finance Information

Bank #4

Address

Phone No's Fax

Web Site Routing No./Swift Code:

Account No. Owner: Type of Account:

Account No. Owner: Type of Account:

Bank Card: Card No. Pin No.

Bank Card: Card No. Pin No.

Remarks:

Bank #5

Address

Phone No's Fax

Web Site Routing No./Swift Code:

Account No. Owner: Type of Account:

Account No. Owner: Type of Account:

Bank Card: Card No. Pin No.

Bank Card: Card No. Pin No.

Remarks:

Employer

Address

Phone No's Fax

Gross Pay: Net Pay: Taxable Income:

Other Sources of Income: *(Rental Income, Insurance Premiums, Pension, etc.)*

Source: Amount:

Source: Amount:

Source: Amount:

Listing of Outstanding Debts

Creditor: _____ Amount: _____

Creditor: _____ Amount: _____

Creditor: _____ Amount: _____

Creditor: _____ Amount: _____

Creditor: _____ Amount: _____

Creditor: _____ Amount: _____

Military Pay Information

Gross Pay: _____ Net Pay: _____ Taxable Income: _____

Deductions:

Survivors Benefits Costs _____

Federal Income Tax _____

State Income Tax _____

Allotments _____

Insurance Premiums _____

_____

Total Deductions: _____

Military Survivors Befefits Plan (SBP)

Election: _____

Annuity Base Amount: _____

Annuity Amount: _____

Social Security (When Applicable)

Social Security Claim Number: _____

Month Filed _____

Type of Benefit(s): _____

Beginning Date: _____

Amount of Benefits: _____

VA Benefits

VA File Number: _____

VA Rating: _____ % ***Effective Date:*** _____

Dependent Educational Assistance: ☐ YES ☐ NO

Monthly Entitlements: **$** _____ **Effective Date:** _____

Breakdown of Compensation:

Medical Description	Percent (%)	Effective Date

My Final Wishes

Name: _____ Religious Affiliation: _____

I Prefer: _____ Choice of Cemetery: _____

If Cremated Ashes to be: _____

Musical Selection: _____

Requested Pallbearer: _____ Requested Pallbearer: _____

Requested Pallbearer: _____ Requested Pallbearer: _____

Requested Pallbearer: _____ Requested Pallbearer: _____

Special Requests: _____

Organ Donation

- ☐ I DO NOT want any of my organs donated
- ☐ I would like to donate ANY organs needed for transplant
- ☐ I would like to donate my body for research
- ☐ I would like to donate the following organs for transplant/research:

List Organs: _____

Request an Obituary ☐ Yes ☐ No

Inclued the Following: _____

My Spouse's Final Wishes

Name: _____ Religious Affiliation: _____

I Prefer: Internment ▾ Choice of Cemetery: _____

If Cremated Ashes to be: _____

Musical Selection: _____

Requested Pallbearer: _____ Requested Pallbearer: _____

Requested Pallbearer: _____ Requested Pallbearer: _____

Requested Pallbearer: _____ Requested Pallbearer: _____

Special Requests: _____

Organ Donation

- ☐ I DO NOT want any of my organs donated
- ☐ I would like to donate ANY organs needed for transplant
- ☐ I would like to donate my body for research
- ☐ I would like to donate the following organs for transplant/research:

List Organs: _____

Request an Obituary ☐ Yes ☐ No

Inclued the Following: _____

Family Contacts

Name 1: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 2: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 3: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 4: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 5: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 6: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 7: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Name 8: _____ Relationship: _____

Address: _____

Hm Phone _____ Wk Phone _____ Email: _____

Professional Contacts

Doctor: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Clergy: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Attorney: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Broker: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Accountant: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Insurance: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Policy No. _____ Cert. No. _____ Contact: _____

Remarks: _____

Insurance: _____ Website: _____

Address: _____

Phone No. _____ Fax No. _____ Email: _____

Policy No. _____ Cert. No. _____ Contact: _____

Remarks: _____

สิ่งที่ครอบครัวของฉันควรรู้

ชื่อ:

