# VETERANS ASSISTANCE COMMISSION OF ST. CLAIR COUNTY

## Intake Packet

**CONTENTS**



**USEFUL CONTACT INFORMATION**

- **VA Hotline – Claim Status**
  - 800-827-1000
- **St. Louis VA Medical Center**
  - Main: 314-652-4100
- **St Clair County Assessor's Office**
  - 618-825-2334
- **Defense Finance Accounting Services**
  - 888-332-7411
- **Illinois Department of Veterans Affairs**
  - 800-437-9824
- **Illinois Armed Forces Legal Aid Network**
  - 855-452-3526
- **Veterans Crisis Hotline**
  - 988 Ext 1

**CONTACT US AT:**


**618-277-0040**

**618-277-9626 FAX**

**veterans@co.st-clair.il.us**

**www.vac4scc.org**

**19 Public Square**
**Suite 300**
**Belleville, IL 62220**


VETERANS ASSISTANCE COMMISSION
of
ST. CLAIR COUNTY

## WELCOME TO THE VAC

Thank you for reaching out to us for assistance and congratulations on taking the first step towards acquiring your VA benefits. Our staff of highly trained and accredited Veteran Service Officers are ready to work with you. Whether this is your first time filing a VA compensation claim, or whether you are looking to appeal wrongfully denied benefits.

This packet contains many of the preliminary tasks and documents that need to be completed in order to get a successful start to the VA claims process. Please review the packet carefully, complete the required sections, and start to gather any supporting documentation that may be beneficial for your claim.

LAST REVISION
02/2025

Please complete the Claims Questionnaire Pages 4 – 9 and sign the Signature Page (page 9). The Signature Page will be used as your digital signature for VA forms. Once you are finished with the packet, you can return via email, mail, fax, or drop off at our office.

Office Hours: Monday through Friday (Except Holidays)
8:00 AM to 4:00 PM

**Please return a completed Claims Questionnaire promptly and call to set up an appointment at (618) 277-0040.**

**Please note, incomplete package will delay processing.**

**Once complete, please return this questionnaire to**

Veterans Assistance Commission of St. Clair County
19 Public Square
Suite 300
Belleville, IL 62220

Email: veterans@co.st-clair.il.us
Phone: (618) 277-0040
FAX: (618) 277-9626

# MY TIMELINE

Feel free to use this timeline to check off your progress through the VA claims process

## ① CLAIMS QUESTIONNAIRE

- ☐ Complete and submit the questionnaire
- ☐ Call **618-277-0040** to schedule your first appointment with a VSO after submittal

## ② GATHER DOCUMENTS

- ☐ Prior to your appointment, gather any relevant documentation such as service medical records or private medical records

## ③ FIRST APPOINTMENT

- ☐ After Claims Questionnaire submission
- ☐ Meet with a VSO to discuss service history, medical history, and VA benefits in general
- ☐ You may be tasked with gathering additional evidence to support your claim

## ④ RECORD REVIEW

- ☐ Provide private medical records to your VSO
- ☐ 3 – 6 months
- ☐ Your VSO will thoroughly review any available service medical records or private treatment records, looking for claimable conditions or previous injuries

## ⑤ FINAL APPOINTMENT

- ☐ Before your fully developed claim is submitted, you'll review your claim packet with a VSO one final time to finalize the compiled claim packet

## ⑥ CLAIM SUBMISSION

- ☐ 9 – 12 months
- ☐ With your final approval, the claim packet will be signed and securely transmitted to the VA Regional Office for intake and processing

## ⑦ CHECK STATUS OF CLAIM

- ☐ Call 1-800-827-1000
- ☐ VA.GOV

# CLAIMS QUESTIONNAIRE

## Applicant Information

Veteran Name: _____ DOB: _____
*Last* *First* *M.I.*

SSN: _____ Birthplace: _____

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *Zip Code*

Phone: _____ Email: _____

## Military Service Information

| | YES | NO |
|---|---|---|
| Are you a Vietnam Veteran with service in Vietnam? | ☐ | ☐ |
| Did you serve onboard a ship off the coast of Vietnam during Vietnam War? | ☐ | ☐ |
| Did you serve at Camp Lejeune between August 1, 1953 and December 31, 1987? | ☐ | ☐ |
| Did you serve in Southwest Asia/Middle East after August 2, 1990? | ☐ | ☐ |

