OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

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, Compensation, Pension, Education, and Rehabilitation 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 number can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.htm#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN ***(Type or Print)***	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

(CONTINUE ON REVERSE)

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

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS ***(Include Area Code)***	
	DAYTIME	EVENING

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.

(CONTINUATION)

Department of Veterans Affairs

GENERAL INSTRUCTIONS FOR VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION, VA FORM 21-526, PARTS A,B,C, & D

What's in these instructions?

Use these instructions to help you complete VA Form 21-526 Parts A, B, C, and D to apply for compensation and/or pension. The "General Instructions" consist of the following four sections:

Section 1: Preparing your application. This section gives you information you should consider before you file your claim. It tells you why you should use VA Form 21-526 and then helps you decide what you are applying for, which parts to use, and which items you will need to fill out.

Section 2: Completing your VA Form 21-526. This section helps you complete your VA Form 21-526. It has specific advice for difficult parts and tells you where to send your forms after you've filled them out.

Section 3: Finding answers to other questions. This section tells you more about other issues that you may have questions about.

Section 4: Explanation of the Privacy Act and Respondent Burden: This section tells you what the Privacy Act is and explains how VA uses the requested information. It also explains the respondent burden which is an estimate of how long it will take you to fill out this form.

INSIDE THESE INSTRUCTIONS

Before you start . . .

Where can I get help filling out my application?

- You can contact a County or National Veterans' Service Organization to help you complete the form, or
- You can ask VA to help you fill out the form by calling or visiting a regional office. Someone in the regional office will help you complete the form. If you go to a regional office, you should have all the materials that are listed on page 3 under "Checklist: Things you will need to prepare for filling out your application." Before you call or go to the regional office, make sure you gather the necessary materials and complete as much of the form as you can.

How can I contact VA if I have questions?

If you have questions about this form, how to fill it out, or about benefits, you can contact VA in the following ways.

- By mail:
  You can locate the address of the closest regional office in your telephone book blue pages under **"United States Government, Veterans"**
- By telephone:
  Please call one of the following telephone numbers:
  1-800-827-1000
  1-800-829-4833 (Hearing Impaired TDD line)
- By Internet:
  http://www.vba.va.gov/benefits/address.htm

Social Security Benefits

The Social Security and Supplemental Security Income disability programs are the largest of several Federal programs that provide assistance to people with disabilities. While these two programs are different in many ways, both are administered by the Social Security Administration (SSA) and only individuals who have a disability and meet medical criteria may qualify for benefits under either program.

How can I contact SSA if I have questions?

If you have a question, call the SSA toll-free phone number at 1-800-772-1213, Monday through Friday, from 7a.m. to 7p.m. If you have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays. People who are deaf or hard of hearing may call the toll-free TTY number, 1-800-325-0778, between 7 a.m. and 7 p.m. on Monday through Friday. Please have your Social Security number handy when you call.

- By Mail:
  You can locate the address of the closest SSA office in your telephone book blue pages under **"United States Government, Social Security Administration"**
- By Internet:
  http://www.ssa.gov/

SECTION 1: PREPARING YOUR APPLICATION

What do I use VA Form 21-526 for?
Use VA Form 21-526 to apply for compensation and/or pension benefits.

You should apply for compensation benefits if *any* of the following are true:

- You were injured while you were in the service.
- You were seriously ill while you were in the service, and you believe you have continuing problems.
- You developed a mental or physical condition that may be related to your military service.
- You are permanently and totally disabled and you believe it is because of your military service.

You should apply for pension benefits if *all* of the following are true:

- You are permanently and totally disabled (but not as a result of your military service).
- You served on active duty during a wartime period.
- Your income is limited.

VA Form 21-526 has four parts. Everyone has to fill out Part A of the form. You fill out some or all of the other parts depending on the benefits you are applying for. Once you have decided what you are applying for, find out which parts you need to use by reading through the check list below called "Which Parts of VA Form 21-526 Should You Use?"

What can I do to help get my application processed faster?

VA will make reasonable efforts to help you get this evidence. You can help us by telling us about all the evidence that supports your claim. Evidence is information that confirms that what you are telling us is correct. For instance, if you are claiming service connection for a certain disability, we will help you by requesting medical records from your doctor or from VA that show you have this disability. We will also help you by requesting records from other Federal or non-Federal agencies or companies. We will request your service medical records in claims for compensation.

CHECK LIST: WHICH PARTS OF VA FORM 21-526 SHOULD YOU USE?

Look at the table below to find out which parts of VA Form 21-526 you should use to apply for different benefits.

If you are applying for:	You must fill out: VA Form 21-526, Part A: General Information	VA Form 21-526, Part B: Compensation	VA Form 21-526, Part C: Dependency	VA Form 21-526, Part D: Pension
Compensation only	✓	✓	✓	
Pension Only	✓		✓	✓
Compensation and Pension	✓	✓	✓	✓

CHECKLIST: THINGS YOU'LL NEED TO PREPARE FOR FILLING OUT YOUR APPLICATION

When you fill out this VA Form. . .	*You'll need this information ready to answer questions. . .*	*You should attach these pieces of information. . .*
21-526 Part A: General Information	☐ Active Duty Information ● dates and places you entered and left duty ● mailing addresses of units you served in ☐ Reserve Duty and National Guard Duty information ● dates and places you entered and left duty ● mailing addresses of units you served in ☐ List of military benefits you receive and amounts	☐ An original or certified copy of DD214 or other separation papers for all periods of service
21-526 Part B: Compensation	☐ List of disabilities you are claiming, including ● treatment dates in service ● name and address of the medical facilities where you have been treated after service ☐ Information about any environmental exposures or events that caused the disabilities you are claiming, including dates they happened	☐ An original or copies of all service medical records you have ☐ Medical records you have showing you currently have this disability ☐ Medical records you have indicating that the disability was caused by or happened during your active service
21-526 Part C: Dependency	☐ Information about your current spouse, including his/her Social Security number (and VA file number if he/she is a veteran) ☐ Information about you and your spouse's previous marriages including dates and places of those marriages and the dates and places those marriages ended ☐ Information about the children who live with you, including their names, Social Security numbers, dates and places of birth ☐ Information about children not living with you, including their names, dates and places of birth, Social Security numbers, and amounts that you contribute in child support for them	☐ Copies of your marriage certificate and all divorce decrees (May be required in some cases) ☐ Copies of the public birth records for each child you claim as a dependent (May be required in some cases) ☐ Copies of the court records for adoption for each adopted child
21-526 Part D: Pension Note: If you are a veteran who is age 65 or older you DO NOT have to submit medical evidence with your application.	☐ Information about your training and employment history for the past year, including ● name and address of employers ● beginning and ending dates of employment ☐ Information about your nursing home, if you live in one ☐ Information about your net worth and your dependents' net worth ☐ Information about your recurring income and your dependents' recurring income ☐ Information about income you and your dependents expect to receive in the next 12 months	☐ Current medical evidence telling us about your disabilities ☐ If you are in a nursing home, attach a statement signed by an official of the nursing home that includes ● the date you were admitted to a nursing home ● your level of care in the nursing home ☐ Your nursing home payment status, which is Medicaid coverage or private pay

SECTION 2: COMPLETING YOUR APPLICATION

You will find instructions on each part of VA Form 21-526 to help you fill them out. However, there still might be some areas of the forms that are difficult. In this section, we've included the answers to some common problems that claimants have with the forms. They should help you fill out your forms more quickly and easily.