อัปเดตล่าสุด:

เอกสารข้อมูลของฉัน

ชื่อ: หมายเลขประกันสังคม:

วันเกิด: สถานที่เกิด:

ที่อยู่ปัจจุบัน:

หมายเลขโทรศัพท์: ที่อยู่อีเมล:

พลเมืองสหรัฐฯ ☐ ใช่ ☐ ไม่ แปลงสัญชาติ ☐ ใช่ ☐ ไม่

วันที่แปลงสัญชาติ: ที่ตั้ง:

หมายเลขใบรับรอง: หมายเลขใบสมัคร:

สถานภาพการสมรส:

☐ เดียว ☐ แต่งงานแล้ว ☐ หย่าร้าง ☐ แยกออก ☐ หม้าย

วันที่แต่งงาน: สถานที่สมรส:

อดีตคู่สมรส

ชื่อ (First-Middle-Maiden):

วันเกิด: สถานที่เกิด:

วันที่แต่งงาน: สถานที่สมรส:

วันที่หย่า: สถานที่หย่าร้าง:

ยังมีชีวิตอยู่ ? ☐ ใช่ ☐ ไม่ วันที่หากการแต่งงานสิ้นสุดลงด้วยความตาย:

การรับราชการทหาร

สาขาบริการ: N/A วันที่สมัคร:

สถานที่สมัคร: วันที่เกษียณอายุ:

หน่วยสุดท้าย: ที่ตั้ง:

วันที่เสียชีวิต: สถานที่เสียชีวิต:

สาเหตุการตาย:

วันฌาปนกิจ/ฌาปนกิจ: ที่ตั้ง:

ชื่อของพ่อ: ยังมีชีวิตอยู่ ? ☐ ใช่ ☐ ไม่

วันเกิด: สถานที่เกิด:

แม่ชื่อ: ยังมีชีวิตอยู่ ? ☐ ใช่ ☐ ไม่

วันเกิด: สถานที่เกิด:

เอกสารข้อมูลคู่สมรสของฉัน

ชื่อ: หมายเลขประกันสังคม:

วันเกิด: สถานที่เกิด:

ที่อยู่ปัจจุบัน:

หมายเลขโทรศัพท์: ที่อยู่อีเมล:

พลเมืองสหรัฐฯ ☐ ใช่ ☐ ไม่ แปลงสัญชาติ ☐ ใช่ ☐ ไม่

วันที่แปลงสัญชาติ: ที่ตั้ง:

หมายเลขใบรับรอง: หมายเลขใบสมัคร:

สถานภาพการสมรส:

☐ เดียว ☐ แต่งงานแล้ว ☐ หย่าร้าง ☐ แยกออก ☐ หม้าย

วันที่แต่งงาน: สถานที่สมรส:

อดีตคู่สมรส

ชื่อ (First-Middle-Maiden):

วันเกิด: สถานที่เกิด:

วันที่แต่งงาน: สถานที่สมรส:

วันที่หย่า: สถานที่หย่าร้าง:

ยังมีชีวิตอยู่ ? ☐ ใช่ ☐ ไม่ วันที่หากการแต่งงานสิ้นสุดลงด้วยความตาย:

การรับราชการทหาร

สาขาบริการ: วันที่สมัคร:

สถานที่สมัคร: วันที่เกษียณอายุ:

หน่วยสุดท้าย: ที่ตั้ง:

วันที่เสียชีวิต: สถานที่เสียชีวิต:

สาเหตุการตาย:

วันฌาปนกิจ/ฌาปนกิจ: ที่ตั้ง:

ชื่อของพ่อ: ยังมีชีวิตอยู่ ? ☐ ใช่ ☐ ไม่

วันเกิด: สถานที่เกิด:

แม่ชื่อ: ยังมีชีวิตอยู่ ? ☐ ใช่ ☐ ไม่

วันเกิด: สถานที่เกิด:

