Department of
Veterans Services

VA Forms Update

Appeals and Accreditation| 03/08/2023

Welcome

WebEx Orientation

Connection options Computer/phone

Camera

Microphone (mute)

Chat box for questions

Unmute and state your name and organization

Certificate of Attendance

Mark Your Calendars

- **2023 Spring Regional Conferences (In-Person)**
  - Region 1 – Thursday, April 13th
  - Region 2 – Tuesday, April 11th
  - Region 3 – Monday, April 17th
  - Region 4 – Thursday, April 20th

- **April 2023 New Service Officer Accreditation Course**
  - April 24-28 Regional Training Institute, Smyrna

- **May 2023 Lunch and Learn: TN State Parks and TN Dept. of Transportation Veteran Programs, May 10th, 11:30 am to 12:30 pm CT**

TDVS Town Hall

Panelist:

- Commissioner Baker, TDVS
- A/C Murphy, TDVS Appeals
- A/C Wills, TDVS Benefits OPS
- Director Ducker, VA TVHS Director
- Charles L. Moore, Jr. VA Executive Director Nashville Regional Office
- Jeff Dent, Tennessee Work Force Development

Agenda

- **PACT Act Updates**
- **New Forms**
- **Updated Forms**
- **Lessons Learned/Best Practices**
- **Open Discussion/Questions**

PACT Act

The Honoring our Pact Act of 2022 or PACT Act is being hailed as the largest expansion of care and benefits in VA history.

Here's how it expands care and benefits:

- Expands and extends eligibility for VA health care for Veterans with toxic exposures and Veterans of the Vietnam, Gulf War, and post-9/11 eras.
- Adds more than 20 new presumptive conditions for burn pits and other toxic exposures.
- Adds more presumptive-exposure locations for Agent Orange and radiation.
- Requires VA to provide a toxic exposure screening to every Veteran enrolled in VA health care.

- Honoring Our PACT Act Toolbox

PACT Act

Honoring Our PACT Act Toolbox

The PACT Act is a new law that expands VA health care and benefits for Veterans exposed to burn pits and other toxic substances. This law helps provide generations of Veterans — and their survivors — with the care and benefits they've earned and deserve. VA has considered all the presumptive conditions established by the PACT Act presumptive on the date the bill became law – August 10, 2022. Veterans and their families are already asking you for advice on whether and how this legislation impacts them. Hope this page provides you a one stop shop for the PACT Act. Any recommendations to this page, please contact Ron Dvorsky - TDVS Training Director @ ronald.dvorsky@tn.gov

- Public Law 117-168 (8/10/2022) – Honoring our PACT Act of 2022
- The PACT Act and your VA benefits
- Improvements to Airborne Hazards and Open Burn Pit Registry Since 2014, VA's Airborne Hazards and Open Burn Pit Registry has been an important tool for recent Veterans and service members to record their airborne hazard exposures and related health conditions, with an optional examination with a health care provider to learn more. VA is making the registry more user-friendly and ensuring that Veterans have the option to have an in-person health exam.
- **PACT Act-Weekly Report (02/04/2023)**: Since the PACT Act was signed, Veterans and their survivors have filed more than 1,008,484 total claims—an increase of more than 23.8% over the same period last year. And to date, VA has already received more than 294,920 PACT Act-related claims since August 10. This increase in receipts has resulted in a net increase of over 139,877 rating claims in VBA's total inventory during that same time period.
- 294,920 PACT related claims received since August 10, 2022
- 249,726 PACT related claims pending
- 110,815 PACT related claims completed since August 10, 2022, to include claims completed before January 1, 2023, under existing regulatory guidance (example: asthma/sinusitis/rhinitis presumptives, direct grants)
- On December 12, 2022, VBA began granting benefits for terminally ill Veterans in cases where service connection for a PACT Act presumptive condition can be established. Since August 10, 2022, VA has completed 1,985 claims for terminally ill Veterans, 1,259 of which were granted.
- Since January 1, 2023, VA has completed 53,096 claims for all Veterans/Survivors, to include terminally ill Veterans, 45,137 of which were granted
- **December 22, 2022** - VA Guidance Processing Claims Involving Public Law 117-168 (PACT Act) Claims processors in ROs must apply this guidance when processing disability compensation claims and appeals for Veterans and survivors impacted by the PACT Act

> PACT Act TDVS Fact Sheet

> NVLSP PACT Act Resources

> PACT Act VA Fact Sheet

> Job Aids

> TDVS Benefits Bulletins

> Press Releases

> Outreach

PACT Act

Since the PACT Act was signed, Veterans and their survivors have filed more than 1,008,484 total claims—an increase of more than 23.8% over the same period last year. And to date, VA has already received more than 294,920 PACT Act – related claims since August 10. This increase in receipts has resulted in a net increase of over 139,877 rating claims in VBA's total inventory during that same time period.

- 294,920 PACT related claims received since August 10, 2022
- 249,726 PACT related claims pending
- 110,815 PACT related claims completed since August 10, 2022, to include claims completed before January 1, 2023, under existing regulatory guidance (example: asthma/sinusitis/rhinitis presumptive, direct grants)

On December 12, 2022, VBA began granting benefits for terminally ill Veterans in cases where service connection for a PACT Act presumptive condition can be established.

Since August 10, 2022, VA has completed 1,985 claims for terminally Ill Veterans, 1,259 of which were granted since January 1, 2023, VA has completed 53,096 claims for all Veterans / Survivors, to include terminally ill Veterans, 45,137 of which were granted.

Overview

The Veterans Benefits Administration (VBA) is an agency within the Department of Veterans Affairs (VA) that is responsible for providing financial and other forms to assist veterans and their dependents when applying for VA disability benefits. It has been making continuous improvements to the claims processes to help veterans and their families receive the benefits to which they are entitled in a more timely and efficient manner.