VA Form 21-526, Part A: General Information

Section III
What is the Gulf War registry? VA has a registry of veterans who served in the Gulf War theater of operations. The information in this registry will be shared only with the Department of Defense and others as permitted by law (such as the National Academy of Sciences). We will keep you informed of significant developments in research on health consequences found to be related to military service in the Gulf War. You may request a VA health examination that will include consultation and counseling covering the results of the examination. You should contact your nearest VA medical facility to request an examination.

Section VII
Should I waive military retired pay for VA compensation? If you currently receive military retired pay, you should be aware that we will reduce your retired pay by the amount of any compensation that you are awarded. However, this is to your advantage because VA compensation **is not taxable and most retired pay is taxable.** Based on your application, if you are awarded compensation, we will tell the Military Retired Pay Center to reduce your retired pay by the amount of compensation you have been awarded. If you do not want this to happen, you must sign **Item 21e** of VA Form 21-526, Part A to let us know.

VA Form 21-526 Part B: Compensation

Section I
What kind of disabilities should I list? When possible, try to list the actual disease and medical condition that a doctor has diagnosed. Be as specific as you can.

Do I have to include any records with this claim form?
If you have records that support your claim you should attach them to this claim form. If you know of other records that will support your claim, VA will help you by requesting them from the person, company, or agency that has them. On this form you must tell us the name and address of the person, company or agency that has these records, the approximate time frame covered these records, and the condition for which you were treated in the case of medical records. If you received treatment from a military health care facility after your discharge from service, private physician, or any other health care provider, complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). We will use this form to request these records.

VA Form 21-526, Part C: Dependency

Section III
Who can I count as a dependent child? VA recognizes your biological children, adopted children, and stepchildren as dependents. But these children must be unmarried and:

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

VA Form 21-526 Part D: Pension

Section IV
What do you mean by "net worth"? Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single family dwelling unit and a reasonable lot area. Net worth also does not include the personal things you use everyday like your vehicle, clothing, and furniture.

NOTE: If you are a veteran who is age 65 or older, you DO NOT have to submit medical evidence with your application.

What do I do when I have finished my application?

1. Make sure you sign and date VA Form 21-526, Part A**.** You must provide your signature in Section IX, Item 25 of this form. If you don't sign the form, VA will return it for you to sign, and it will take longer for us to process it.
2. Attach any materials that support and explain your claim**.** Be sure to look at the checklist on page 3 of these instructions to make sure that you have attached all important pieces of information to your application.

SECTION 2: COMPLETING YOUR APPLICATION (Continued)

3. You may complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA), with your VA Form 21-526 if you want help getting additional records. By signing VA Form 21-4142, you authorize any doctors, hospitals, or caregivers that have treated you to release information about your treatment to VA. Be sure to sign and date the form. Make as many copies of VA Form 21-4142 as you need to give authorization to all the doctors, medical facilities, or caregivers that treated you. You do not need to complete this form for any treatment you received at a VA facility.

4. Make a photocopy of your application and everything that you submit to VA. By having copies, you will be prepared if VA has a question about your application.

Where do I send my application?

Mail the original application and your supporting materials to the closest VA office. You can find the address in your local telephone book or at the VBA internet web site:
http://www.vba.va.gov/benefits/address.htm

What if I need to change or add information to my application after I give it to VA?

If you find that you need to change or add information to your application, contact the VA office where you submitted your application immediately. In a letter, make sure you specify:

- your name,
- claim number if you know it (or Social Security number if you don't know the claim number), and
- the item number you want to change or add to.

TIPS FOR FILLING OUT YOUR VA FORM 21-526

ATTACHING FORMS AND OTHER INFORMATION:
Throughout this form, you will be asked to attach certain pieces of information to the form itself. For example, you are asked to attach a DD214 to your Form 21-526, Part A. The **DD214 needs to be an original or certified copy,** other documents do not. To get a certified copy, you can take your original to the courthouse and have it copied and signed by an official of the court. A VA employee can also "certify" a copy for you.

ANSWERING QUESTIONS COMPLETELY:
Remember that the more questions you answer, the faster your claim can be processed. Try to answer every question that applies to your situation and fill out as much of the form as you can. The list below answers some questions that you might be wondering about:

- *What if my answer to a question is "none" or "0"?* Write that as your answer.
- *What if I need to include an address that is not in the United States?* Make sure that you include the name of the country in your answer.
- *What if I need more space to answer a question?* You can use Part A of the 21-526, page 5, Item 29 "Remarks" or attach a sheet of paper to your form. Write "Continuation of answers" at the top of the page, your name, and your VA claim number. If this is your first claim, you will not have a VA claim number, so write your Social Security number instead. For each question that you need more room, write "Continuation of Item"and the item number. For example, if you need more room to answer Item 16 on VA Form 21-526, part A, write "Continuation of Item 16, VA Form 21-526, Part A."

KEEPING RECORDS: It is important that you keep a copy of all the forms you fill out and give to VA. This way you will have your own complete record to refer to.

SIGNING FORMS: Be sure to sign every form you fill out before you send it to us.

SECTION 3: FINDING ANSWERS TO OTHER QUESTIONS

What can you tell me about VA benefits and how VA decides what I will or will not receive?

VA pays veterans' disability compensation for disability(ies) that are a result of their military service. If VA determines that your disability(ies) are 30% or more disabling, VA can pay additional compensation for your spouse, children, and dependent parents. VA will pay a higher amount of compensation for a spouse when the spouse is a patient in a nursing home or is disabled and requires the regular aid and attendance of another person.

VA pays disability pension to veterans who:

- are permanently and totally disabled, but not as a result of military service or the veteran's own willful misconduct
- served during:
  - Mexican Border Period
  - World War I
  - World War II
  - Korean Conflict
  - Vietnam Era
  - Gulf War

VA pays disability pension based on the amount of income that the veteran and family received and the number of dependents in the family. This is based on law. VA must include as income all sources that federal law specifies. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA office. See page 1, "How can I contact VA if I have a question?" for ways to contact us.