เอกสารข้อมูลเด็กของเรา

ชื่อ: เอสเอสเอ็น: สถานะ: Natural

วันเกิด: สถานที่เกิด: เพศ:

ที่อยู่ปัจจุบัน:

หมายเลขโทรศัพท์: ที่อยู่อีเมล:

พลเมืองสหรัฐฯ ☐ ใช่ ☐ ไม่ แปลงสัญชาติ ☐ ใช่ ☐ ไม่

วันที่แปลงสัญชาติ: ที่ตั้ง:

หมายเลขใบรับรอง: หมายเลขใบสมัคร:

ชื่อ: เอสเอสเอ็น: สถานะ: Natural

วันเกิด: สถานที่เกิด: เพศ:

ที่อยู่ปัจจุบัน:

หมายเลขโทรศัพท์: ที่อยู่อีเมล:

พลเมืองสหรัฐฯ ☐ ใช่ ☐ ไม่ แปลงสัญชาติ ☐ ใช่ ☐ ไม่

วันที่แปลงสัญชาติ: ที่ตั้ง:

หมายเลขใบรับรอง: หมายเลขใบสมัคร:

ชื่อ: เอสเอสเอ็น: สถานะ: Natural

วันเกิด: สถานที่เกิด: เพศ:

ที่อยู่ปัจจุบัน:

หมายเลขโทรศัพท์: ที่อยู่อีเมล:

พลเมืองสหรัฐฯ ☐ ใช่ ☐ ไม่ แปลงสัญชาติ ☐ ใช่ ☐ ไม่

วันที่แปลงสัญชาติ: ที่ตั้ง:

หมายเลขใบรับรอง: หมายเลขใบสมัคร:

ชื่อ: เอสเอสเอ็น: สถานะ:

วันเกิด: สถานที่เกิด: เพศ:

ที่อยู่ปัจจุบัน:

หมายเลขโทรศัพท์: ที่อยู่อีเมล:

พลเมืองสหรัฐฯ ☐ ใช่ ☐ ไม่ แปลงสัญชาติ ☐ ใช่ ☐ ไม่

วันที่แปลงสัญชาติ: ที่ตั้ง:

หมายเลขใบรับรอง: หมายเลขใบสมัคร:

• รายการเอกสาร•

- DD-214s

แบบฟอรมDD-214s

- บัตรประจำตัวทหารสหรัฐ บตัรประ

จาาตวัตรขากางเกงขายาวอเมรกิน้

- ใบรับรองการแปลงสัญชาติสหรัฐอเมริกา ใบ

ขบรองสญัชาตอิเมรกิน้

- กรีนการ์ดของสหรัฐอเมริกา เอกสารอน

ยูนาต์ใหอาศยัในสหรฐัอเมรกิา

- บัตรประกันสังคมของสหรัฐอเมริกา

บตัรประกนัสงัคมอเมรกิน้

- บัตรประจำตัวประชาชน

บตัรประจัตวัส

- หนังสือเดินทางไทย (+ หนังสือเดินทางสหรัฐอเมริกา)

หนงสอีนิทางของประเทศไทยและสหรฐัอเมรกิา

- ทะเบียนสมรส (+ ภาษาอังกฤษ) ใบท้า

เบท้าท้า(อัลอังกฤษ)

- หนังสือรับรองการหย่า (+ อังกฤษ) (ทั้งคู่) กรณไีฮ

ยานำมาทังท้าทายเบเต้เม้และใบหยา(อองคักกฤษ)

- สูติบัตร - ภรรยา (+ อังกฤษ) ใบเกดิของ

ภรรยา(ภาษาอังอังกฤษ)

- สูติบัตร - เด็ก (+ อังกฤษ) ใบเกดิของตุร(

ภาษาอังอังกฤษ)