As part of these improvement efforts, VBA is standardizing current VA forms and creating new forms. VA aims to make it easier for veterans to communicate their intentions or submit supporting statements by providing more specific forms for different types of requests. Specifically, VA has introduced five new forms and updated dozens of forms which we will discuss a few of those that we use often.

New Forms

Until now, VA Form 21-4138, Statement in Support of Claim was the only form veterans could use to submit a variety of statements or make certain requests. In order to address the gap in forms, VBA has created five new forms to be used in lieu of VA Form 21-4138. These new forms will be tailored to specific requests, and will make it easier for veterans to communicate with VA.

Additionally, the new forms will help VA to expedite the claims process. The creation of these forms will allow for greater use of computerized optical character recognition, or the automated processes by which VA computers read, organize, and store information provided by veterans. Updating forms so that they can be processed automatically allows VA to process claims more quickly, meaning veterans will get their benefits faster.

New Forms

- VA Form 20-10206 – FOIA/Privacy Act Request
- VA Form 20-10207 – Priority Processing Request
- VA Form 20-10208 – Document Evidence Submission
- VA Form 21-10210 – Lay/Witness Statement
- VA Form 28-10212 – Chapter 31 Request for Assistance

VA Form 20-10206 – FOIA/Privacy Act Request

SECTION III: RECORDS YOU ARE SEEKING
(This information is required in order to complete the request)

17. SELECT THE TYPE(S) OF RECORDS YOU ARE REQUESTING, BELOW:

- ☐ CLAIMS FILE (C-FILE)
- ☐ SERVICE TREATMENT RECORDS / MILITARY TREATMENT RECORDS
- ☐ VOCATIONAL REHABILITATION AND EMPLOYMENT RECORDS
- ☐ PENSION BENEFIT DOCUMENTS
- ☐ DD FORM 214
- ☐ LIFE INSURANCE RECORDS
- ☐ FIDUCIARY SERVICES RECORDS
- ☐ EDUCATION BENEFIT RECORDS
- ☐ HUMAN RESOURCE RECORDS
- ☐ HOME LOAN BENEFIT RECORDS
- ☐ MILITARY TO CIVILIAN TRANSITION (TAP) DOCUMENTS
- ☐ FINANCIAL RECORDS
- ☐ LIFE INSURANCE BENEFIT RECORDS (If applicable, enter policy number in Section IV, Item 18, Remarks)
- ☐ DISABILITY EXAMINATIONS (C & P EXAMS) (If applicable enter date of exam in Section IV, Item 18, Remarks)

☐ OTHER (Specify)

SECTION IV: REMARKS

18. REMARKS (If any)

VA Form 20-10206 – FOIA/Privacy Act Request

SECTION V: WILLINGNESS TO PAY FEES

19. **IMPORTANT**: For the purpose of fees only, FOIA divides requesters into three categories: (1) commercial requesters may be charged fees for searching for records, reviewing the records, and photocopying them; (2) educational, non-commercial scientific institutions, and representatives of the news media are charged for photocopying after the first 100 pages; (3) all other requesters (requesters who do not fall into any of the other two categories) are charged for photocopying after the first 100 pages and for time spent searching for records in excess of two hours. VA charges $0.15 per single-sided page for photocopying. Actual costs are charged for a format other than paper copies.

An agency may grant fee waivers if the requester successfully demonstrates that the disclosure of information is in the publics interest because it is likely to contribute significantly to the public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

☐ **I AM WILLING** TO PAY THE APPLICABLE FEES UP TO THE AMOUNT OF $ ______ .00

☐ IF YOU BELIEVE YOU ARE ENTITLED TO A FEE WAIVER OR EXPEDITED PROCESSING, INDICATE HERE:

SECTION VI: REQUESTER CERTIFICATION AND SIGNATURE

I CERTIFY THAT I have completed this FOIA/PA request and declare it is true and correct to the best of my knowledge and belief.

20A. REQUESTER'S SIGNATURE (REQUIRED)	20B. DATE SIGNED
Choose File No file chosen	Month Day Year 03/08/2023

SECTION VII: THIRD-PARTY CERTIFICATION AND SIGNATURE
(Valid only if Section II has been completed and requester has an authorized third party)

I CERTIFY THAT the requester has authorized me as the undersigned representative and certifies that the truth and completion of the information contained in this document is to the best of the requesters knowledge and belief.
NOTE: A third-party signature will not be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third Party* is of record or completed and attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

21A. THIRD-PARTY SIGNATURE	21B. DATE SIGNED
Choose File No file chosen	Month Day Year 03/08/2023

SECTION VIII: POWER OF ATTORNEY (POA) CERTIFICATION AND SIGNATURE
(Valid only if Section II has been completed and requester has authorized POA representation)

I CERTIFY THAT the requester has authorized me as the undersigned representative and certifies the truth and completion of the information contained in this document to the best of the requesters knowledge and belief.
NOTE: A POA's signature ***will not*** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative* or VA Form 21-22a, *Appointment of Individual as Claimant's Representative* is of record or attached to this request.