VA may pay a higher rate of disability pension to a veteran who is a patient in a nursing home, otherwise needs regular aid and attendance, or who is permanently confined to his or her home because of a disability.

I would like help in understanding the process of getting my benefits. What can I do?

You can ask someone to act as your representative. A representative can be:

- An accredited member of an accredited organization or other service organization that the Secretary of Veterans Affairs recognizes.
- An agent recognized by VA or a licensed lawyer. Agents and attorneys can charge you for services that you get from them only after the Board of Veterans Appeals (BVA) gives you their final decision about your application. That means you can use an attorney during any stage of your application for benefits. However, the agent or attorney cannot charge you for services unless you are trying to resolve a dispute with VA after BVA has made a decision about your claim.

If you want to use a representative to help you with your application, contact the closest VA office. Depending on the type of representative you want to designate, we will send you one of the following forms:

- VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative
- VA Form 22A, Appointment of Individual as Claimant's Representative

What if I believe that VA has made an error in processing or deciding on my benefits?

You can ask for a personal hearing at any time during the processing of your claim. That means you can ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA office and tell them that you want a personal hearing on your case. Someone in the local VA office will arrange a time and a place for your hearing. At this hearing, you can bring witnesses. VA will record whatever you and your witnesses say during the hearing and include it in the official record. VA will furnish the hearing room and officials, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing. After your claim has been decided you will have **one year** from the date of notice to appeal that decision.

SECTION 4: Explanation of the Privacy Act and Respondent Burden

PRIVACY ACT INFORMATION: No allowance of compensation or pension may be granted unless this form is completed fully as required by law (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 Compensation, Pension, Education, and Rehabilitation Records - VA. 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. 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.

Income and employment information: The income and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103 (1)(7)(D) of the Internal Revenue Code of 1986.

Social Security information: You are required to provide the Social Security number(s), 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 the purposes stated above.

Respondent Burden: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting for this collection of information is estimated to average 1 hour and 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

Department of Veterans Affairs

OMB Approved No. 2900-0001
Respondent Burden: 1 hour 30 minutes

(DO NOT WRITE IN THIS SPACE)

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

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

SECTION I Tell us what you are applying for

Check the box that says what you are applying for. Be sure to complete the other Parts you need.

1. What are you applying for? If you are unsure please refer to the "General Instructions" page 2 Section 1: Preparing your application

Compensation	►	Fill out Part A of VA Form 21-526 and Parts B and C
Pension	►	Fill out Part A of VA Form 21-526 and Parts C and D
Compensation and Pension	►	Fill out Part A of VA Form 21-526 and Parts B, C and D

2a. Have you ever filed a claim with VA

No *(If "No," skip Item 2b and go to Item 3)*

(If "Yes," provide file number below)

Yes _____ *(Go to 2b)*

2b. I filed a claim for

Compensation Pension

Other _____

SECTION II Tell us about you

We need information about you to process your claim faster.

3. What is your name?

_____

First Middle Last Suffix (If applicable)

4. What is your Social Security number?

_____

5. What is your sex?

Male Female

6a. Did you serve under another name?

Yes *(If "Yes," go to Item 6b)*

No *(If "No," go to Item 7)*

6b. Please list the other name(s) you served under

_____

_____

Give us your current mailing address in the space provided. If it will change within the next three months, give us that new address in block 29 "Remarks." Also in block 29, give us the date you think you will be at the new address. ►

7. What is your address?

_____

Street address, rural route, or P.O. Box Apt. number

_____

City State ZIP Code Country

8. What are your telephone numbers?

Daytime ( ) _____

Evening ( ) _____

9. What is your e-mail address?

_____

10. What is your date of birth?

_____/_____/_____

11. Where were you born?

_____

City State Country

OWCP used to be called the U.S. Bureau of Employees Compensation ►

12a. Are you receiving disability benefits from the Office of Workers' Compensation *(OWCP)*?

Yes No

(If "Yes," answer 12b and 12c also)

12b. When was the claim filed?

_____/_____

12c. What disability are you receiving benefits for?

_____

13a. What is the name of your nearest relative or other person we could contact if necessary?

13b. What is his/her telephone number?

Daytime ( ) _____

Evening ( ) _____

13c. What is this person's address?

13d. How is this person related to you?

_____

SECTION III Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed use Item 29 "Remarks".

2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

14a. I entered active service the **first** time. . . mo day yr	**14b.** Place:	**14c.** My service number was . . .	
14d. I left this active service. . . mo day yr	**14e.** Place:	**14f.** Branch of Service	**14g.** Grade, rank, or rating
14h. I entered my **second** period of active service. . . mo day yr	**14i.** Place:	**14j.** My service number was . . .	
14k. I left this active service. . . mo day yr	**14l.** Place:	**14m.** Branch of Service	**14n.** Grade, rank, or rating

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

15a. Did you serve in Vietnam?

☐ Yes ☐ No

(If "Yes," answer Item 15b also)

15b. When were you in Vietnam?

from mo day yr to mo day yr

16a. Were you stationed in the Gulf after August 1, 1990?

☐ Yes ☐ No

(If "Yes," answer Item 16b also)

16b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry?"

☐ Yes ☐ No

17a. Have you ever been a prisoner of war?

☐ Yes ☐ No

(If "Yes," answer Items 17b, 17c, and 17d also)

17b. What country or government imprisoned you?

17c. When were you confined?

from mo day yr to mo day yr

17d. What was the name of the camp or sector and what are the names of the city and country near its location

SECTION IV Tell us about your reserve duty

18a. Are you currently assigned to an active reserve unit?

☐ Yes ☐ No

(If "Yes," answer Item 18b also)

18b. What is the name, mailing address, and telephone number of your current unit?

18c. Were you previously assigned to an active reserve unit within the last 2 years?

☐ Yes ☐ No

(If "Yes," answer Item 18d also)

18d. What is the name, mailing address, and telephone number of that unit?

SECTION IV (*Continued*) Tell us about your reserve duty

18e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency)

☐ Yes ☐ No ☐ Don't know

(If "Yes," answer Item 18f also)

18f. What is your reserve obligation termination date?

___/___/___
mo day yr

Instructions 18g-18k

If you are currently or have ever been a full time reservist for operational or support duty,

1. Complete 18g-18k for that service only.
2. Attach proof of reserve service

18g. I entered reserve service. . .

___/___/___
mo day yr

Place:

18h. My service number was . . .