- เอกสารการรับเลี้ยงบุตรบุญธรรม

เอกสารการบรจิาคใหญ่แกมลูนธิติางๆ

- เอกสารประกันภัย

เอกสารประกนัภยั

- ใบแจ้งยอดธนาคาร / เอกสาร รายการถอน

ถอนออกจากบัญชีเงินฝากในบัญชี

- งบหุ้นและพันธบัตร ใบหนุทนุ

หนุกหูรอืพนัธบตัร

- ใบแจ้งยอดบัญชีเกษียณ รายการนิพ

ถอนถอนในบญัชเีกษยีณญญญญญ

- เอกสารกิจการทหารผ่านศึก (VA) เอกสารกอง

บัญชาการผานศกึ

- พินัยกรรม / หนังสือมอบอำนาจ พนิ

ยักรรม/หนงสงัโปงอานาจ

- บันทึกภาษีเงินได้ เอกสา

รบธกึการเสยภาษีเงนิได

- ตู้เซฟ ต้นริภัย

- สำเนาโฉนด / สินเชื่อที่อยู่อาศัย เอกสาร

โฉนดรียเอกสารจาลนอสงัรหารมิทรพัย

- หนี้ค้างชำระ

หนีคคคเคลีย่งณ องชาล ระ

- สมาชิกสมาคม สกปรกสมาชกิ

ของวิริยะ

ข้อมูลเบ็ดเตล็ด:

ทำสำเนาใบมรณะอย่างน้อย 8 ชุดพร้อมคำแปล ทำการเปลี่ยนแปลงที
จำเป็นในโปรแกรม DEERS, Tricare ฯลฯ ของคุณ เปลี่ยนเงินประกัน
สังคมและการเกษียณอายุทหาร
ตรวจสอบกับ VA สำหรับสิทธิ์ (เครื่องหมายหลุมฝังศพ การชำระเงิน ใบรับรองอนุสรณ์ประธานาธิบดี)
ตรวจสอบกับ VFW เกี่ยวกับบริการอนุสรณ์และธงโลงศพ
ผู้รอดชีวิตควรอัปเดตตามความเหมาะสม จะ
ติดต่อธนาคารตามความเหมาะสม
บัตรเครดิต/บัตรเอทีเอ็มพิเศษควรถูกทำลายหรือยกเลิก การ
เปลี่ยนแปลงที่เหมาะสมควรกระทำกับเจ้าของร่วมทั้งหมด ติดต่อ
บริษัทประกันภัยตามความเหมาะสม
ส่งทหารและบัตรประจำตัวผู้อยู่ในความอุปการะ (ที่ไหนและเมื่อจำเป็น)

* พยายามทุกวิถีทางที่จะรักษาเอกสาร "ต้นฉบับ" ที่ให้สำเนารับรองเมื่อใดก็ตามที
เป็นไปได้

ข้อมูลธนาคารและการเงิน

ธนาคาร #1

ที่อยู่

หมายเลขโทรศัพท์ แฟกซ์

เว็บไซต์ หมายเลขเส้นทาง/รหัสสวิฟท์:

เลขที่บัญชี เจ้าของ: ประเภทบัญชี:

เลขที่บัญชี เจ้าของ: ประเภทบัญชี:

บัตรเครดิตธนาคาร: หมายเลขบัตร. หมายเลขพิน

บัตรเครดิตธนาคาร: หมายเลขบัตร. หมายเลขพิน

หมายเหตุ:

ธนาคาร #2

ที่อยู่

หมายเลขโทรศัพท์ แฟกซ์

เว็บไซต์ หมายเลขเส้นทาง/รหัสสวิฟท์:

เลขที่บัญชี เจ้าของ: ประเภทบัญชี:

เลขที่บัญชี เจ้าของ: ประเภทบัญชี:

บัตรเครดิตธนาคาร: หมายเลขบัตร. หมายเลขพิน

บัตรเครดิตธนาคาร: หมายเลขบัตร. หมายเลขพิน

หมายเหตุ:

ธนาคาร #3

ที่อยู่

หมายเลขโทรศัพท์ แฟกซ์

เว็บไซต์ หมายเลขเส้นทาง/รหัสสวิฟท์:

เลขที่บัญชี เจ้าของ: ประเภทบัญชี:

เลขที่บัญชี เจ้าของ: ประเภทบัญชี:

บัตรเครดิตธนาคาร: หมายเลขบัตร. หมายเลขพิน

บัตรเครดิตธนาคาร: หมายเลขบัตร. หมายเลขพิน

หมายเหตุ:

รายการหนี้คงค้าง

เจ้าหนี้: _____ จำนวน: _____

เจ้าหนี้: _____ จำนวน: _____

เจ้าหนี้: _____ จำนวน: _____

เจ้าหนี้: _____ จำนวน: _____

เจ้าหนี้: _____ จำนวน: _____

เจ้าหนี้: _____ จำนวน: _____

ข้อมูลการจ่ายทหาร

จ่ายรวม: _____ จ่ายสุทธิ: _____ รายได้ที่ต้องเสียภาษี: _____

การหักเงิน:

ค่าใช้จ่ายผลประโยชน์ของผู้รอดชีวิต _____

ภาษีเงินได้ของรัฐบาลกลาง _____

ภาษีเงินได้ของรัฐ _____

การจัดสรร _____

เบี้ยประกันภัย _____

_____

การหักเงินทั้งหมด: _____

แผนสวัสดิการผู้รอดชีวิตจากทหาร (SBP)

การเลือกตั้ง: _____

จำนวนฐานเงินรายปี: _____

จำนวนเงินงวด: _____

ประกันสังคม (ถ้ามี)

หมายเลขประกันสังคม: _____

เดือนที่ยื่น _____

ประเภทของผลประโยชน์: _____

วันที่เริ่มต้น: _____

จำนวนผลประโยชน์: _____

ประโยชน์ของเวอร์จิเนีย

หมายเลขไฟล์ VA: _____

คะแนน VA: _____ % ***วันที่มีผล:*** _____

ความช่วยเหลือด้านการศึกษาขึ้นอยู่กับ: ☐ ใช่ ☐ ไม่

สิทธิรายเดือน:$ _____ **วันที่มีผล:** _____

รายละเอียดของค่าตอบแทน:

คำอธิบายทางการแพทย์	เปอร์เซ็นต์ (%)	วันที่มีผล

ความปรารถนาสุดท้ายของฉัน

ชื่อ: สังกัดทางศาสนา:

ฉันชอบ: Cremation ทางเลือกของสุสาน:

หากเผาเถ้าถ่านจะเป็น:

การเลือกดนตรี:

Pallbearer ที่ร้องขอ: Pallbearer ที่ร้องขอ:

Pallbearer ที่ร้องขอ: Pallbearer ที่ร้องขอ:

Pallbearer ที่ร้องขอ: Pallbearer ที่ร้องขอ:

คำขอพิเศษ:

การบริจาคอวัยวะ

- ☐ ฉันไม่ต้องการบริจาคอวัยวะใด ๆ ของฉัน
- ☐ ฉันต้องการบริจาคอวัยวะใด ๆ ที่จำเป็นสำหรับการปลูกถ่าย ฉัน
- ☐ ต้องการบริจาคร่างกายเพื่อการวิจัย
- ☐ ฉันต้องการบริจาคอวัยวะต่อไปนี้เพื่อการปลูกถ่าย/วิจัย:

รายการอวัยวะ:

ขอข่าวมรณกรรม ☐ ใช่ ☐ ไม่

รวมสิ่งต่อไปนี้:

ความปรารถนาสุดท้ายของคู่สมรสของฉัน

ชื่อ: สังกัดทางศาสนา:

ฉันชอบ: ทางเลือกของสุสาน:

หากเผาเถ้าถ่านจะเป็น:

การเลือกดนตรี:

Pallbearer ที่ร้องขอ: Pallbearer ที่ร้องขอ:

Pallbearer ที่ร้องขอ: Pallbearer ที่ร้องขอ:

Pallbearer ที่ร้องขอ: Pallbearer ที่ร้องขอ:

คำขอพิเศษ:

การบริจาคอวัยวะ

- ◯ ฉันไม่ต้องการบริจาคอวัยวะใด ๆ ของฉัน
- ◯ ฉันต้องการบริจาคอวัยวะใด ๆ ที่จำเป็นสำหรับการปลูกถ่าย ฉัน
- ◯ ต้องการบริจาคร่างกายเพื่อการวิจัย
- ◯ ฉันต้องการบริจาคอวัยวะต่อไปนี้เพื่อการปลูกถ่าย/วิจัย:

รายการอวัยวะ:

ขอข่าวมรณกรรม ◯ ใช่ ◯ ไม่

รวมสิ่งต่อไปนี้:

รายชื่อครอบครัว

ชื่อ 1: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 2: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 3: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 4: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 5: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 6: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 7: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ชื่อ 8: _____ ความสัมพันธ์: _____

ที่อยู่: _____

หมายเลขโทรศัพท์ _____ Wk Phone _____ อีเมล: _____

ติดต่อมืออาชีพ

หมอ: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

พระสงฆ์: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

อัยการ: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

นายหน้า: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

นักบัญชี: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

ประกันภัย: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

นโยบายเลขที่ ใบรับรอง เลขที่ ติดต่อ:

หมายเหตุ:

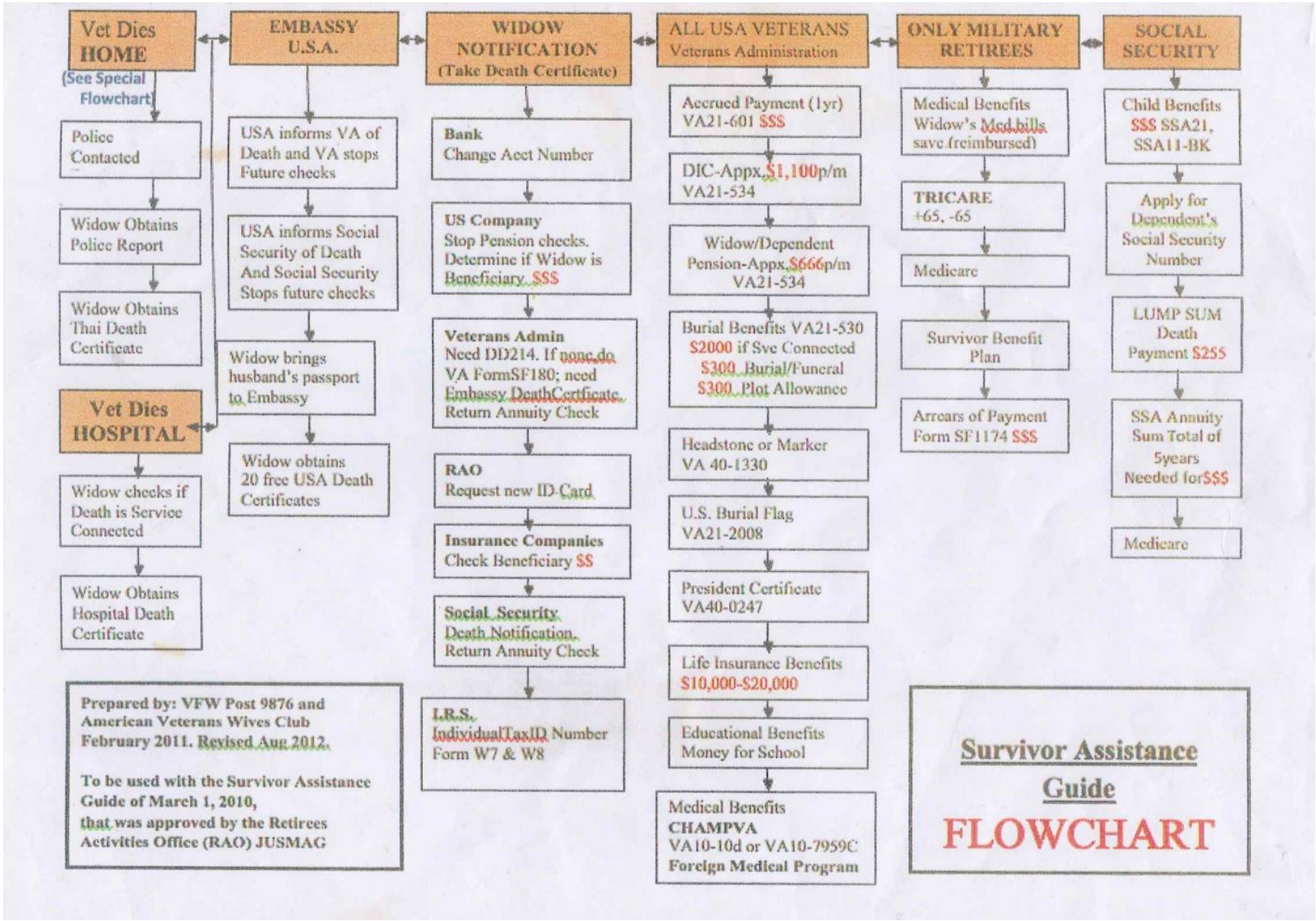
ประกันภัย: เว็บไซต์:

ที่อยู่:

หมายเลขโทรศัพท์ หมายเลขแฟกซ์ อีเมล:

นโยบายเลขที่ ใบรับรอง เลขที่ ติดต่อ:

หมายเหตุ:


Vet Dies HOME
(See Special Flowchart)
Police Contacted
Widow Obtains Police Report
Widow Obtains Thai Death Certificate
Vet Dies HOSPITAL
Widow checks if Death is Service Connected
Widow Obtains Hospital Death Certificate
EMBASSY U.S.A.
USA informs VA of Death and VA stops Future checks
USA informs Social Security of Death And Social Security Stops future checks
Widow brings husband's passport to Embassy
Widow obtains 20 free USA Death Certificates
WIDOW NOTIFICATION
(Take Death Certificate)
Bank
Change Acct Number
US Company
Stop Pension checks. Determine if Widow is Beneficiary $$$
Veterans Admin
Need DD214. If none do VA FormSF180; need Embassy DeathCertficate. Return Annuity Check
RAO
Request new ID Card
Insurance Companies
Check Beneficiary $$
Social Security
Death Notification. Return Annuity Check
I.R.S.
IndividualTaxID Number
Form W7 & W8
ALL USA VETERANS
Veterans Administration
Accrued Payment (1yr)
VA21-601 $$$
DIC-Appx.$1,100p/m
VA21-534
Widow/Dependent Pension-Appx.$666p/m
VA21-534
Burial Benefits VA21-530
$2000 if Svc Connected
$300 Burial/Funeral
$300 Plot Allowance
Headstone or Marker
VA 40-1330
U.S. Burial Flag
VA21-2008
President Certificate
VA40-0247
Life Insurance Benefits
$10,000-$20,000
Educational Benefits
Money for School
Medical Benefits
CHAMPVA
VA10-10d or VA10-7959C
Foreign Medical Program
ONLY MILITARY RETIREES
Medical Benefits
Widow's Med bills save (reimbursed)
TRICARE
+65, -65
Medicare
Survivor Benefit Plan
Arrears of Payment
Form SF1174 $$$
SOCIAL SECURITY
Child Benefits
$$$ SSA21, SSA11-BK
Apply for Dependent's Social Security Number
LUMP SUM Death Payment $255
SSA Annuity Sum Total of 5years Needed for$$$
Medicare
Prepared by: VFW Post 9876 and American Veterans Wives Club February 2011. Revised Aug 2012.
To be used with the Survivor Assistance Guide of March 1, 2010, that was approved by the Retirees Activities Office (RAO) JUSMAG
Survivor Assistance Guide
FLOWCHART

How Social Security Can Help You When a Family Member Dies

Social Security is here to support you when you lose a family member. Contacting us when you lose a loved one is very important. This ensures that we are able to provide information regarding benefits you may be entitled to.