22A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE)	22B. DATE SIGNED
Choose File No file chosen	Month Day Year 03/08/2023

VA Form 20-10207 – Priority Processing Request

SECTION III - REASON(S) FOR REQUEST
(This information is required in order to complete your request)

16. HOMELESS INFORMATION (Check all that apply)

16A. ARE YOU CURRENTLY HOMELESS?
☐ YES (If "YES," complete item 16B regarding your living situation)
☐ NO (If "NO," skip to item 16C)

16B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION
☐ LIVING IN A HOMELESS SHELTER
☐ STAYING WITH ANOTHER PERSON
☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g. living in a car or tent)
☐ 16A. ARE YOU CURRENTLY HOMELESS? Radio button. YES
☐ OTHER (Specify)

VA FORM OCT 2020 **20-10207** **PAGE 3**

VETERAN'S SSN 789-56-1234

16C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?
☐ YES (If "YES," complete item 16D regarding your living situation)
☐ NO (If "NO," skip to item 17)

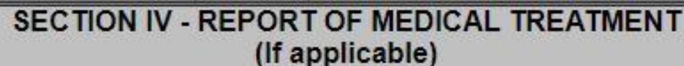
16D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION
☐ HOUSING WILL BE LOST IN 30 DAYS
☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE IN 30 DAYS OR LESS (e.g. homeless shelter)
☐ OTHER (Specify)

17. OTHER REASON(S)/CIRCUMSTANCES FOR REQUEST (Check all that apply)

☐ EXPERIENCING EXTREME FINANCIAL HARDSHIP
☐ TERMINALLY ILL
☐ MEDAL OF HONOR/PURPLE HEART RECIPIENT
☐ DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS) ALSO KNOWN AS LOU GEHRIG'S DISEASE
☐ 85 YEARS OF AGE OR OLDER
☐ VERY SERIOUSLY INJURED/ILL OR SERIOUSLY ILL/INJURED (VSI/SI) DURING MILITARY SERVICE
☐ FORMER PRISONER OF WAR (Provide date(s) of confinement) (MM-DD-YYYY)

FROM	mm/dd/yyyy	TO	mm/dd/yyyy
FROM	mm/dd/yyyy	TO	mm/dd/yyyy

VA Form 20-10207 – Priority Processing Request



SECTION IV - REPORT OF MEDICAL TREATMENT
(If applicable)

18. LIST VA MEDICAL CENTERS (VAMC), DEPARTMENT OF DEFENSE (DoD) MILITARY TREATMENT FACILITIES (MTF), OR PRIVATE MEDICAL FACILITIES WHERE YOU WERE TREATED FOR THE CIRCUMSTANCE YOU IDENTIFIED IN ITEM 17 AND PROVIDE APPROXIMATE BEGINNING DATE OF TREATMENT:

NAME/LOCATION OF TREATMENT FACILITY	DATE OF TREATMENT (MM-DD-YYYY)
Name of Treatment Facility City: City State/Province: State Country:	mm/dd/yyyy
NAME/LOCATION OF TREATMENT FACILITY Name of Treatment Facility City: City State/Province: State Country:	DATE OF TREATMENT (MM-DD-YYYY) mm/dd/yyyy

VA Form 20-10207 – Priority Processing Request

SECTION V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT I have completed this form and it is true and correct to the best of my knowledge and belief.

18A.SIGNATURE OF REQUESTER ***(Required)***	18B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	03/08/2023

SECTION VI - THIRD PARTY SIGNATURE
(Only required if requester has an authorized third party)

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

NOTE: A third-party signature ***will not*** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, is of record or attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

19A. THIRD-PARTY SIGNATURE ***(Required)***	19B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	03/08/2023

SECTION VII - POWER OF ATTORNEY (POA) SIGNATURE
(Required only if requester has an authorized POA representation)

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual as Claimant's Representative*, is of record or attached to this request.

20A. POWER OF ATTORNEY (POA) SIGNATURE ***(Required)***	20B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	03/08/2023

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

VA Form 20-10208 – Document Evidence Submission

SECTION III: DOCUMENT/EVIDENCE TYPE YOU ARE SUBMITTING

15. IS THIS FORM BEING SUBMITTED IN RESPONSE TO A REQUEST YOU RECEIVED FROM VA?

☐ YES ☐ NO

VA FORM OCT 2020 **20-10208** SUPERSEDES VA FORM 20-10208, APR 2020. PAGE 1

SOCIAL SECURITY NUMBER **789-56-1234**

16. IDENTIFY THE DOCUMENT(S) OR EVIDENCE YOU ARE SUBMITTING TO SUPPORT YOUR ESTABLISHED CLAIM.

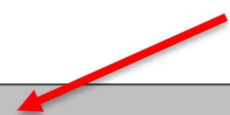
NOTE: You may select one or more type(s), depending on the type of documentation/evidence being provided with this form.

☐ BIRTH CERTIFICATE	☐ DEATH CERTIFICATE
☐ DEPENDENCY INFORMATION	☐ DIVORCE DECREE
☐ FINANCIAL INFORMATION	☐ MARRIAGE CERTIFICATE
☐ MEDICAL TREATMENT RECORDS	☐ COURT PAPERS/DOCUMENTS
☐ MILITARY PERSONNEL RECORDS	☐ SERVICE TREATMENT RECORDS

☐ LAY STATEMENT (Describe)

☐ OTHER (Describe)

VA Form 20-10208 – Document Evidence Submission



SECTION IV: CERTIFICATION AND SIGNATURE

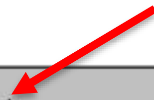
I CERTIFY THAT I have filled this form out completely and that it is true and correct to the best of my knowledge and belief.

17A. VETERAN/CLAIMANT'S SIGNATURE (REQUIRED)	17B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	03/08/2023

SECTION V: THIRD-PARTY SIGNATURE
(Valid only if requester has an authorized third-party)

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge. **NOTE**: A third-party signature ***will not*** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, is of record or attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

18A. THIRD-PARTY SIGNATURE	18B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	03/08/2023



SECTION VI: POWER OF ATTORNEY (POA) SIGNATURE
(Valid only if requester has an authorized POA representation)

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of veteran/claimant's knowledge.

NOTE: A POA's signature will not be accepted unless a valid VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, or VA Form 21-22a, Appointment of Individual as Claimant's Representative, is of record or attached to this request.