18i. I left reserve service. . .

___/___/___
mo day yr

Place:

18j. Branch of of service

18k. Grade, rank, or rating

Instructions 18l-18p

If your disability occurred or was aggravated during any period of reserve duty,

1. Complete 18l-18p for the period when your disability occurred.
2. Attach proof that your disability occurred during reserve service.

18l. I entered reserve service. . .

___/___/___
mo day yr

Place:

18m. My service number was . . .

18n. I left reserve service. . .

___/___/___
mo day yr

Place:

18o. Branch of service

18p. Grade, rank, or rating

SECTION V Tell us about your National Guard duty

19a. Are you currently a member of the National Guard?

☐ Yes ☐ No ☐ Not assigned yet

(If "Yes," answer Item 19b also)

19b. What is the name, mailing address, and telephone number of your current unit?

19c. Were you previously assigned to a guard unit within the last 2 years?

☐ Yes ☐ No

(If "Yes," answer Item 19d also)

19d. What is the name, mailing address, and telephone number of that unit?

Instructions 19e-19i

If you were activated to Federal Active Duty under the Authority of Title 10, United States Code,

1. Complete 19e-19i for that service only
2. Attach proof of this Federal Active Duty.

19e. I entered Federal Active Duty. . .

___/___/___
mo day yr

Place:

19f. My service number was . . .

19g. I left Federal Active Duty. . .

___/___/___
mo day yr

Place:

19h. Branch of service

19i. Grade, rank, or rating

Instructions 19j-19n

If your disability occurred or was aggravated during any period of guard duty,

1. Complete 19j-19n for the period when your disability occurred
2. Attach proof that your disability occurred during National Guard Service.

19j. I entered National Guard. . .

___/___/___
mo day yr

Place:

19k. My service number was . . .

19l. I left National Guard. . .

___/___/___
mo day yr

Place:

19m. Branch of service

19n. Grade, rank, or rating

SECTION VI Tell us about your travel status

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

SECTION VII Tell us about your military benefits

When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes.

You must sign 21e if you want to keep getting military retired pay instead of VA compensation.

Please see page 4 of the General Instructions for VA Form 21-526.

If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, by the Department of Defense

21a. Are you receiving or will you receive retired or retainer pay that is based on your military service? ☐ Yes ☐ No (If "Yes," answer Items 21b thru 21f. If "No," skip to Item 22)	21b. What branch of service is paying or will pay your retired or retainer pay?	21c. What is the monthly amount? $.

21d. What is your retirement based on?

☐ Length of service ☐ Disability ☐ TDRL (Temporary Disability Retired List)

21e. Sign here if you want to receive military retired pay *instead of* VA compensation

_____

21f. Have you received or will you receive any of the following military benefits?
(Please check the appropriate boxes and tell us the amount)

Benefit	*Amount*
(1) ☐ Lump Sum Readjustment Pay	$.
(2) ☐ Separation pay under 10 USC 1174	$.
(3) ☐ Special Separation Benefit (SSB)	$.
(4) ☐ Voluntary Separation Incentive (VSI)	$.
(5) ☐ Disability Severance Pay (name of disability_____)	$.
(6) ☐ Other (tell us the type of benefit_____)	$.

SECTION VIII Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer questions 22-24 to the right.

All federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 22, 23 and 24 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 22. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

22. Account number (Please check the appropriate box and provide that account number, if applicable)

☐ Checking ☐ Savings

☐ I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

23. Name of financial institution

_____

24. Routing or transit number

_____

SECTION IX Give us your signature

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

I certify and authorize the release of information:

I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

25. Your signature	**26.** Today's date ___/___/____ mo day yr

27a. Signature of witness (If claimant signed above using an "X")	**27b.** Printed name and address of witness
28c. Signature of witness (If claimant signed above using an "X")	**28b.** Printed name and address of witness

SECTION X

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

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

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

Department of Veterans Affairs

VA Form 21-526, Part B: Compensation

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

SECTION I Tell us about your disability

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

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

1. What disability are you claiming?	**2.** When did your disability begin?	**3b.** When were you treated?	**4a.** What medical facility or doctor treated you?	**4b.** What is the address of that medical facility or doctor?
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from mo day yr to mo day yr		
	mo day yr	from to		
	mo day yr	from mo day yr to mo day yr		

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

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

☐ Yes ☐ No

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

5b. What is your disability?

5c. In what country were you exposed?

6a. Were you exposed to asbestos?

☐ Yes ☐ No

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

6b. What is your disability?

6c. When and how were you exposed?

7a. Were you exposed to mustard gas?

☐ Yes ☐ No

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

7b. What is your disability?

7c. When and how were you exposed?

8a. Were you exposed to ionizing radiation?

☐ Yes ☐ No

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

8b. What is your disability?

8c. When was your last exposure?

___/___/___

mo day yr

8d. How were you exposed to radiation?

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

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

☐ Yes ☐ No

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

9b. What is your disability?

9c. What was the hazard?

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

☐ Yes ☐ No

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

10b. When was the exam?

___/___/___

mo day yr

10c. Where did the exam occur?

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

11. Explanation

Your Name	**Your Social Security Number**

Department of Veterans Affairs

VA Form 21-526, Part C: Dependency

Use this form to tell us more about your dependents. Remember that you must also fill out a VA Form 21-526, Part A: General Information, Part B and/or Part D, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 3.

SECTION I Tell us about your marriage

NOTE: You should provide a copy of your marriage certificate.

1. What is your marital status?

☐ Married ☐ Surviving Spouse ☐ Divorced ☐ Never married

(If your spouse died, you are "divorced," or "never married" skip to Section III beginning on page 2)

2. When were you married?

____/____/____
mo day yr

3. Where did you get married?
(city/state or country)

_____

4. What is your spouse's name?

_____
First Middle Last

5. When is your spouse's birthday?

____/____/____
mo day yr

6. What is your spouse's Social Security number?

_____

7a. Is your spouse also a veteran?

☐ Yes ☐ No

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

7b. What is your spouse's VA file number (If any)?

_____

8. Do you live with your spouse?

☐ Yes
☐ No

9. What is your spouse's address?

_____
Street address, rural route, or P.O. Box Apt. number

_____
City State Zip code Country

10. Tell us why you are not living with your spouse

11. How much do you contribute monthly to your spouse's support?

$ _____ .