Branch of Service: _____ Dates of Service: _____

Type of Discharge? _____

## VA Compensation Status

| | YES | NO |
|---|---|---|
| Have you ever filed a VA compensation claim before? | ☐ | ☐ |

If yes, what is your current overall rating? _____

| | YES | NO |
|---|---|---|
| Do you have your Service Medical Records? | ☐ | ☐ |
| Do you have relevant Private Medical Records? | ☐ | ☐ |

Examples:

- X-rays from your non-VA physician related to the back condition you would like to claim
- Mental health treatment record from your non-VA physician with a diagnosis of PTSD
- Prescription record from your non-VA physician

## Spouse Information (if applicable)

Is Spouse a Veteran? YES ☐ NO ☐

Spouse Name: _____ DOB: _____
*Last* *First* *M.I.*

SSN: _____ Date and Place of Marriage: _____

Address: _____
*Street Address* ***(if different from the Veteran)*** *Apartment/Unit #*

_____
*City* *State* *Zip Code*

Phone: _____ Email: _____

Does spouse have prior marriages? YES ☐ NO ☐ Do you have prior marriages? YES ☐ NO ☐

## Dependent Children Information (if applicable)

Name: _____ DOB: _____

SSN: _____ Birthplace: _____

Address: _____
*Street Address* ***(if different from the Veteran)*** *Apartment/Unit #*

_____
*City* *State* *Zip Code*

**STATUS:** ☐ Biological ☐ Adopted ☐ Stepchild ☐ 18-23 years old in school
*(Check all that apply)* ☐ Severely Disabled ☐ Previously Married

- If stepchild, is the child the spouse's biological child? YES ☐ NO ☐
- Date stepchild became member of Veteran's household? _____

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Name: _____ DOB: _____

SSN: _____ Birthplace: _____

Address: _____
*Street Address* ***(if different from the Veteran)*** *Apartment/Unit #*

_____
*City* *State* *Zip Code*

**STATUS:** ☐ Biological ☐ Adopted ☐ Stepchild ☐ 18-23 years old in school
*(Check all that apply)* ☐ Severely Disabled ☐ Previously Married

- If stepchild, is the child the spouse's biological child? YES ☐ NO ☐
- Date stepchild became member of Veteran's household? _____

Name: _____ DOB: _____

SSN: _____ Birthplace: _____

Address: _____
*Street Address* ***(if different from the Veteran)*** *Apartment/Unit #*

_____
*City* *State* *Zip Code*

**STATUS:** ☐ Biological ☐ Adopted ☐ Stepchild ☐ 18-23 years old in school
*(Check all that apply)* ☐ Severely Disabled ☐ Previously Married

- If stepchild, is the child the spouse's biological child? YES ☐ NO ☐
- Date stepchild became member of Veteran's household? _____

---

Name: _____ DOB: _____

SSN: _____ Birthplace: _____

Address: _____
*Street Address* ***(if different from the Veteran)*** *Apartment/Unit #*

_____
*City* *State* *Zip Code*

**STATUS:** ☐ Biological ☐ Adopted ☐ Stepchild ☐ 18-23 years old in school
*(Check all that apply)* ☐ Severely Disabled ☐ Previously Married

- If stepchild, is the child the spouse's biological child? YES ☐ NO ☐
- Date stepchild became member of Veteran's household? _____

---

Name: _____ DOB: _____

SSN: _____ Birthplace: _____

Address: _____
*Street Address* ***(if different from the Veteran)*** *Apartment/Unit #*

_____
*City* *State* *Zip Code*

**STATUS:** ☐ Biological ☐ Adopted ☐ Stepchild ☐ 18-23 years old in school
*(Check all that apply)* ☐ Severely Disabled ☐ Previously Married

- If stepchild, is the child the spouse's biological child? YES ☐ NO ☐
- Date stepchild became member of Veteran's household? _____