19A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	19B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	03/08/2023

VA Form 21-10210 – Lay/Witness Statement

SECTION III: STATEMENT **(Use this section to submit your statement, or a statement from someone else writing on your behalf)**
NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.
17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

VA Form 21-10210 – Lay/Witness Statement

SECTION IV: WITNESS CONTACT INFORMATION
(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME (First, Middle Initial, Last)
First | MI | Last

19. RELATIONSHIP TO VETERAN (Check all that apply)
☐ SERVED WITH CLAIMANT ☐ FAMILY/FRIEND OF CLAIMANT ☐ COWORKER/SUPERVISOR OF CLAIMANT
☐ OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)
Enter International Phone Number (If applicable)

21. E-MAIL ADDRESS

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***
Choose File No file chosen

22B. DATE SIGNED
Month Day Year
03/08/2023

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 fraudulent receipt of any document to which you are not entitled.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records-VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: This form is used to submit a statement that supports a claim already pending or already established with VA. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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 28-10212 – Chapter 31 Request for Assistance

5. E-MAIL ADDRESS

micky.mouse@dw.com

☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II: ASSISTANCE YOU ARE REQUESTING
(IMPORTANT: Sections II and III must be completed in order to process your request)

6. SELECT THE ASSISTANCE YOU ARE REQUESTING, BELOW:

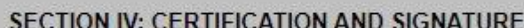
- ☐ WITHDRAW MY APPLICATION FOR CHAPTER 31 BENEFITS
- ☐ REQUEST FOR A REVOLVING FUND LOAN
- ☐ REQUEST FOR REIMBURSEMENT
- ☐ MITIGATING CIRCUMSTANCES FOR REDUCTION OR COMPLETE WITHDRAWAL FROM TRAINING
- ☐ OTHER (Specify)
- ☐ REQUEST TO DISCONTINUE MY CHAPTER 31 PROGRAM AND CLOSE MY CASE
- ☐ REQUEST FOR SUPPLIES OR EQUIPMENT TO PARTICIPATE IN MY REHABILITATION PROGRAM
- ☐ DISCUSS AN ISSUE/CONCERN REGARDING MY REHABILITATION SERVICES

VA FORM FEB 2021 **28-10212** PAGE 1

SECTION III: ADDITIONAL INFORMATION NEEDED TO PROCESS REQUEST
(Use this section to describe and explain the reason for the requested assistance)

7. REMARKS

VA Form 28-10212 – Chapter 31 Request for Assistance



SECTION IV: CERTIFICATION AND SIGNATURE

I CERTIFY THAT I have filled this form out completely and that it is true and correct to the best of my knowledge and belief.

8A.SIGNATURE OF CLAIMANT ***(REQUIRED)*** (Note: During COVID-19 ink and electronic signatures are accepted)	8B. DATE SIGNED (MM-DD-YYYY)
Choose File No file chosen	Month Day Year 03/08/2023

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: This form is used to submit a request for assistance by a Chapter 31 claimant. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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
FEB 2021 **28-10212** PAGE 1

Updated Forms

- **VA Form 21-526 EZ Application for Disability Compensation and Related Compensation Benefits** (Updated November 2022)

- **VA Form 21P-534EZ Application for DIC, Survivors Pension, and/or Accrued Benefits** (Updated July 2022)

- **VA Form 21P-527EZ Application for Veterans Pension** (Updated February 2023)

- **10-10EZ Instructions and Enrollment Application for Health Benefits** (Updated February 2023)

Disclaimer-There are many more forms that were updated with slight changes. We will address those that affect a veteran or claimant. Some of the changes that the VA makes to their forms are delayed in VeteraSpec. The VA M21-1 Adjudication Procedures Manual has not caught up to theses changes.

Expired Forms

Logged in: Ronald Dvorsky JR (rwdvorsky) | Logout

FORMS | CALENDAR | MY TASKS | GENERAL CONTACT LOG

NDENTS | COMMUNICATION | RECORDS | FINANCIALS | PACKAGE A CLAIM | MY VETS | DIRECT SUBMIT

DOB: | VA CLAIM #: | POA: Tennessee Department of Veterans Services

RMS

TDVS
TDVS
TDVS
TDVS
VBA
PMC
NCA
VBA
VBA
VBA
VBA
VBA
VBA
VHA
VHA

Forms printed for this veteran
(opens in a new window)

FORM #	DATE PRINTED	ACTION		
5103	Jan. 25, 2023	Edit	Print	X
21686c	Jan. 25, 2023	Edit	Print	X
214142a	Jan. 25, 2023	Edit	Print	X
214142	Jan. 25, 2023	Edit	Print	X
21526ez	Jan. 25, 2023	Edit	Print	X
210966	Jan. 25, 2023	Edit	Print	X
2122	Jan. 25, 2023	Edit	Print	X
21p530ez_112021	Oct. 21, 2022		Print	X
214142	Oct. 19, 2022	Edit	Print	X
214142a	Oct. 19, 2022	Edit	Print	X
214142	Oct. 19, 2022	Edit	Print	X
21686c_092018	Oct. 19, 2022		Print	X
21526ez_092019	Oct. 19, 2022		Print	X
2122	Oct. 19, 2022	Edit	Print	X
210966	Oct. 18, 2022	Edit	Print	X
210966	Oct. 18, 2022	Edit	Print	X
2122	Oct. 18, 2022	Edit	Print	X
21686c_092018	Jul. 27, 2022		Print	X
21526ez_092019	Jul. 27, 2022		Print	X
210966	Jul. 27, 2022	Edit	Print	X
2122	Jul. 27, 2022	Edit	Print	X

VA Form 21-526 EZ

SECTION IV: EXPOSURE INFORMATION

15A. ARE YOU CLAIMING ANY CONDITIONS RELATED TO TOXIC EXPOSURES? **NOTE**: See Page 4 of the Instructions for further information on the evidence needed to support your claim for presumptive service connection. (You can also refer to the following websites for more information: PACT ACT (https://www.va.gov/PACT) and PUBLIC HEALTH MILITARY EXPOSURES (https://www.publichealth.va.gov/exposures/index.asp))

☐ YES (If "Yes," complete Items 15B, 15C, 15D and 15E) ☐ NO (If "No," skip to Item 16, Section V: Claim Information)

15B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?
Iraq; Kuwait; Saudi Arabia; the neutral zone between Iraq and Saudi Arabia; Bahrain; Qatar; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan; Israel; Egypt; Turkey; Syria; Jordan; Djibouti; Uzbekistan; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; and the Red Sea.