12. How were you married?

a. ☐ Ceremony by a clergyman or other authorized public official

b. ☐ Common-law

c. ☐ Tribal

d. ☐ Proxy

e. ☐ Other (please describe in the space below)

_____

_____

_____

SECTION II Tell us about any previous marriages

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

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

Your previous marriages

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

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

Your spouse's previous marriages

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

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

SECTION III Tell us about your other dependents

In this section we want to know whether your parents are financially dependent on you (Question **15**) and more about your **dependent children.** VA may recognize a veteran's biological children, adopted children, and stepchildren as dependent. These children must be unmarried and:
- be under the age of 18, **or**
- be at least 18 but under 23 and pursuing an approved course of education, **or**
- have become permanently unable to support themselves before reaching the age of 18.

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

15. Are your parents financially dependent on you?

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

16. Do you have dependent children?

☐ Yes

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

☐ No

17. How many dependent children do you have?

_____

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

SECTION III Tell us about your dependents (continued)

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

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

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

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

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

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

_____

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

Your name	**Your Social Security Number**

Department of Veterans Affairs

VA Form 21-526, Part D: Pension

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

SECTION I Tell us about your disability and background

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

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

Note: If you are a veteran who is age 65 or older or determined to be disabled by the Social Security Administration, you DO NOT have to submit medical evidence with your application.

1a. What disability(ies) prevent you from working?

1b. When did the disability(ies) begin?

mo / day / yr

2. Are you claiming a special monthly pension because you need the regular assistance of another person, are blind, nearly blind, or having severe visual problems, or are housebound?

☐ Yes ☐ No

3a. Are you now, or have you recently been hospitalized or given outpatient or home-based care?

☐ Yes ☐ No

(If "Yes," answer Items 3b and 3c also)

3b. Tell us the dates of the recent hospitalization or care

Began mo / day / yr

Ended mo / day / yr

3c. What is the name and complete mailing address of the facility or doctor?

4a. Are you now employed?

☐ Yes ☐ No

(If "No," answer Item 4b also)

4b. When did you last work?

mo / day / yr

4c. Were you self-employed before becoming totally disabled?

☐ Yes ☐ No

(If "Yes," answer Item 4d and 4e also)

4d. What kind of work did you do?

4e. Are you still self-employed?

☐ Yes ☐ No

(If "Yes," answer Item 4f also)

4f. What kind of work do you do now?

4g. Have you claimed or are you receiving disability benefits from the Social Security Administration (SSA)?

☐ Yes ☐ No

4h. Circle the highest year of education you completed:

Grade school
1 2 3 4 5 6 7 8 9 10 11 12
College
1 2 3 4 over 4

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

SECTION II Tell us your work history

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

5a. What was the name and address of your employer?	**5b.** What was your job title?	**5c.** When did your work begin?	**5d.** When did your work end?	**5e.** How many days were lost due to disability?	**5f.** What were your total annual earnings?
		___/___/___ mo day yr	___/___/___ mo day yr		$.
		___/___/___ mo day yr	___/___/___ mo day yr		$.
		___/___/___ mo day yr	___/___/___ mo day yr		$.

SECTION III Tell us if you are in a nursing home

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

To get your claim processed faster, provide a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability and tells us the daily charge for your care.

6a. Are you now in a nursing home?

☐ Yes ☐ No

(If "yes," answer Item 6b also)

6b. What is the name and complete mailing address of the facility or doctor?

6c. Does Medicaid cover all or part of your nursing home costs?

☐ Yes ☐ No

(If "no," answer Item 6d also)

6d. Have you applied for Medicaid?

☐ Yes ☐ No

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

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

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

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

Definitions:
Net worth is the market value of all interest and rights in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture.

Go to Page 3 and fill out the table.

SECTION IV (Continued)

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

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

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

SECTION V

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

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

Report the total amounts before you take out deductions for taxes, insurance, etc.
Do not report the same information in both tables.
If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.
If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space.
If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

Payments from any source will be counted, unless the law says that they don't need to be counted. VA will determine any amount that does not count.

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

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

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

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

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

SECTION VI

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

Tell us any information concerning, Medical, Legal or Other Expenses Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid for yourself or relatives you are under an obligation to support. Also, show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. **Do not** include any expenses for which you were reimbursed. Show the Medicare deduction in line 1. If more space is needed attach a separate sheet.

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

Your name	**Your Social Security Number**

Department of Veterans Affairs

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

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000

(TDD 1-800-829-4833 FOR HEARING IMPAIRED)

SECTION I —VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME *(If other than Veteran)* LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II —SOURCE OF INFORMATION

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

8. COMMENTS:

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

SECTION III —CONSENT TO RELEASE INFORMATION

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

9A. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Privacy Act of 1974, 5 U.S.C. 552a, 38 U.S.C. 7332, and the Health Insurance Portability and Accountability Act (HIPAA), implemented by 45 Code of Federal Regulations Parts 160 and 164. Your disclosure of the information requested on this form is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. Further, VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A to release any information that may have been obtained in connection with physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 7A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If I do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

9C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the above source to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism, alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

_____

_____

10A. SIGNATURE OF VETERAN/CLAIMANT	10B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State.)*	10C. DATE

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

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS

OMB Approved 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note –If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual As Claimant's Representative."

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER (Include prefix)

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on reverse side before selecting organization)

3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZED TO ACT ON VETERAN'S BEHALF

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) (Include letter prefix)
6A. SERVICE NUMBER(S)	6B. BRANCH OF SERVICE
7. NAME OF CLAIMANT (If other than veteran)	8. RELATIONSHIP (If other than veteran)
9. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)	10. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)
	A. DAYTIME ( ) / B. EVENING ( )
	11. DATE OF THIS APPOINTMENT

12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I **do not 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 3A 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 above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT ~~M~~y consent in Item 12 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 C.F.R. §20.608. *Additionally, in those cases where a veteran's income is being developed because of an income verification necessitated by an Internal Revenue Service verification match, the assignment of the service organization as the veteran's representative is only valid for five years from the date this form is signed for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

14. SIGNATURE OF CLAIMANT (Do Not Print)	15. DATE SIGNED

VA USE ONLY	VA FORM 21-22-1 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)
	☐ CER FILE ☐ EDU FILE ☐ INSURANCE FILE ☐ CH. 30 ☐ DEA FILE ☐ LG FILE			

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

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 Organizations recognized by the Secretary in the preparation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
American Veterans Committee
AMVETS
American Ex-Prisoners of War, Inc.
American Defenders of Bataan and Corregidor, Inc.
American GI Forum, National Veterans Outreach Program
Army and Navy Union, USA
Army and Air Force Mutual Aid Association
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Eastern Paralyzed Veterans Association
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 Order of the Purple Heart
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Non Commissioned Officers Association of the USA
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization
The Retired Enlisted Association
United Spanish War Veterans of the United States
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Veterans of the Vietnam War, Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America

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

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

PRIVACY ACT INFORMATION: The information requested on this form is solicited under 38 U.S.C. § 5902, which authorizes VA to recognize representatives of certain organizations for the preparation, presentation, and prosecution of claims for VA benefits. We will use the information to recognize the service organization you named to act on your behalf and to identify any VA records which VA may disclose to the service organization under 38 U.S.C. 5701(b). Except for information protected by 38 U.S.C. 7332, the service organization is not prohibited from redisclosing records. Provision of the requested information is voluntary, but your failure to provide us the information could impede the recognition of the service organization as your representative and/or the identification of disclosable records. The Privacy Act authorizes VA to disclose the requested information outside VA for certain routine uses, which have been published in the Federal Register with reference to a VA system of records entitled, "Compensation, Pension, Education, and Rehabilitation Records-VA (58VA21/22). Such routine uses include debt collection, civil or criminal law enforcement, communications with members of Congress or other representatives, benefits delivery, program administration, and personnel administration.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

OMB Approved 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note –If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual As Claimant's Representative."