## *DO NOT SKIP THIS SECTION*

**In the space below, please list any medical conditions that you believe to be related to your military service, or other service-connected condition, and how. The VSO will discuss in further detail.**

| Condition | How is it related to service? |
|---|---|
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## Additional Comments

_____

_____

_____

_____

_____

## What is your overall goal, expectations, or purpose for our assistance?

_____

_____

_____

_____

_____

_____

## Final Checklist

| | YES | NO |
|---|---|---|
| Copy of Veteran's DD214 (Member 4 copy)? | ☐ | ☐ |
| Questionnaire Completed? | ☐ | ☐ |
| Signature Page Completed? | ☐ | ☐ |

# SIGNATURE PAGE

**PLEASE SIGN LEGIBLY INSIDE THE BOX BELOW**

With your consent, this signature will be scanned and used as a digital signature for future claim forms or documents that need to be submitted to the VA.

**PRINT NAME:** _____

For VA purposes only

## PLEASE KEEP SIGNATURE WITHIN THE BOX

**HOW DID YOU HEAR ABOUT US?**

- ☐ **Referral**
- ☐ **VA Hospital**
- ☐ **St. Clair County Referral**
- ☐ **Social Media**
- ☐ **VAC4SCC.org Website**
- ☐ **Veteran Service Organization** _____
- ☐ **Other** _____

# TO-DO LIST

Please provide any applicable documents or information listed.

- ☐ **DD 214 – (Member 4)**
  - DD 215 (If applicable)
  - Any discharge paperwork before DD 214's were issued upon discharge
  - Discharge documents from Reserve or National Guard
    - Line of Duty documents for claimed conditions (If applicable)
  - If you have multiple DD 214's from reenlistments or breaks in service, bring in copies

- ☐ **Marriage Certificate** (If applicable)

- ☐ **Birth Certificate**
  - Dependent's & Stepchildren Birth Certificate

- ☐ **Divorce Decree** (If Applicable)
  - Prior marriage and divorce information for Veteran and spouse if applicable
    - To include marriage date, city/state of marriage, divorce date, city/state ofdivorce for each prior marriage

- ☐ **Death Certificate** (If applicable)

- ☐ **Banking information – please include copy of a voided check** ***(used for direct deposit, may provide later)***

- ☐ **Service Medical Records**
  - Review your records and identify and separate any medical records related to the conditions that your claiming. If you have multiple medical records detailing treatment ordiagnosis of the condition, injury, or illness, group the documents together in chronological order.
  - If you don't have your service medical records you can order them online from theNational Personnel Records Center (NPRC)/website: vetrecs.archives.gov

- ☐ **Civilian Medical Records**
  - Another option; Veteran obtains the problem list, medication list, surgical history, labs, x-ray reports, and MRI's from any private primary care provider, specialists, alternative treatments (chiropractor, massage therapist, acupuncturist, etc). Ensure that they are relevant to your claimed conditions
  - Ensure you have your private provider **name, address, treatment dates from start tofinish** for any condition you want to submit a claim for

☐ **VA Medical Records**

- Request and review your VA medical records and identify and separate any medical records related to the conditions that your claiming. If you have multiple medical recordsdetailing treatment or diagnosis of the condition, injury, or illness, group the documents together in chronological order.
- Include Problem list, medication list, diagnosis history, labs, x-rays and surgeries

☐ **Lay statements in Support of Claim**

- Ensure that statements are relevant and helpful to your claimed condition.
- Ensure that statements include the following phrase at the end:
  - *"I certify that the statements on this form are true and correct to the best of myknowledge and belief."*
- Ensure that statements are signed and dated by the author.
  - Personal statement
    - Include duty station
    - Deployments
    - Locations
    - Unit assigned
    - Awards received (If applicable)
    - Triggers (If applicable)
    - Describe overall picture of what is going on
  - Spousal statement
    - Elaborate on what their observations/experiences are regarding theVeterans claimed conditions
  - Buddy statement
    - Elaborate on what their observations/experiences are regarding theVeterans claimed conditions

# VA PRESUMPTIVE CONDITIONS

VA presumes that specific disabilities diagnosed in certain veterans were caused by their military service. VA does this because of the unique circumstances of their military service. If one of these conditions is diagnosed in a Veteran in one of these groups, VA presumes that the circumstances of his/her service caused the condition, and disability compensationcan be awarded.