☐ YES ☐ NO

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

FROM: Month Year TO: Month Year

15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCATIONS?
Republic of Vietnam to include the 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a C-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves).

☐ YES ☐ NO

Please list other location(s) where you served, if not listed above:

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

FROM: Month Year TO: Month Year

15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply)

☐ ASBESTOS ☐ MUSTARD GAS ☐ RADIATION
☐ SHAD (Shipboard Hazard and Defense) ☐ MILITARY OCCUPATIONAL SPECIALTY (MOS)-related toxin ☐ CONTAMINATED WATER AT CAMP LEJEUNE
☐ OTHER (Specify)

WHEN WERE YOU EXPOSED? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

FROM: Month Year TO: Month Year

15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATES AND LOCATIONS OF POTENTIAL EXPOSURE

VA Form 21-526 EZ

Presumptive Service Connection

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

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

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

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

VA Form 21-526 EZ

VIII.iii.9.A.1.a. Exposure to Environmental and Military Occupational Hazards	Veterans may have been exposed to a variety of environmental and occupational hazards during their military service. Exposure events can be claimed either based on service in a specific location, as discussed in **M21-1, Part VIII, Subpart iii, 9.A.1.b**, or based on occupational duties and responsibilities. ***Important***: When the Department of Veterans Affairs (VA) does not recognize presumption of exposure or a presumption of service connection (SC) for specific disabilities due to claimed environmental and occupational hazards, the claim must be processed under direct SC provisions, or other theory(ies) of SC raised by the Veteran or evidence of record. ***References***: For more information on •direct SC, see • **38 CFR 3.303**, and • **M21-1 Part V, Subpart ii, 2.A** •presumptive SC, see **M21-1, Part V, Subpart ii, 2.B**, and •other exposure-based claims, see **M21-1, Part VIII, Subpart iii, 1-8**.

TN Department of Veterans Services

VA Form 21-526 EZ

SECTION VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES (If "Yes," complete Item 18B) ☐ NO (If "No," skip to Item 19A)

18B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

19A. BRANCH OFSERVICE
You must check one.
☐ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

19B. COMPONENT
You must check one.
☐ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES
Required.

	Month	Day	Year
ENTRY DATE:	Month	Day	Year
EXIT DATE:	Month	Day	Year

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
Required.

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
You must check one.
☐ YES ☐ NO

20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable)

	Month	Day	Year
FROM:	Month	Day	Year
TO:	Month	Day	Year

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
You must check one.
☐ YES (If "Yes," complete Items 21B through 21F)
☐ NO (If "No," skip to Item 22A)

21B. COMPONENT
REQUIRED if 21A is "YES".
☐ NATIONAL GUARD
☐ RESERVES

21C. OBLIGATION TERM OF SERVICE
REQUIRED if 21A is "YES".

	Month	Day	Year
FROM:	Month	Day	Year
TO:	Month	Day	Year

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:
REQUIRED if 21A is "YES".
Unit Name
Address
City State ZIP

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)
REQUIRED if 21A is "YES".
( )

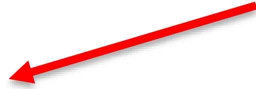
21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
REQUIRED if 21A is "YES".
☐ YES ☐ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?

22B. DATE OF ACTIVATION: REQUIRED if 22A is "YES".
Month Day Year

22C. ANTICIPATED SEPARATION DATE:
REQUIRED if 22A is "YES".
Month Day Year

VA Form 21-526 EZ



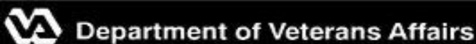
SECTION XIII: CLAIM INFORMATION (ADDENDUM)
(Please submit this page with the completed application if you have additional disabilities to add to your claim. If more space is needed, please make additional copies of this page to submit with your application.)

LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)
NOTE: List your claimed conditions below. **See the following three examples on guidance on how to complete Section XIII.**

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.				
2.				
3.				
4.				
5.				
6.				

VA Form 21P-534 EZ



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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

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

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

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

1B. VETERAN'S SOCIAL SECURITY NUMBER

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

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

1E. VA FILE NUMBER (If known)

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

1G. VETERAN'S SERVICE NUMBER

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

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

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

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
☐ SURVIVING SPOUSE ☐ CHILD 18-23 IN SCHOOL ☐ CUSTODIAN FILING FOR CHILD UNDER 18 ☐ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER

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

2E. ARE YOU A VETERAN?
☐ YES ☐ NO

2F. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province State

Country

ZIP Code/Postal Code

2G. YOUR TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

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

VA Form 21P-534 EZ

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)	
3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY)	3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY)
3D. BRANCH OF SERVICE ☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS	3E. PLACE OF LAST SEPARATION
3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard) ☐ YES ☐ NO (If "NO," skip to Item 3J)	3G. DATE OF ACTIVATION (MM/DD/YYYY) mm/dd/yyyy
3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?	3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)
3J. WAS THE VETERAN EVER A PRISONER OF WAR? ☐ YES ☐ NO (If "NO," skip to Section IV)	3K. DATES OF CONFINEMENT (MM/DD/YYYY) START: mm/dd/yyyy END: mm/dd/yyyy

VA Form 21P-534 EZ

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

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

☐ DIC

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

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

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

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: mm/dd/yyyy END: mm/dd/yyyy
	START: mm/dd/yyyy END: mm/dd/yyyy
	START: mm/dd/yyyy END: mm/dd/yyyy

VA Form 21P-534 EZ

EVIDENCE TABLES (Continued)

DIC Re-evaluation Based on PL 117-168 (PACT Act)
Public Law 117-168 (PACT ACT) was signed into law on August 10, 2022. This resulted in a substantial expansion of a veteran's military service that qualifies for presumptive toxic exposure and new presumptive conditions linked to that exposure. The law allows prior claimants for DIC to request a re-evaluation based on the expanded eligibility within the PACT Act. More information about the PACT Act can be found at https://www.va.gov/resources/the-pact-act-and-your-va-benefits/. In order to support your claim for **DIC re-evaluation based on PL 117-168 (PACT Act)** the evidence must show: • A claim was submitted and denied prior to August 10, 2022, the date the PACT Act went into effect; **AND** • The claimant has elected re-evaluation of the previously denied claim.