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER (Include prefix)

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on reverse side before selecting organization)

3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZED TO ACT ON VETERAN'S BEHALF

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) (Include letter prefix)
6A. SERVICE NUMBER(S)	6B. BRANCH OF SERVICE
7. NAME OF CLAIMANT (If other than veteran)	8. RELATIONSHIP (If other than veteran)
9. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)	10. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)
	A. DAYTIME ( ) / B. EVENING ( )
	11. DATE OF THIS APPOINTMENT

12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I **do not 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 3A 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 above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT ~~M~~y consent in Item 12 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 C.F.R. §20.608. *Additionally, in those cases where a veteran's income is being developed because of an income verification necessitated by an Internal Revenue Service verification match, the assignment of the service organization as the veteran's representative is only valid for five years from the date this form is signed for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

14. SIGNATURE OF CLAIMANT (Do Not Print)	15. DATE SIGNED

VA USE ONLY	VA FORM 21-22-1 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)
	☐ CER FILE ☐ EDU FILE ☐ INSURANCE FILE ☐ CH. 30 ☐ DEA FILE ☐ LG FILE			

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

OMB Approved 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note –If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual As Claimant's Representative."

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER (Include prefix)

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on reverse side before selecting organization)

3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZED TO ACT ON VETERAN'S BEHALF

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) (Include letter prefix)
6A. SERVICE NUMBER(S)	6B. BRANCH OF SERVICE
7. NAME OF CLAIMANT (If other than veteran)	8. RELATIONSHIP (If other than veteran)
9. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)	10. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)
	A. DAYTIME ( ) / B. EVENING ( )
	11. DATE OF THIS APPOINTMENT

12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I **do not 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 3A 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 above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT ~~M~~y consent in Item 12 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 C.F.R. §20.608. *Additionally, in those cases where a veteran's income is being developed because of an income verification necessitated by an Internal Revenue Service verification match, the assignment of the service organization as the veteran's representative is only valid for five years from the date this form is signed for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

14. SIGNATURE OF CLAIMANT (Do Not Print)	15. DATE SIGNED

VA USE ONLY	VA FORM 21-22-1 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)
	☐ CER FILE ☐ EDU FILE ☐ INSURANCE FILE ☐ CH. 30 ☐ DEA FILE ☐ LG FILE			

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

Form Approved: OMB No. 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affairs

1. VA FILE NO(S). *(Include prefix)*

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

Note — If you would prefer to have a service organization assist you with your claim, you may use VA Form 21-22, "Appointment of Veterans Service Organization As Claimant's Representative."

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE: The information requested on this form is solicited under 38 U.S.C., Sections 5902 and 5904, which authorize VA to recognize individuals for the preparation, presentation, and prosecution of claims for VA benefits. We will use the information to recognize your claim representative to act on your behalf and to identify any VA records which VA may disclose to the representative under 38 U.S.C., Section 5701(b). Except for information protected by 38 U.S.C., Section 7332, the claim representative is not prohibited from redisclosing records. Provision of the requested information is voluntary, but your failure to provide us the information could impede the recognition of your representative and/or the identification of disclosable records. The Privacy Act authorizes VA to disclose the requested information outside VA for certain routine uses, which have been published in the Federal Register with reference to a VA system of records entitled, "Compensation, Pension, Education, and Rehabilitation Records-VA" (58VA21/22). Such routine uses include debt collection, civil or criminal law enforcement, communications with members of Congress or other representatives, benefits delivery, program administration, and personnel administration.

RESPONDENT BURDEN: VA may not conduct or sponsor, and you are not required to respond to this collection of information unless it displays a valid OMB Control Number. The public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

2. NAME OF CLAIMANT *(Veteran, guardian, beneficiary, dependent, or next of kin)*	3. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*
4. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	5. SERVICE NO(S).

6. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER *(Specify)*

7A. NAME OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE	8. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE *(No. and street or rural route, city or P.O., State, and ZIP code)*
7B. INDIVIDUAL IS *(check appropriate box)* ☐ ATTORNEY ☐ AGENT ☐ ACCREDITED SERVICE ORGANIZATION REPRESENTATIVE *(Specify organization below)*	

9. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 7A any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I authorize the VA facility having custody of my VA claimant records to disclose to the individual named in Item 7A 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 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

10. LIMITATION OF CONSENT. My consent in Item 9 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

CONDITIONS OF APPOINTMENT: I, the claimant named in Item 2, hereby appoint the individual named in Item 7A as my representative to prepare, present, and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 4. I authorize the Department of Veterans Affairs to release any and all of my records *(other than as provided in Items 9 and 10)* to that individual appointed as my representative. Signed and accepted subject to the foregoing conditions.

11. SIGNATURE OF CLAIMANT	12. DATE OF SIGNATURE	13. CLAIMANT'S RELATIONSHIP TO VETERAN *(If other than the veteran)*
14. SIGNATURE OF REPRESENTATIVE		15. DATE OF SIGNATURE

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

Department of Veterans Affairs

GENERAL INSTRUCTIONS
FOR INCOME-NET WORTH AND EMPLOYMENT STATEMENT
VA FORM 21-527

Note: Read very carefully, detach, and keep these instructions for your reference.

A. How can I contact VA if I have questions?

If you have questions about this form, how to fill it out, or about benefits, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government, Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line 1-800-829-4833). You may also contact VA by Internet at http://www.vba.va.gov/benefits/address.htm.

B. What do I use VA Form 21-527 for?

Use VA Form 21-527 to apply for disability pension if you have previously filed a claim for compensation and/or pension. If you have not filed a claim for compensation or pension previously, you must use VA Form 21-526, Veteran's Application for Compensation and/or Pension.