**Gulf War/Southwest Asia/Burn Pit Veterans**

**Presumptive Conditions:**

- Asthma that was diagnosed after service
- Chronic Bronchitis
- Chronic Fatigue Syndrome
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Rhinitis
- Chronic Sinusitis
- Constrictive Bronchiolitis or Obliterative Bronchiolitis
- Emphysema
- Fibromyalgia
- Granulomatous Disease
- Interstitial Lung Disease (ILD)
- Irritable Bowel Syndrome
- Pleuritis
- Pulmonary Fibrosis
- Sarcoidosis

**These Cancers are now Presumptive:**

- Brain Cancer
- Gastrointestinal Cancer of any type
- Glioblastoma
- Head Cancer of any type
- Kidney Cancer
- Lymphatic Cancer of any type
- Lymphoma of any type
- Melanoma
- Neck Cancer
- Pancreatic Cancer
- Reproductive Cancer of any type
- Male Breast Cancer
- Respiratory (Breathing-related) Cancer of any type
- Urethral Cancer
- Cancer of the paraurethral glands

**Medically Unexplained Chronic Multi-Symptom Illnesses that exist for six months or more, such as:**

- Cardiovascular Symptoms
- Fatigue
- GI Symptoms
- Headaches
- Joint Pain
- Menstrual Disorders
- Muscle Pain
- Neurological Symptoms
- Skin Symptoms
- Sleep Disturbance
- Weight Loss

# VA PRESUMPTIVE CONDITIONS

VA presumes that specific disabilities diagnosed in certain veterans were caused by their military service. VA does this because of the unique circumstances of their military service. If one of these conditions is diagnosed in a Veteran in one of these groups, VA presumes that the circumstances of his/her service caused the condition, and disability compensationcan be awarded.

| Former Prisoners of War | Agent Orange (AO) Exposure | Camp Lejeune Contaminated Water |
|---|---|---|
| **Imprisoned for any length of time.**<br><br>- Any of the Anxiety States<br>- Dysthymic Disorder<br>- Heart Disease or Hypertensive Vascular Disease and their Complications<br>- Organic Residuals of Frostbite<br>- Post Traumatic Osteoarthritis<br>- Psychosis<br>- Stroke and its Residuals<br><br>**Imprisoned for at least 30 days.**<br><br>- Avitaminosis<br>- Beriberi<br>- Chronic Dysentery<br>- Cirrhosis of the Liver<br>- Helminthiasis<br>- Irritable Bowel Syndrome<br>- Malnutrition<br>- Any other Nutritional Deficiency<br>- Pellagra<br>- Peptic Ulcer Disease<br>- Peripheral Neuropathy | - Acute and Subacute Peripheral Neuropathy<br>- AL Amyloidosis<br>- B-Cell Leukemias<br>- Chloracne or other Acne Form Disease<br>- Bladder Cancer<br>- Chronic LymphocyticLeukemia<br>- Diabetes Type II<br>- Hodgkin's Disease<br>- Ischemic HeartDisease<br>- High Blood Pressure (also called Hypertension)<br>- Hypothyroidism<br>- Monoclonal Gammopathy of Undetermined Significance (MGUS)<br>- Multiple Myeloma<br>- Non-Hodgkin'sLymphoma<br>- Parkinson'sDisease<br>- Porphyria Cutanea Tarda<br>- Prostate Cancer<br>- RespiratoryCancers<br>- Soft TissueSarcoma<br>- Parkinson's-Like Symptoms<br><br>**Veterans may have been exposed if they served in:**<br><br>* Vietnam to include Blue Water Navy (1/9/1962 – 5/7/1975)<br>* Korean DMZ (9/1/1967 – 8/31/1971)<br>* Thai Air Force bases (1/9/1962 – 6/30/1976)<br>* Laos (12/1/1965 – 9/30/1969)<br>* Cambodia at Mimot or Krek (4/16/1969 – 4/30/1969)<br>* Guam or American Samoa & territorial waters (1/9/1962 – 7/30/1980)<br>* Johnson Atoll (1/1/1972 – 9/30/1977)<br>* C-123 aircraft (1969 – 1986)<br>* Limited US military CONUS installations | **Served at Camp Lejeune or MCAS New River for at least 30 cumulative days from August 1953 through December 1987.**<br><br>- Adult Leukemia<br>- Aplastic Anemia and other Myelodysplastic Syndromes<br>- Bladder Cancer<br>- Kidney Cancer<br>- Liver Cancer<br>- Multiple Myeloma<br>- Non-Hodgkin's Lymphoma<br>- Parkinson's Disease |