You may be able to receive Social Security benefits if your loved one worked long enough in jobs insured under Social Security to qualify for benefits.

What to do

There are a few things you need to do:

- You should give the deceased's Social Security number to the funeral director because they usually report the person's death to us.
- ***Contact us as soon as you can to make sure your family gets all the benefits they're entitled to.***

Who can get Social Security survivors benefits

- We can pay a one-time lump sum death payment (LSDP) of $255 to the surviving spouse under one of the following conditions:
  - —If they were living with the deceased.
  - —If they were living apart from the deceased and eligible for certain Social Security benefits on the deceased's record.
  - —If there's no surviving spouse, a child who's eligible for benefits on the deceased's record in the month of death can receive this payment.
- Certain family members **may be eligible** to receive monthly benefits, including:
  - —A surviving spouse who is:
    - Age 60 or older (age 50 or older if they have a disability).
    - Any age and caring for the deceased's child who is under age 16, or who has a disability and is receiving Social Security benefits.
  - —An unmarried child of the deceased who is either:
    - Younger than age 18 (or up to age 19 if they're a full-time student in an elementary or secondary school).
    - Age 18 or older with a disability that began before age 22.
  - —A stepchild, grandchild, step-grandchild, or adopted child under certain circumstances.
  - —Parents, age 62 or older, who were dependent on the deceased for at least ½ of their support.
  - —A surviving divorced spouse, under certain circumstances.

More Information

If the deceased was receiving Social Security benefits, you must return the benefits received for the month of death and any later months. If the payment was received by direct deposit, contact the bank or other financial institution. Ask them to return any funds received for the month of death or later. If the benefit was paid by check, please do not cash. Instead, return the checks to us as soon as possible.

Keep in mind that eligible family members may be able to receive survivors' benefits for the month the beneficiary died.

Visit our Survivors Benefits webpage at ***www.ssa.gov/benefits/survivors/*** for more information.

Contacting Us

There are several ways to do business with us including online, by mail, by phone, and in person. If you cannot use our online services, we can help you by phone when you call our national toll-free 800 number.

If you don't have access to the internet, we offer many automated services by telephone, 24 hours a day, 7 days a week, so you may not need to speak with a representative. Call us toll-free at **1-800-772-1213** or at our TTY number, **1-800-325-0778**, if you're deaf or hard of hearing. We provide free interpreter services upon request. For quicker access to a representative, try calling early in the day (between 8 a.m. and 10 a.m. local time) or later in the day. **We are less busy later in the week (Wednesday to Friday) and later in the month.**

Securing today and tomorrow

SSA.gov

Social Security Administration
Publication No. 05-10008
January 2023 (Recycle prior editions)
How Social Security Can Help You When a Family Member Dies
Produced and published at U.S. taxpayer expense

Phone

You may call us at (+63) 2 5301-6200 from 8:00 a.m. to 11:00 a.m. (Manila Time) every Tuesday and Thursday, except on U.S. and Philippine Holidays.

In-Office Appointments

To ensure the health and safety of our clients and staff, our in-person services are limited to **appointment only**. Currently, appointments are available on Wednesdays and Fridays from 8:00 AM to 11:30 AM. To schedule an appointment, please contact us via our FBU Inquiry Form and we will contact you to schedule the appointment. Please note that electronic devices (e.g., cell phones, laptops, etc.) are not allowed inside the Embassy.

Facsimile or Postal Mail

You may send your inquiry via fax to (+63) 2 8708-9714 or write to us at the following address:

Mailing Address:
U.S. Embassy – Manila Social Security Administration 1201 Roxas Boulevard Manila, Philippines 0930

IMPORTANT:

For OPM annuitants, we provide general services such as direct deposit enrollment, reporting of death and appointment of a Representative Payee. For all other services, please email OPM directly at retire@opm.gov. For more information about OPM, you may visit their website at www.opm.gov .