C. What is disability pension and how does VA decide what I will or will not receive?

You should apply for pension benefits if *all* of the following are true:

- Your income is limited.
- You are permanently and totally disabled (but not as a result of your military service).
- At least part of your active duty was during a wartime period.

VA pays disability pension based on the amount of income that the veteran and family receive and the number of dependents in the family. This is based on law. VA must include as income all sources that federal law specifies. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA office.

Benefits may only be paid from the date of receipt of your application in VA unless you were incapacitated because of a disability which prevented you from filing a claim for a period of at least 30 days beginning with the date you became permanently and totally disabled. If you want this claim considered as a claim for retroactive payment, so indicate in Item 42, "Remarks," and identify the specific disability which prevented you from filing.

D. What is special monthly pension?

VA may pay a higher rate of disability pension to a veteran who is blind, a patient in a nursing home, otherwise needs regular aid and attendance, or who is permanently confined to his or her home because of a disability. If you wish to apply for this benefit, check "Yes" for Item 24.

E. What medical evidence should I submit?

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

Note: If you are age 65 or older or determined to be disabled by the Social Security Administration, you do not have to submit medical evidence with your application unless you are claiming special monthly pension.

If you wish to claim special monthly pension and are not in a nursing home, furnish a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, and whether Medicaid covers all or part of your nursing home costs.

If you want help getting existing medical records, you may complete VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). By signing VA Form 21-4142, you authorize any doctors, hospitals, or caregivers that have treated you to release information about your treatment to VA. You do not need to complete this form for any treatment you received at a VA facility. If you need a copy of this form, you may contact VA as shown under Item A, or download the form from our website at http://www.va.gov/vaforms/.

F. How do I complete my application?

Print all answers clearly. If you must write the answers do so very clearly and plainly. If an answer is "none" or "0," write that. Your answer to every question is important to help us complete your claim. If you do not know the answer, write "unknown." For additional space, use Item 42, "Remarks," or attach a separate sheet, indicating the item number to which the answers apply. Make sure you sign and date this application (Items 38 and 39).

G. What do I do when I have completed my application?

When you have completed this application mail it or take it to a VA regional office. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before you mail it.

H. How can I assign someone to act as my representative?

A representative can be an accredited member of an accredited organization or other service organization that the Secretary of Veterans Affairs recognizes, an agent recognized by VA, or a licensed lawyer. Agents and attorneys can charge you for services that you get from them only after the Board of Veterans' Appeals (BVA) gives you their final decision about your application. That means you can use an attorney during any stage of your application for benefits. However, the agent or attorney cannot charge you for services unless you are trying to resolve a dispute with VA after BVA has made a decision about your claim.

If you want to use a representative to help you with your application, contact the nearest VA office. Depending on the type of representative you want to designate, we will send you one of the following forms:

VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, or VA Form 22A, Appointment of Individual as Claimant's Representative. You may also download these forms at http://www.va.gov/vaforms/. If you have already designated a representative, no further action is required on your part.

I. What if I believe that VA has made an error in processing or deciding my benefits?

You can ask for a personal hearing at any time during the processing of your claim. That means you can ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA office and tell them that you want a personal hearing on your case. Someone in the local VA office will arrange a time and a place for your hearing. At this hearing, you can bring witnesses. VA will record whatever you and your witnesses say during the hearing and include it in the official record. VA will furnish the hearing room and officials, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing.

Privacy Act Notice: 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 Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38 USC 5101 (c) (1). 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 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.

Respondent Burden: We need this information to determine eligibility for disability pension under 38 U.S.C. 1502 and 1503. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 60 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.whitehouse.gov/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Department of Veterans Affairs

OMB Approved No. 2900-0002
Respondent Burden: 1 hour

(DO NOT WRITE IN THIS SPACE)

INCOME-NET WORTH AND EMPLOYMENT STATEMENT
VA FORM 21-527

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

SECTION I Tell us about you

1. What is your name?

First Middle Last Suffix (If applicable)

2. What is your Social Security number?

3. What is your VA file number?

4. What is your address?

Street address, Rural Route, or P.O. Box Apt. number

City State ZIP Code Country

5. What are your telephone numbers? (Include Area Code)

Daytime

Evening

6. What is your e-mail address?

SECTION II Tell us about your marriage

NOTE: You should provide a copy of your marriage certificate

7. What is your marital status?

☐ Married ☐ Divorced ☐ Widowed ☐ Never Married

(If you are divorced, widowed or never married skip to Section III)

8. When were you married?

mo day yr

9. Where did you get married? (city/state or country)

10. What is your spouse's name?

First Middle Last

11. When is your spouse's birthday?

mo day yr

12. What is your spouse's Social Security number?

13a. Is your spouse also a veteran?

☐ Yes ☐ No

(If "Yes," answer Item 13b also)

13b. What is your spouse's VA file number (If any)?

14. Do you live with your spouse?

☐ Yes ☐ No *(If "No," answer Items 15 through 17 also. If "Yes" , skip to Section III.)*

15. What is your spouse's address?

Street address, Rural Route, or P.O. Box Apt. number

City State ZIP Code Country

16. Tell us why you are not living with your spouse

17. How much do you contribute monthly to your spouse's support?

$

SECTION III Tell us about any previous marriages

You must furnish complete information about **all** your and your present spouse's previous marriages. If you need additional space, please attach a separate sheet of paper providing the requested information about the marriages.

Your previous marriages

18a. How many times have you been married? _____

18b. Date of Marriage	18c. Place (city/state or country)	18d. To whom married (first, middle initial, last name)	18e. Date marriage ended	18f. Place (city/state or country)	18g. How marriage ended (death, divorce)
mo day yr			mo day yr		
mo day yr			mo day yr		

Your spouse's previous marriages

19a. How many times has your current spouse been married? _____

19b. Date of Marriage	19c. Place (city/state or country)	19d. To whom married (first, middle initial, last name)	19e. Date marriage ended	19f. Place (city/state or country)	19g. How marriage ended (death, divorce)
mo day yr			mo day yr		
mo day yr			mo day yr		

SECTION IV Tell us about your unmarried children

VA recognizes your biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- between 18 and 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 20h) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

If you need additional space, please attach a separate sheet of paper providing the requested information about each child.

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

20. Do you have any dependent children?

☐ Yes ☐ No *(If "No," skip to Section V)*

SECTION IV Tell us about your unmarried children (continued).