Supplemental DIC:

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

VA Form 21P-534 EZ

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

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

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

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

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

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

5. WHAT IS THE FACILITY TELEPHONE NUMBER?

International Phone Number *(If applicable)*

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

No. & Street: Address

Apt./Unit Number: Apt # City: City

State/Province: State Country: Country ZIP Code/Postal Code: ZIP

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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

- ☐ A. EATING
- ☐ B. BATHING/SHOWERING
- ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
- ☐ D. DRESSING
- ☐ E. USING THE TOILET
- ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

- ☐ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
- ☐ THE FACILITY IS LICENSED
- ☐ THE FACILITY IS RESIDENTIAL
- ☐ THE FACILITY IS STAFFED 24 HOURS

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

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

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

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

mm / dd / yyyy

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

mm / dd / yyyy ☐ INDEFINITE

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

$ PER MONTH

FACILITY CERTIFICATION

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

VA Form 21P-534 EZ

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

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

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

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

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL? (A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)
☐ YES ☐ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
☐ YES ☐ NO *(If "NO," skip to question 7)*

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

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

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

No. & Street: Address

Apt./Unit Number: Apt # City: City

State/Province: State Country: Country ZIP Code/Postal Code: ZIP

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A.SHOPPING ☐ B. FOOD PREPARATION ☐ C. NON-MEDICAL TRANSPORTATION
☐ D. LAUNDERING ☐ E. USING TELEPHONE ☐ F. MANAGING FINANCES
☐ G. HOUSEKEEPING ☐ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? *(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)*
☐ YES ☐ NO

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

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

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$ ____ PER HOUR

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

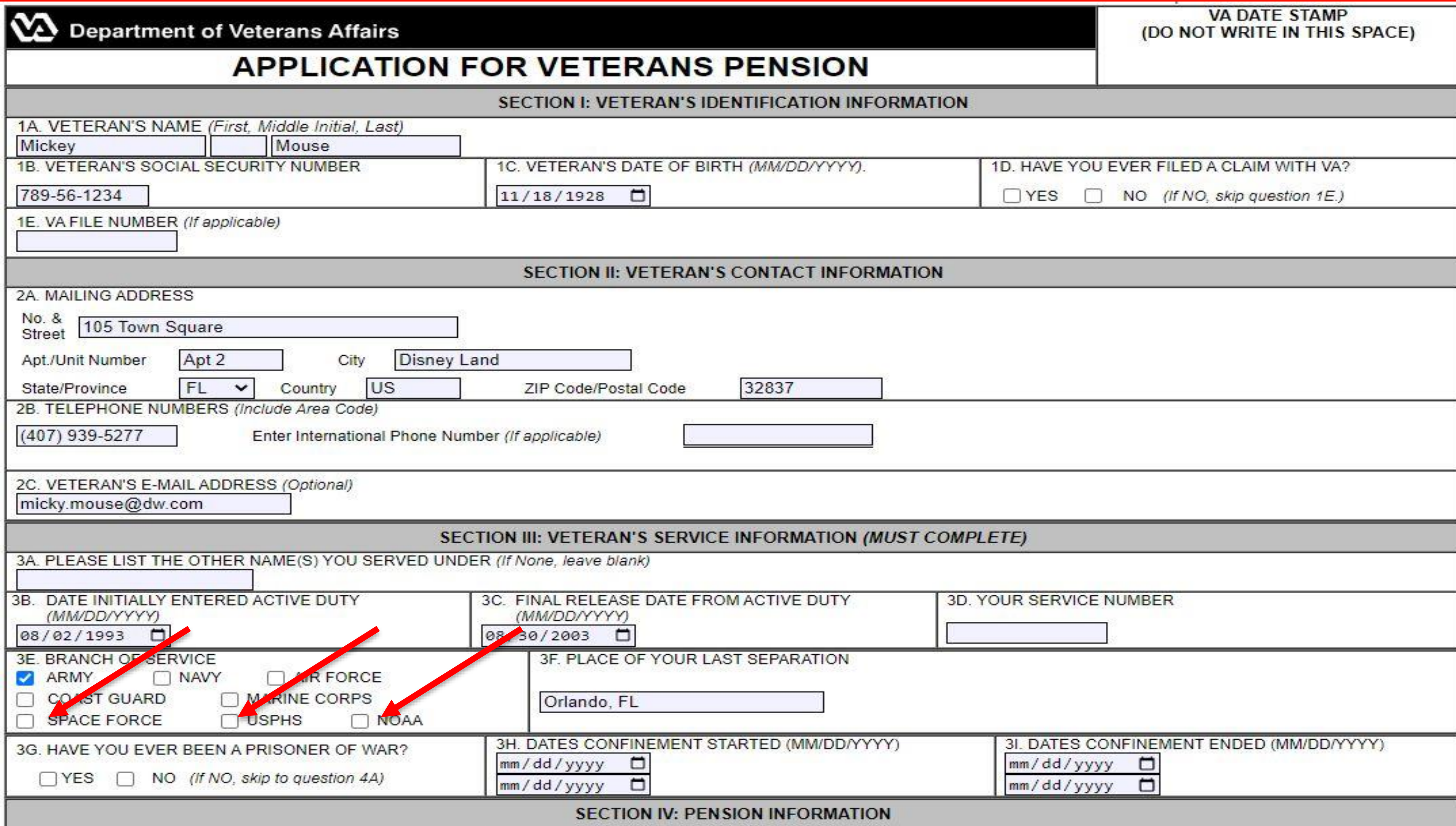
CERTIFICATION

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

15. SIGNATURE OF PROVIDER *(From question 2)*
Choose File No file chosen

16. DATE SIGNED *(MM/DD/YYYY)*
03/06/2023

VA Form 21P-527 EZ



Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME *(First, Middle Initial, Last)*: Mickey | | Mouse

1B. VETERAN'S SOCIAL SECURITY NUMBER: 789-56-1234

1C. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*: 11/18/1928

1D. HAVE YOU EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO *(If NO, skip question 1E.)*

1E. VA FILE NUMBER *(If applicable)*:

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street: 105 Town Square

Apt./Unit Number: Apt 2 City: Disney Land

State/Province: FL Country: US ZIP Code/Postal Code: 32837

2B. TELEPHONE NUMBERS *(Include Area Code)*: (407) 939-5277 Enter International Phone Number *(If applicable)*:

2C. VETERAN'S E-MAIL ADDRESS *(Optional)*: micky.mouse@dw.com

SECTION III: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

3A. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER *(If None, leave blank)*:

3B. DATE INITIALLY ENTERED ACTIVE DUTY *(MM/DD/YYYY)*: 08/02/1993

3C. FINAL RELEASE DATE FROM ACTIVE DUTY *(MM/DD/YYYY)*: 08/30/2003

3D. YOUR SERVICE NUMBER:

3E. BRANCH OF SERVICE

☑ ARMY ☐ NAVY ☐ AIR FORCE

☐ COAST GUARD ☐ MARINE CORPS

☐ SPACE FORCE ☐ USPHS ☐ NOAA

3F. PLACE OF YOUR LAST SEPARATION: Orlando, FL

3G. HAVE YOU EVER BEEN A PRISONER OF WAR? ☐ YES ☐ NO *(If NO, skip to question 4A)*

3H. DATES CONFINEMENT STARTED (MM/DD/YYYY): mm/dd/yyyy; mm/dd/yyyy

3I. DATES CONFINEMENT ENDED (MM/DD/YYYY): mm/dd/yyyy; mm/dd/yyyy

SECTION IV: PENSION INFORMATION

TN Department of Veterans Services

VA Form 21P-527 EZ

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

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

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

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

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

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

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

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

No. & Street: Address

Apt./Unit Number: Apt # City: City

State/Province: State Country: Country ZIP Code/Postal Code: ZIP

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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

- ☐ A. EATING
- ☐ B. BATHING/SHOWERING
- ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
- ☐ D. DRESSING
- ☐ E. USING THE TOILET
- ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

- ☐ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
- ☐ THE FACILITY IS LICENSED
- ☐ THE FACILITY IS RESIDENTIAL
- ☐ THE FACILITY IS STAFFED 24 HOURS

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

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

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

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

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

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

FACILITY CERTIFICATION

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

TN Department of Veterans Services

VA Form 21P-527 EZ

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

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

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

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

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL? (A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)
☐ YES ☐ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
☐ YES ☐ NO *(If "NO," skip to question 7)*

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

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

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

No. & Street: Address

Apt./Unit Number: Apt # City: City

State/Province: State Country: Country ZIP Code/Postal Code: ZIP

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A. SHOPPING ☐ B. FOOD PREPARATION ☐ C. NON-MEDICAL TRANSPORTATION
☐ D. LAUNDERING ☐ E. USING TELEPHONE ☐ F. MANAGING FINANCES
☐ G. HOUSEKEEPING ☐ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? *(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)*
☐ YES ☐ NO

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

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

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$ ____ PER HOUR

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

CERTIFICATION

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

15. SIGNATURE OF PROVIDER *(From question 2)*
Choose File No file chosen

16. DATE SIGNED *(MM/DD/YYYY)*
03/06/2023

VA Form 10-10 EZ

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION** ***(Complete Sections I, II, and III)*** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

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

1B. PREFERRED NAME

2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX
☐ MALE
☐ FEMALE

3B. SELF-IDENTIFIED GENDER IDENTITY
☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN
☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

4. ARE YOU SPANISH, HISPANIC,OR LATINO?
☐ YES
☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER

6. SOCIAL SECURITY NO.

7A. DATE OF BIRTH *(mm/dd/yyyy)*

7B. PLACE OF BIRTH *(City and State)*

8. PREFERRED LANGUAGE

9. RELIGION

VA Form 10-10 EZ

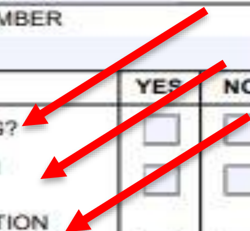
APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	G. DID YOU SERVE IN AN AGENT ORANGE LOCATION BETWEEN JANUARY 9, 1962 AND JULY 31, 1980?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	J. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐



SECTION III - INSURANCE INFORMATION ***(Use a separate sheet for additional information)***

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)* ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:

SECTION IV - DEPENDENT INFORMATION ***(Use a separate sheet for additional dependents)***

VA Form 10-10 EZ

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY

- [ ] MAN
- [ ] WOMAN
- [ ] TRANSGENDER MAN
- [ ] TRANSGENDER WOMAN
- [ ] NON-BINARY
- [ ] PREFER NOT TO ANSWER
- [ ] A GENDER NOT LISTED HERE

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?

- [ ] YES
- [ ] NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*

- [ ] SON
- [ ] DAUGHTER
- [ ] STEPSON
- [ ] STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?

- [ ] YES
- [ ] NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?

- [ ] YES
- [ ] NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

VA Form 10-10 EZ

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

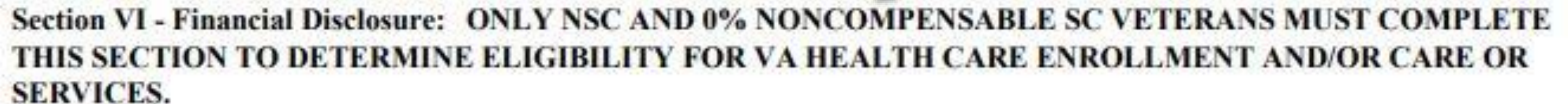
Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN
(Use a separate sheet for additional dependents)

VA Form 10-10 EZ



Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in an Agent Orange exposure location; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Lessons Learned/Best Practices

FDC vs Standard Claim Process

- Does the VA have to pick-up the phone?
- Yes=Standard Claim Process (i.e. 21-4142/21-4142a) requires further development
- No = Fully Developed Claim

Medical evidence when submitting a claim (three legged stool)

- VA Form 21-4138

Vietnam vs Gulf War Veteran with regards to PACT Act (exposures)

Pre-August 10, 2022 PACT Act Decisions for Veterans Law Judges to Consider

Package a Claim

Package a Claim

Show: My claims ◯ Submitted by county ◯ Received by Claims Office ◯ Need more information from county ◯ Filed by Claims Office ◯ Rating received by Claims Office ◯ All claims [Submit]

Sent between: Month Day Year and Month Day Year (leave blank to see all)

[Submit] < Mark as Received **Total:** 220

VET	VS ID	DATE PACKAGED	STATUS	NOTES	COUNTY	CVSO	CLAIMS OFFICER	SUBMITTED TO D2D BY	ACTION
		03-06-2023	☐ Received Sent to state on: 03-06-2023	Package 214138					Edit Delete Print Assign
		03-06-2023	☐ Received Sent to state on: 03-06-2023	FROM THE CLAIMS OFFICE: 2122, ITF					Edit Delete Print Assign
		03-06-2023	☐ Received Sent to state on: 03-06-2023	FROM THE CLAIMS OFFICE: 526, PACT ACT 2022					Edit Delete Print Assign
		03-06-2023	☐ Received Sent to state on: 03-06-2023	compensation/MAL					Edit Delete Print Assign
		03-06-2023	☐ Received Sent to state on: 03-06-2023	FROM THE CLAIMS OFFICE: **2122, ITF**					Edit Delete Print Assign
		03-06-2023	☐ Received Sent to state on: 03-06-2023	FROM THE CLAIMS OFFICE: 1199a					Edit Delete Print Assign
		03-06-2023	☐ Received Sent to state on: 03-06-2023	FROM THE CLAIMS OFFICE: 0995					Edit Delete Print Assign

Package a Claim

Department of Veterans Services | tyler technologies VetraSpec

PACKAGE A CLAIM

Today is: Mar. 07, 2023
Logged in: Ronald Dvorsky JR (rwdvorsky) | Logout

HOME | SEARCH | ADD | RESOURCES | DOCUMENTS | REPORTS | FORMS | CALENDAR | MY TASKS | GENERAL CONTACT LOG

QUICK OVERVIEW | MORE DETAILS | MILITARY SERVICE | CURRENT RATINGS | PENDING ISSUES | FINANCIAL ASSISTANCE | PAYMENTS | DEPENDENTS | COMMUNICATION | RECORDS | FINANCIALS | PACKAGE A CLAIM | MY VETS | DIRECT SUBMIT

NAME: Mouse, Mickey VETRASPEC ID: 86403 SSN: 789-56-1234 DOB: Nov. 18, 1928 VA CLAIM #: POA: Tennessee Department of Veterans Services

PACKAGE A NEW CLAIM

This form allows you to prepare a claim and send it electronically to the State Department Claims Office. Select the forms and documents you wish to attach, enter any information you'd like to communicate to the State Department and click Send. When you have finished, you may check the History below or the Claims Status page to see the status of the claim.

FORMS TO ATTACH		DOCUMENTS TO ATTACH
☐ 210779_022017	02-13-20 10:10	☐ 11459 CodeSheet
☐ 210845_092016	05-29-20 03:05	☐ 11459 Narrative
☐ 210966	04-01-20 04:14	☐ 690 CodeSheet
☐ 210966	05-29-20 03:26	☐ 690 DBQ Audio Hearing and Tinnitus Exam
☐ 210966	05-18-22 03:32	☐ 690 Narrative
☐ 210966	06-30-22 12:58	☐ DD214
		☐ DD214
		☐ DD214
		☐ Mickey mouse signature email 05292020
		☐ Mouse cemetery DOC 052920
		☐ TESTD

NOTES

526, 534, 527, 0996, 0995, 10182, 21-22 (POA) or 0966 (ITF)

Path: p

Package a Claim

ATTENTION: DO *NOT* SEND ANY ATTACHMENTS (COVERLETTERS, DD214...) WITH THE 21-22.

The **21-526ez** may have attachments such as other forms or uploaded documents. If sending a 21-22 and a 21-526ez send the 21-22 first. Wait until you see the final "Success" message, then go back into Package This Claim and send the 21-526ez and other forms/documents.

If sending a 21-686c, send that form with the 21-526ez.
IT CAN NO LONGER BE SENT BY ITSELF OVER D2D.

D2D issues have been resolved. Resubmit any claims that failed.

Send to VA

REMINDER: You may only submit a 21-22, 21-0966 or 21-526EZ **(and attached forms/documents)** to VA electronically.

This button is used to process the claim in the normal fashion --> Send

Open Discussion/Questions