# EXPLANATION OF FORMS

**PLEASE NOTE:** The following forms are **samples only**. These forms will be completed on your behalf by the VACLC staff.

**VA FORM 21-22**
The VA Form 21-22 will appoint us as your representatives for VA claims and appeals. Additionally, it will grant us access to your VA file so that we can review historical claims and evidence. Samples have been included so that you can review the forms to which your digital signature will be applied.

**VA FORM 21-0966**
The VA Form 21-0966 establish the earliest possible effective date for benefits and will entitle you to a lump sum retroactive payment if your claim is approved. Samples have been included so that you can review the forms to which your digital signature will be applied.

For example, if this form is filed in July of 2021, and your claim is approved in June 2022, you will be entitled to retroactive pay going back to July 2021.

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

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

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

## SECTION I: VETERAN'S INFORMATION

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

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

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

3. VA FILE NUMBER *(If applicable)*

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

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

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

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Co

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



## SECTION II: CLAIMANT'S INFORMATION (Complete this section if claimant is other than veteran)

10. CLAIMANT'S NAME *(First, M*

11. CLAIMANT'S MAILING ADDRE *, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

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

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

14. RELATIONSHIP TO VETERAN

## SECTION III: SERVICE ORGANIZATION INFORMATION

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

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

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

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

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

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

## SECTION IV: AUTHORIZATION INFORMATION

**19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.** - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

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

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

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

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

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service [illegible]15 as my representative to prepare, present and prosecute my claim(s) for any and all benef[illegible]Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to r[illegible]isclosure of my Federal tax information (other than as provided in Items [illegible] I understand that my appointed representative will not charge any fe[illegible]s appointment. I understand that the service organization I have appo[illegible]nt at any time, subject to 38 CFR 20.6. *Additionally, in some case[illegible]ch with the Internal Revenue Service necessitated income verific[illegible]rganization as the veteran's representative is valid for only five years fro[illegible]poses restricted to the verification match.* Signed and accepted subject to the forego[illegible]



## [illegible]N V: SIGNATURES

**NOTE: THIS POWER O[illegible] DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC**

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

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

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

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

OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

**Department of Veterans Affairs**

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

# INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

**(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)**

**NOTE**: Please read the Privacy Act and Respondent Burden below before completing the form.

## SECTION I: CLAIMANT/VETERAN IDENTIFICATION

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

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

2. CLAIMANT'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

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

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***

6. VETERAN'S SOCIAL SECURITY NUMBER

7. VETERAN'S SEX ☐ MALE ☐ FEMALE

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

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Co

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO

11.TELEPHONE NUMBER *(I*

ESS *(If applicable)*



***IMPORTANT:*** *VA may not be able to use thi*

*e or more of the general benefits listed below.*

**13. I intend to file for the general**

☐ **COMPENSATION** ☐

**NOTE: Only check the box belo**

☐ **SURVIVORS PENSION AND/**

**NSATION (DIC)**

**IMPORTANT**: After receiving this fo priate application to file for the general benefit you select above. You can also apply for VA disability compensation online at ve VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will ied as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after yo orm will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this for or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

## SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE

14B. DATE SIGNED *(MM,DD,YYYY)*

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*

(**NOTE**: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

**PRIVACY ACT NOTICE**: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. 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 the appropriate application and provide it to the claimant.

**RESPONDENT BURDEN**: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM AUG 2018 **21-0966** SUPERSEDES VA FORM 21-0966, MAR 2017.