20a. Name of child (First, middle initial, Last)	20b. Date and place of birth (City/State or Country)	20c. Social Security Number	20d. Biological	20e. Adopted	20f. Stepchild	20g. 18 - 23 yrs old and in school	20h. Seriously disabled	20i. Child previously married
	mo day yr		☐	☐	☐	☐	☐	☐
	mo day yr		☐	☐	☐	☐	☐	☐
	mo day yr		☐	☐	☐	☐	☐	☐

Tell us about the children listed above who don't live with you.

21a. Name of child (first, middle initial, last)	21b. Child's Complete Address	21c. Name of person the child lives with (if applicable)	21d. Monthly amount you contribute to child's support
			$
			$
			$

SECTION V Tell us about your disability and background

23a. What disability(ies) prevent you from working?

23b. When did the disability(ies) begin?
mo day yr

24. Are you claiming a special monthly pension because you need the regular assistance of another person, are blind, nearly blind, or having severe visual problems, or are housebound?
☐ Yes ☐ No

25a. Are you now, or have you recently been hospitalized or given outpatient or home-based care?
☐ Yes ☐ No *(If "Yes," answer Items 25b and 25c also)*

25b. Tell us the dates of the recent hospitalization or care.
Began
mo day yr
Ended
mo day yr

25c. What is the name and complete mailing address of the facility or doctor?

26a. Are you now employed?
☐ Yes ☐ No *(If "No," answer Item 26b also)*

26b. When did you last work?
mo day yr

26c. Were you self-employed before becoming totally disabled?
☐ Yes ☐ No *(If "Yes," answer Item 26d and 26e also)*

26d. What kind of work did you do?

26e. Are you still self-employed?
☐ Yes ☐ No *(If "Yes," answer Item 26f also)*

26f. What kind of work do you do now?

SECTION V Tell us about your disability and background (continued).

27a. Check the highest year of education you completed:

Grade school:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Over 4

27b. List the other training or experience you have and any certificates that you hold.

SECTION VI Tell us your work history

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

28a. What was the name and address of your employer?	28b. What was your job title?	28c. When did your work begin?	28d. When did your work end?	28e. How many days were lost due to disability?	28f. What were your total annual earnings?
		mo day yr	mo day yr		$
		mo day yr	mo day yr		$
		mo day yr	mo day yr		$

SECTION VII Tell us if you are in a nursing home

To get your claim processed faster, provide a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability and tells us the amount you pay out of pocket for your care.

29a. Are you now in a nursing home?

☐ Yes ☐ No

(If "Yes," answer Item 29b also)

29b. What is the name and complete mailing address of the facility?

29c. Does Medicaid cover all or part of your nursing home costs?

☐ Yes ☐ No

(If "No," answer Item 29d also)

29d. Have you applied for Medicaid?

☐ Yes ☐ No

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

VA cannot pay you pension if your net worth is sizeable. Net worth is the market value of all interest and rights you have in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture. If property is owned jointly by yourself and your spouse, report one-half of the total value held jointly for each of you. You must report net worth for yourself and all persons for whom you are claiming benefits.

For Items 30a through 30f, provide the amounts. If none, write "0" or "None".

Source	Veteran	Spouse	Child(ren)		
			Name: (first, middle initial, last)	Name: (first, middle initial, last)	Name: (first, middle initial, last)
30a. Cash, bank accounts, certificates of deposit (CDs)					
30b. IRAs, Keogh Plans, etc.					
30c. Stocks, bonds, mutual funds					
30d. Value of business assets					
30e. Real property (not your home)					
30f. All other property					

SECTION IX Tell us about the income of you and your dependents

Payments from any source will be counted, unless the law says that they don't need to be counted. Report **all** income, and VA will determine any amount that does not count.

Report the total amounts before you take out deductions for taxes, insurance, etc.
Do not report the same information in both tables.
If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.
If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space.
If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

31. Have you claimed or are you receiving disability benefits from the Social Security Administration (SSA)?

☐ Yes ☐ No

SECTION IX Tell us about the income of you and your dependents (continued).

Monthly Income - Tell us the income you and your dependents receive every month

Sources of recurring monthly income	Veteran	Spouse	Child(ren)		
			Name: (first, middle initial, last)	Name: (first, middle initial, last)	Name: (first, middle initial, last)
32a. Social Security					
32b. U.S. Civil Service					
32c. U.S. Railroad Retirement					
32d. Military Retirement					
32e. Black Lung Benefits					
32f. Supplemental Security Income (SSI)/Public Assistance					
32g. Other income received monthly (Please write source below)					

Expected income for the next 12 months - Tell us about other income for you and your dependents

Sources of income for the next 12 months	Veteran	Spouse	Child(ren)		
			Name: (first, middle initial, last)	Name: (first, middle initial, last)	Name: (first, middle initial, last)
33a. Gross wages and salary					
33b. Total interest and dividends					
33c. Worker's compensation or unemployment compensation					
33d. Other income expected (Please write source below)					

SECTION X

Tell us about medical, legal or other unreimbursed expenses

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid 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 paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. **Do not** include any expenses for which you were reimbursed. If more space is needed attach a separate sheet.

34a. Amount paid by you	34b. Date Paid	34c. Purpose (Doctor's fees, hospital charges, attorney fees, etc.)	34d. Paid to (Name of doctor, hospital, pharmacy, etc.)	34e. Disability or relationship of person for whom expenses paid
$	mo day yr			
$	mo day yr			
$	mo day yr			
$	mo day yr			

SECTION XI

Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All Federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer Items 35-37 to the right.

All Federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 35, 36 and 37 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 35. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

35. Account number (Please check the appropriate box and provide that account number, if applicable)

☐ Checking
☐ Savings
☐ I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

36. Name of financial institution

_____

37. Routing or transit number

_____

SECTION XII Give us your signature

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

I certify and authorize the release of information:
I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

38. Your signature	39. Today's date mo day yr

40a. Signature of witness (If claimant signed above using an "X")	40b. Printed name and address of witness
41a. Signature of witness (If claimant signed above using an "X")	41b. Printed name and address of witness

SECTION XIII

Remarks - Use this space for any additional statements that you would like to make concerning your application.

IMPORTANT

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

42. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form please identify your answer or statement by the part and item number)*

OMB Approved No. 2900-0001
Respondent Burden: 5 Mins.

Department of Veterans Affairs

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

Important Notice About Information Collection: 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. 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.whitehouse.gov/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000

(TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

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

SECTION II - SOURCE OF INFORMATION

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

8. COMMENTS:

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

SECTION III - CONSENT TO RELEASE INFORMATION

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

9A. Privacy Act Notice: 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 Rehabilitation Records - VA, and 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.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 7A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

9C. I (AUTHORIZE) (DO NOT AUTHORIZE) the source shown in Item 7A to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

_____

_____

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)*	10C. DATE

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

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS