

### **U.S. Department of Veterans Affairs**

Veterans Benefits Administration Compensation Service

## VSO and VSO Senior Leaders: Forms Automation Update

Briefed by: Jane Che, Director, VASRD Program Office Compensation Service November 12, 2020

### **Background**

- VBA continues to modernize our claims processes to provide faster and more efficient delivery of benefits to Veterans and their families, particularly during the time of the Novel Coronavirus (COVID-19) pandemic and state of emergency.
- Previously, VA did not have a standard form for these types of requests. Veterans, claimants, and Veterans Service Organizations (VSOs) had to submit such information on VA Form 21-4138, Statement in Support of Claim due to this gap in forms.
- VA is making it easier for Veterans/claimants to communicate their intent by providing specific forms for specific requests.
  - These changes allow greater use of computerized optical character recognition which is the automated processes to "read" forms for information upload – all of which are critical for faster processing and ultimately, faster delivery of benefits to claimants.
- VBA has created <u>5 new forms</u> to be used in lieu of the current
   VA Form 21-4138, Statement in Support of Claim:
  - VAF 20-10206 FOIA/ Privacy Act Request
  - VAF 20-10207 Priority Processing Request
  - VAF 20-10208 Document Evidence Submission
  - VAF 20-10210 Lay/Witness Statement
  - VAF 28-10212 Ch 31 Request for Assistance

# VA Form 20-10206 FOIA/Privacy Act Request

- VA Form 20-10206 FOIA/Privacy Act Request
  - 4-pages including instructions



#### INFORMATION AND INSTRUCTIONS ON HOW TO SUBMIT A FREEDOM OF INFORMATION ACT (FOIA) OR PRIVACY ACT REQUEST (PA)

Please complete the attached form to submit a Freedom of Information Act (FOIA) or Privacy Act (PA) request. It must be signed by the requester or third-party authorized to act on behalf of the requester.

#### WHAT IS A FOIA REQUEST?

A FOIA request provides the public the right to request access to records from Federal agencies, except those protected by the nine FOIA exemptions. For additional information please visit <a href="https://www.va.gov/FOIA/index.asp">https://www.va.gov/FOIA/index.asp</a>.

#### WHAT IS A PA REQUEST?

A citizen of the United States or an alien lawfully admitted for permanent residence may request access to or amendment of records on herself/himself from a System of Records (SORs). Examples of PA records are personal Claims Files (C-File), educational loan, and beneficiary records. For additional information please visit https://www.oprm.va.gov/privacy/.

#### VERIFICATION OF IDENTITY AND CONSENT FOR PA REQUESTS ONLY

A request must include the following information:

- Your full name:
- Your date of birth;
- Your place of birth; and
- · Your current mailing address.

Note: To help us locate requested records, please include your Social Security number (SSN) or Alien Registration number (A-number).

#### WHERE TO SEND YOUR REQUEST:

NOTE - All Privacy Act requests must be sent to the Centralized Support Division address listed below.

| RECORDS CUSTODIAN                                       | MAIL TO  | ELECTRONIC SUBMISSION           |
|---|--|---------------------------------|
| Centralized Support Division<br>(Claim Files)           | Department of Veterans Affairs<br>Evidence Intake Center<br>PO Box 4444<br>Janesville, WI 53547-4444                     | EMAIL: FOIA.vbarmc@va.gov       |
| Veterans Benefits Administration<br>(All other records) | Department of Veterans Affairs<br>Veterans Benefits Administration (20)<br>810 Vermont Avenue NW<br>Washington, DC 24020 | EMAIL: <u>FOIA.vbaco@va.gov</u> |

### Department of Veterans Affairs

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

#### FREEDOM OF INFORMATION ACT (FOIA) OR PRIVACY ACT(PA) REQUEST

INSTRUCTIONS: Read the Privacy Act and Respondent Burden information on Page 4 before completing the form. This form must be signed by the requester, authorized organization, or third party who has been authorized by the requester. For additional information on VA FOIA and PA requests visit our website at <a href="https://www.va.gov/FOIA/">https://www.va.gov/FOIA/</a> Requests.asp. You may also contact the VA at <a href="https://iris.custhelp.va.gov">https://iris.custhelp.va.gov</a> or call us toll-free at 1-800-827-1000. If you use a Telecommunications device for the deaf (TDD), the Federal Relay number is 711. VA forms are

| available at <u>www.va.gov/vaforms.</u>   |   |  |  |
|---|---|--|--|
| SECTION I: REQUEST  | T FOR INFORMATION ON YOURSELF   |  |  |
|   | mplete Sections I, III, V and VI. Complete Section IV, if applicable.)                                |  |  |
| circle to help expedite processing of the form.   | l, print the information requested in ink, neatly and legibly, and completely fill in each applicable |  |  |
| 1. NAME (First, Middle Initial, Last)   |   |  |  |
|   |   |  |  |
| 2. SOCIAL SECURITY NUMBER 3. ALIEN REGISTRA   | ATION NUMBER (A-number) (If applicable)  4. VA FILE NUMBER (If applicable)                            |  |  |
|   |   |  |  |
| 5. DATE OF BIRTH 6. PLACE OF BIRTH  | H (Provide City and State, County and State or City and Country)                                      |  |  |
| Month Day Year  |   |  |  |
|   |   |  |  |
| 7. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. B  | Box, City, State, ZIP Code and Country)   |  |  |
| No. &<br>Street   |   |  |  |
| Apt./Unit Number City   |   |  |  |
|   |   |  |  |
| State/Province Country ZIP Code/Postal C  | Code  |  |  |
| 8A. TELEPHONE NUMBER (Include Area Code) 8B. F  | FAX NUMBER (If applicable)  |  |  |
|   |   |  |  |
|   | er International FAX Number   |  |  |
| (If applicable) (If applicable)   | pplicable)  |  |  |
| 9. E-MAIL ADDRESS   I agree to receive electronic correspondence from to my claim.                          | from VA in regards  |  |  |
|   |   |  |  |
|   | RMATION ON A PERSON OTHER THAN YOURSELF   |  |  |
| (If you are seeking information on an individual other than your  | rself, complete Sections II, III, V and VII or VIII. Complete Section IV, if applicable.)             |  |  |
| 10. NAME (First, Middle Initial, Last) OR YOUR ORGANIZATION'S NAME  |   |  |  |
|   |   |  |  |
|   |   |  |  |
| 11. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country) |   |  |  |
| No. &<br>Street   |   |  |  |
| Apt./Unit Number City   |   |  |  |
|   |   |  |  |
| State/Province Country ZIP Code/Postal Code — —   |   |  |  |
| 12A. TELEPHONE NUMBER (Include Area Code)  12B. FAX NUMBER (If applicable)                                  |   |  |  |
|   |   |  |  |
|   | nter International FAX Number<br>applicable)  |  |  |

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| SOCIAL SECURITY NUMBER  |               |  |  |
|---|---------------|--|--|
| SECTION II: REQUEST FOR INFORMATION ON A PERSON OTHER THAN YOURSELF (Continued) (If you are seeking information on an individual other than yourself, complete Sections II, III, V and VII or VIII. Complete Section IV, if applicable.)  |               |  |  |
| NOTE: Items 13 through 16 must be completed to inform VA on whom the person is you are requesting the information about.  |               |  |  |
| 13. NAME OF THE PERSON YOU ARE REQUESTING INFORMATION ON (First, Middle Initial, Last)  |               |  |  |
|   |               |  |  |
| 14. SOCIAL SECURITY NUMBER 15. ALIEN REGISTRATION NUMBER (A-number) (If applicable) 6. VA FILE NUMBER (If applicable)   |               |  |  |
|   |               |  |  |
| 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) DD FORM 214 HUMAN RESOURCE RECORDS LIFE INSURANCE BENEFIT I (If applicable, enter policy nun Section IV, Item 18, Remarks  | nber in       |  |  |
| SERVICE TREATMENT  RECORDS / MILITARY TREATMENT RECORDS  O HOME LOAN BENEFIT RECORDS  DISABILITY EXAMINATIONS  EXAMS) (If applicable enter decords)   | ate of        |  |  |
| VOCATIONAL  REHABILITATION AND EMPLOYMENT RECORDS  WILITARY TO CIVILIAN TRANSITION  (TAP) DOCUMENTS  (TAP) DOCUMENTS  | lemarks)      |  |  |
| PENSION BENEFIT DOCUMENTS DOCUMENTS FINANCIAL RECORDS   |               |  |  |
| OTHER (Specify)   |               |  |  |
|   |               |  |  |
|   | $\overline{}$ |  |  |
| SECTION IV: REMARKS   |               |  |  |
| 18. REMARKS (If any)  |               |  |  |
|   |               |  |  |
|   |               |  |  |
|   |               |  |  |
|   |               |  |  |
|   |               |  |  |
|   |               |  |  |
| SECTION V: WILLINGNESS TO PAY FEES  |               |  |  |
| 19. <b>IMPORTANT</b> : 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 to contribute significantly to the public understanding of the operations or activities of the government and is not primarily in the commercial interrequester.   |               |  |  |
| OI AM WILLING TO PAY THE APPLICABLE FEES UP TO THE AMOUNT OF \$ .00   |               |  |  |
| O IF YOU BELIEVE YOU ARE ENTITLED TO A FEE WAIVER OR EXPEDITED PROCESSING, INDICATE HERE:   |               |  |  |

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| SOCIAL SECURITY NUMBER   |  |  |
|--|--|--|
| SECTION VI: REQUESTER CERTIFICATION AND SIGNATURE  |  |  |
| I CERTIFY THAT I have completed this FOIA/PA request and declare i   | t is true and correct to the best of my knowledge and belief.                    |  |
| 20A. REQUESTER'S SIGNATURE ( <i>REQUIRED</i> )   | 20B. DATE SIGNED   |  |
|  | Month Day Year   |  |
|  | ERTIFICATION AND SIGNATURE d 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. <b>NOTE</b> : A third-party signature <i>will not</i> be accepted unless a valid VA Form 21-0845, <i>Authorization to Disclose Personal Information to a Third Party</i> 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   |  |
|  | Month Day Year   |  |
|  | (POA) CERTIFICATION AND SIGNATURE d requester has authorized POA representation) |  |
| I CERTIFY THAT the requester has authorized me as the undersigned contained in this document to the best of the requesters knowledge and   | representative and certifies the truth and completion of the information         |  |
| NOTE: A POA's signature will not be accepted unless a valid VA Form 21-Representative or VA Form 21-22a, Appointment of Individual as Claimant's   | 22, Appointment of Veterans Service Organization as Claimant's                   |  |
| 22A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE)  | 22B. DATE SIGNED   |  |
|  | Month Day Year   |  |
| <b>PENALTY</b> : The law provides severe penalties which include fine or imprisonment knowing it to be false, or for fraudulent receipt of any document to which you are n   |  |  |
| 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. |  |  |
| <b>RESPONDENT BURDEN</b> : We need this information to identify and obtain the information you are requesting. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <a href="https://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a> . If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.              |  |  |
|  |  |  |

VA Form 20-10206, OCT 2020

# VA Form 10207 Priority Processing Request

- VA Form 20-10207 Priority Processing Request
  - 5 pages including instructions



#### PRIORITY PROCESSING REQUEST INSTRUCTIONS

Please complete the attached form to submit a request for priority processing of a claim due to certain circumstances or status as described below along with any supporting information or evidence.

| If you are  | Then submit the following evidence if available or not already on file with VA   |
|---|--|
| Experiencing extreme financial hardship   | Documentation showing extreme financial hardship, including but not limited to the following:  |
| Terminally ill  | <ul> <li>Copy of medical evidence showing illness that is terminal in nature, and/or</li> <li>If you want VA to get your private treatment records, submit a completed VA Form 21-4142,         <i>Authorization to Disclose Information to the Department of Veterans Affairs</i>, and VA Form         21-4142a, <i>General Release for Medical Provider Information to the Department of Veterans</i>         Affairs. NOTE: VA Forms are available at: <a href="www.va.gov/vaforms">www.va.gov/vaforms</a></li> </ul> |
| Diagnosed with Amyotrophic Lateral<br>Sclerosis (ALS) also known as Lou<br>Gehrig's disease   | <ul> <li>Copy of medical evidence showing ALS also known as Lou Gehrig's disease diagnosis, and/or</li> <li>If you want VA to get your private treatment records, submit a completed VA Form 21-4142 and VA Form 21-4142a</li> </ul>   |
| Very Seriously Injured/Ill or Seriously<br>Injured/Ill during military operations<br>(Defined as a disability resulting from<br>a military operation that will likely<br>result in discharge from military<br>service.) | <ul> <li>Copy of military personnel records, such as a determination from the Department of Defense (DOD), and</li> <li>Medical evidence showing severe disability or injury, and/or</li> <li>If you want VA to get your private treatment records, submit a completed VA Form 21-4142 and VA Form 21-4142a</li> </ul>   |
| Age 85 or older   | Date of birth  |
| Former Prisoner of War  | <ul> <li>Copy of military personnel records such as DD Form 214, Certificate of Release or Discharge from Active Duty, or</li> <li>Information such as service number, branch and dates of service, dates and location of internment, detaining power, or any other information relevant to the detainment</li> </ul>  |
| Medal of Honor or Purple Heart Award<br>recipient   | <ul> <li>Copy of military personnel records such as DD Form 214, or</li> <li>Information showing receipt of Medal of Honor or Purple Heart Award</li> </ul>  |

#### WHERE TO SEND INFORMATION AND EVIDENCE:

The time it takes your response to reach VA affects how long it takes us to process your request. We recommend calling our National Call Center at 1-800-827-1000 for immediate assistance whenever possible. If you are not a claimant or representative, we recommend mailing the information.

**Note**: You may designate one person or organization as a third-party representative to act on your behalf. A third-party may be a family member or other designated person who is not a Power of Attorney (POA), agent, or fiduciary. If you designate a third-party to represent you, a VA Form 21-0845, Authorization to Disclose Personal Information to a Third-Party, must be attached or of record.

20-10207

The **fastest** way to respond to VA is to contact us at 1-800-827-1000.

If you need to mail your correspondence, identify the benefit type; then, use the corresponding mailing address below:

| MAILING ADDRESSES   |   |
|---|---|
| Compensation Claims  Department of Veterans Affairs  Compensation Intake Center  P.O. Box 4444  Janesville, WI 53547-4444 | Pension & Survivors Benefit Claims  Department of Veterans Affairs  Pension Intake Center  P.O. Box 5365  Janesville, WI 53547-5365 |
| Board of Veterans' Appeals Department of Veterans Affairs Board of Veterans' Appeals P.O. Box 27063 Washington, DC 20038  | Fiduciary Department of Veterans Affairs Fiduciary Intake Center P.O. Box 95211 Lakeland, FL 33804-5211                             |

These addresses serve all United States and foreign locations.

Attention: If you are currently receiving GI Bill Education benefits and are experiencing any of the reasons listed within Section III: Reason(s) for Request, please call the 1-888-GIBILL1 (1-888-442-4551) or send an email through Ask A Question at www.gibill.va.gov for immediate assistance.

#### **IMPORTANT**

If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1, or visit https://www.VeteransCrisis/line.net/ to chat online, or send a text message to 838255

to receive confidential support 24 hours a day, 7 days a week, 365 days a year.

Support for deaf and hard of hearing individuals is available.

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OMB Approved No. 2900-0877

NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g. living in a car or tent)

PAGE 3

|  | Respondent Burden: 7 Minutes<br>Expiration Date: 10/31/2023 |
|--|---|
| Department of Veterans Affairs   | (DO NOT WRITE IN THIS SPACE)<br>(VA DATE STAMP)             |
| PRIORITY PROCESSING REQUEST  | (VADALE GIAIII)   |
| INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 5. Use this  |   |
| form to request priority processing of a claim due to certain status or circumstances. For more information, contact   |   |
| us at <a href="https://iris.custhelp.va.gov">https://iris.custhelp.va.gov</a> , or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device   |   |
| for the Deaf (TDD), the Federal relay number is 711. VA forms are available at <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a> .   |   |
| SECTION I - VETERAN'S IDENTIFICATION INFORMATION   |   |
| (This information is required to process your request)  NOTE: You can either complete the form on-line or by hand. If completed by hand, print the information requested in ink, neatly, and legent expedite processing of the form. | gibly and completely fill in each circle to                 |
| VETERAN'S NAME (First, Middle Initial, Last)   |   |
|  |   |
| 2. SOCIAL SECURITY NUMBER  3. DATE OF BIRTH (MM-DD-YYYY)   |   |
|  |   |
| 4. VA FILE NUMBER (If applicable)  5. INSURANCE NUMBER (If applicable)   |   |
|  |   |
| 6. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)   |   |
| No. &  |   |
| Street   |   |
| Apt./Unit Number City  |   |
| State/Province Country ZIP Code/Postal Code -  |   |
| 7. TELEPHONE NUMBER (Include Area Code)  8. E-MAIL ADDRESS I agree to receive electronic correspondence  | from VA in regards to my claim.                             |
|  |   |
| Enter International Phone Number (If applicable)   |   |
| SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION   |   |
| (If other than Veteran)  |   |
| 9. CLAIMANTS NAME (First, Middle Initial, Last)  |   |
|  |   |
| 10. SOCIAL SECURITY NUMBER 11. VA FILE NUMBER (If applicable) 12. DATE OF BIRTH  | i (MM-DD-YYYY)  |
|  |   |
| 13. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  |   |
| No. & Street   |   |
| Apt./Unit Number City  |   |
|  |   |
| State/Province Country ZIP Code/Postal Code — — — — — — — — — — — — — — — — — — —  |   |
| 14. TELEPHONE NUMBER (Include Area Code)  15. E-MAIL ADDRESS I agree to receive electronic correspondence  | e from VA in regards to my claim.                           |
|  |   |
| Enter International Phone Number (If applicable)   |   |
| SECTION III - REASON(S) FOR REQUEST (This information is required in order to complete your request)   |   |

item 16B regarding your living situation) OTHER HOMELESS? Radio button. YES 16C) (Specify) 20-10207

16A. ARE YOU CURRENTLY

16. HOMELESS INFORMATION (Check all that apply)

16B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION LIVING IN A HOMELESS SHELTER STAYING WITH ANOTHER PERSON

16A. ARE YOU CURRENTLY HOMELESS?

NO (If "NO,"

skip to item

YES (If "YES," complete

| VETERAN'S SSN   |   |  |  |
|---|---|--|--|
| 16C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS? 6D. CHECK THE BOX THAT APPLIES TO YOU  | JR LIVING SITUATION   |  |  |
| YES (If "YES," complete item 16D regarding your NO (If "NO," skip to item 17)   HOUSING WILL BE LOST IN 30 DAYS   Siving situation) | VING PUBLICLY FUNDED SYSTEM OF CARE IN DAYS OR LESS (e.g. homeless shelter) |  |  |
| OTHER (Specify)   |   |  |  |
| 17. OTHER REASON(S)/CIRCUMSTANCES FOR REQUEST (CI   | neck all that apply)  |  |  |
| EXPERIENCING EXTREME FINANCIAL HARDSHIP TERMINALLY ILL MEDAL OF HONOR/F   | PURPLE HEART RECIPIENT  |  |  |
| O 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-YY)  | Υ)  |  |  |
| FROM TO TO  |   |  |  |
| FROM TO TO  | •   |  |  |
| SECTION IV - REPORT OF MEDICAL TREATME<br>(If applicable)   | NT  |  |  |
| 18. LIST VA MEDICAL CENTERS (VAMC), DEPARTMENT OF DEFENSE (DoD) MILITA  | RY TREATMENT FACILITIES (MTF), OR   |  |  |
| PRIVATE MEDICAL FACILITIES WHERE YOU WERE TREATED FOR THE CIRCUMST  |   |  |  |
| PROVIDE APPROXIMATE BEGINNING DATE OF TRE   | ATMENT:   |  |  |
| NAME/LOCATION OF TREATMENT FACILITY   | DATE OF TREATMENT (MM-DD-YYYY)  |  |  |
|   |   |  |  |
| City  |   |  |  |
| State/Province Country  |   |  |  |
|   |   |  |  |
| NAME/LOCATION OF TREATMENT FACILITY   | DATE OF TREATMENT (MM-DD-YYYY)  |  |  |
|   |   |  |  |
| City  |   |  |  |
| State/Province Country  |   |  |  |
|   |   |  |  |
| NAME/LOCATION OF TREATMENT FACILITY   | DATE OF TREATMENT (MM-DD-YYYY)  |  |  |
|   |   |  |  |
| City  |   |  |  |
| State/Province Country  |   |  |  |
|   |   |  |  |
| NAME/LOCATION OF TREATMENT FACILITY   | DATE OF TREATMENT (MM-DD-YYYY)  |  |  |
|   |   |  |  |
| City  |   |  |  |
| State/Province Country  |   |  |  |
|   |   |  |  |

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| VETERAN'S SSN — — — —   |   |
|---|---|
| SECTION V - CERTIFIC  | CATION AND SIGNATURE  |
| I CERTIFY THAT I have completed this form and it is true and corr   | rect to the best of my knowledge and belief.  |
| 18A.SIGNATURE OF REQUESTER (REQUIRED)   | 18B. DATE SIGNED (MM-DD-YYYY)   |
|   |   |
|   | RD PARTY SIGNATURE r has an authorized third party)   |
| I CERTIFY THAT the veteran/claimant has authorized me as the undersign true and complete to the best of the veteran/claimant's knowledge.   | ned representative and certifies that the information contained in this document is   |
|   | 21-0845, Authorization to Disclose Personal Information to a Third-Party, is of other designated person who is not a Power of Attorney, agent, or fiduciary.  |
| 19A. THIRD-PARTY SIGNATURE ( <i>REQUIRED</i> )  | 19B. DATE SIGNED (MM-DD-YYYY)   |
|   |   |
|   | ATTORNEY (POA) SIGNATURE s an authorized POA representation)  |
|   | ned representative and certifies that the information contained in this document  |
| is true and complete to the best of the veteran/claimant's knowledge.   |   |
| <b>NOTE</b> : A POA's signature <i>will not</i> be accepted unless a valid VA Form 21-Representative, or VA Form 21-22a, Appointment of Individual as Claimant  |   |
| 20A. POWER OF ATTORNEY (POA) SIGNATURE (REQUIRED)   | 20B. DATE SIGNED (MM-DD-YYYY)   |
|   |   |
| <b>PENALTY</b> : The law provides severe penalties (including fine and/or imprisonment  | t) 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.   |   |
| the Privacy Act of 1974 or Title 38, Code of Federal Regulation congressional communications, epidemiological or research studies the United States is a party or has an interest, the administration of  | on this form to any source other than what has been authorized under lons, 1.576 for routine uses (i.e., civil or criminal law enforcement, s, the collection of money owed to the United States, litigation in which of VA programs and delivery of VA benefits, verification of identity and em of records, 58VA21/22/28, Compensation, Pension, Education, and in the Federal Register. Your obligation to respond is voluntary. |
| allows us to ask for this information. It should take you about 7 mir form. VA cannot conduct or sponsor a collection of information unled displayed. You are not required to respond to a collection of information unled to respond to a collection of information. | n support of or response to your claim. Title 38, United States Code, nutes to review the instructions, find the information, and complete this less a valid Office of Management and Budget (OMB) control number is mation if this number is not displayed. Valid OMB control numbers can <a href="mailto:ublic/do/PRAMain">ublic/do/PRAMain</a> . If desired, you can call 1-800-827-1000 to get form.                            |
|   |   |

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## VA Form 20-10208 Document Evidence Submission

- VA Form 20-10208 Document Evidence Submission
  - 2 pages

OMB Approved No. 2900-0877 Respondent Burden: 5 Minutes Expiration Date: 10/31/2023

### Department of Veterans Affairs

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

#### **DOCUMENT EVIDENCE SUBMISSION**

**INSTRUCTIONS**: Read the Privacy Act and Respondent Burden on Page 2 before completing this form. This form is used for the submission of additional documentation or evidence in support of a claim. For more information, contact us at <a href="https://iris.custhelp.va.gov">https://iris.custhelp.va.gov</a>, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a>.

| number is 711. VA forms are available at <u>www.va.gov/vaforms</u> .  |  |  |
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| SECTION I: VETERAN'S IDENTIFICATION INFORMATION   |  |  |
| <b>NOTE</b> : You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable circle to help expedite processing of the form. |  |  |
| 1. VETERAN'S NAME (First, Middle Initial, Last)   |  |  |
|   |  |  |
| 2. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. DATE OF BIRTH (MM-DD-YYYY)   |  |  |
|   |  |  |
| 5. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  |  |  |
| No. & Street  |  |  |
|   |  |  |
| Apt./Unit Number City   |  |  |
| State/Province Country ZIP Code/Postal Code -   |  |  |
| 6. TELEPHONE NUMBER (Include Area Code)  7. E-MAIL ADDRESS  I agree to receive electronic correspondence from VA in regards to my claim.  |  |  |
|   |  |  |
| Enter International Phone Number (If applicable)  |  |  |
| SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION  (If other than veteran)  |  |  |
| 8. CLAIMANTS NAME (First, Middle Initial, Last)   |  |  |
|   |  |  |
| 9. SOCIAL SECURITY NUMBER 10. VA FILE NUMBER (If applicable) 11. DATE OF BIRTH (MM-DD-YYYY)   |  |  |
|   |  |  |
| 12. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)   |  |  |
| No. & Street  |  |  |
| Apt./Unit Number City   |  |  |
| State/Province Country ZIP Code/Postal Code —   |  |  |
| 13. TELEPHONE NUMBER (Include Area Code)  14. E-MAIL ADDRESS I agree to receive electronic correspondence from VA in regards to my claim.   |  |  |
|   |  |  |
| Enter International Phone Number (If applicable)  |  |  |
| 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  |  |  |

| VETERAN/CLAIMANT'S SOCIAL SECURITY NO.   | -   |  |  |
|--|---|--|--|
| 16. IDENTIFY THE DOCUMENT(S) OR EVIDENCE YOU ARE SUBMITTING TO SUPPORT YOUR ESTABLISHED CLAIM.   |   |  |  |
| <b>NOTE</b> : You may select one or more type(s), depending on the type of   | f documentation/evidence being provided with this form.   |  |  |
| ○ BIRTH CERTIFICATE  | ○ DEATH CERTIFICATE   |  |  |
| O DEPENDENCY INFORMATION   | ○ DIVORCE DECREE  |  |  |
| C FINANCIAL INFORMATION  | MARRIAGE CERTIFICATE  |  |  |
| MEDICAL TREATMENT RECORDS  | COURT PAPERS/DOCUMENTS  |  |  |
| MILITARY PERSONNEL RECORDS   | C SERVICE TREATMENT RECORDS   |  |  |
| CLAY STATEMENT (Describe)  |   |  |  |
|  |   |  |  |
| OTHER (Describe)   |   |  |  |
|  |   |  |  |
|  |   |  |  |
| SECTION IV: CERTIFICA  | ATION AND SIGNATURE   |  |  |
| I CERTIFY THAT I have filled this form out completely and that it is tr  | ue and correct to the best of my knowledge and belief.  |  |  |
| 17A. VETERAN/CLAIMANT'S SIGNATURE (REQUIRED)   | 17B. DATE SIGNED (MM-DD-YYYYY)  |  |  |
|  |   |  |  |
|  | -PARTY SIGNATURE<br>s 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)   |  |  |
|  |   |  |  |
| SECTION VI: POWER OF ATTORNEY (POA) SIGNATURE  (Valid only if requester has an authorized POA representation)  |   |  |  |
|  | lersigned representative and certifies that the information contained in  |  |  |
| <b>NOTE</b> : A POA's signature <i>will not</i> be accepted unless a valid VA Fo <i>Claimant's Representative</i> , or VA Form 21-22a, <i>Appointment of Indiv</i> request.  |   |  |  |
| 19A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE   | 19B. DATE SIGNED (MM-DD-YYYY)   |  |  |
| <b>PENALTY:</b> 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.   |   |  |  |
| Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congres<br>the United States, litigation in which the United States is a party or has an interest, the adm  | v source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of sional communications, epidemiological or research studies, the collection of money owed to inistration of VA programs and delivery of VA benefits, verification of identity and status, and ensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, |  |  |

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 <a href="www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

desired, you can can 1 000 027 1000 to get information on where to send comments of suggestions about this sort

published in the Federal Register. Your obligation to respond is voluntary.

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RESPONDENT BURDEN: This information will let us help you in support of or response to your claim. We estimate that you will need an average of 5 minutes to review the

# VA Form 20-10210 Lay/Witness Statement

- VA Form 20-10210 Lay/Witness Statement
  - 3 pages

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#### epartment of Veterans Affairs

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

#### LAY/WITNESS STATEMENT

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA

| SECTION I: VETERAN'S IDENTIFICATION INFORMATION  NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, nearly and legibly, insert one letter per box, and completely it in each applicable crite to help opening or possing of the form.  1. VETERAN'S NAME (First, Middle Initial, Lust)  2. SOCIAL SECURITY NUMBER  3. VA FILE NUMBER (If applicable)  4. DATE OF BIRTH Month Day Year  5. VA INSURANCE FILE NUMBER (If applicable)  6. CURRENT MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. & Street  7. TELEPHONE NUMBER (Include Area Code)  8. E-MAIL ADDRESS  1. agree to receive electronic correspondence from VA invegards to my disin.  (Complete this section ONLY IF the claimant is NOT the veteran)  9. CLAIMANT'S NAME (First, Middle Initial, Last)  10. SOCIAL SECURITY NUMBER  11. VA FILE NUMBER (If applicable)  12. DATE OF BIRTH Month Day Year  13. VA INSURANCE FILE NUMBER (If applicable)  14. RELATIONSHIP TO VETERAN (Check all that apply)  5. SERVICE WITH CLAIMANT FAMILY FILE NUMBER (If applicable)  15. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. & SERVICE WITH CLAIMANT FAMILY FILE NUMBER (If applicable)  15. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. & SERVICE WITH CLAIMANT FAMILY FILE NUMBER (If applicable)  16. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. & SERVICE WITH CLAIMANT FAMILY FILE NUMBER (If applicable)  16. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. & Service WITH CLAIMANT | forms are available at <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a> . |  |
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| No. & Street  Apt./Unit Number  | Month Day Year   |  |
| No. & Street  Apt./Unit Number  |  |  |
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| OTHER (Specify)  15. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. &   | 14. RELATIONSHIP TO VETERAN (Check all that ap                                       | oly)   |
| 15. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. &  | ○ SERVED WITH CLAIMANT ○ FAMILY  | /FRIEND OF CLAIMANT COWORKER/SUPERVISOR OF CLAIMANT                          |
| No. &   | OTHER (Specify)  |  |
|   | 15. CURRENT MAILING ADDRESS (Number and stre   | eet or rural route, P.O. Box, City, State, ZIP Code and Country)             |
|   |  |  |
| Apt./Unit Number City   | Apt./Unit Number C   | ity  |
|   | State/Province Country   | ZIP Code/Postal Code   |
| State/Province Country 7IP Code/Postal Code 7   | Country  |  |

VA FORM 21-10210 PAGE 1

| SOCIA    | AL SEC   | CURIT  | YNUI   | MBER    |         |        |       | -[     |       | ]-[   |        |        |        |          |        |          |        |        |         |         |         |        |        |       |         |       |          |          |          |
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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 <a href="https://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

# VA Form 10212 Chpt 31 Request for Assistance

- VA Form 20-10212 Chapter 31 Request for Assistance
  - 2 pages

OMB Control No. 2900-0882 Respondent Burden: 10 minutes Expiration Date: 02/28/2021

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

### **CHAPTER 31 REQUEST FOR ASSISTANCE**

**INSTRUCTIONS:** Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a request for assistance with your Chapter 31 benefits. For more information, contact us at <a href="https://iris.custhelp.va.gov">https://iris.custhelp.va.gov</a>, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA Forms are available at <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a>.

| SECTION I: CLAIMANT'S INFORMATION  |        |
|--|--------|
| <b>NOTE</b> : You may <i>either</i> 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. VA FILE NUMBER  |        |
|  |        |
| 3. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)   |        |
| No. & Street   | _      |
| Apt./Unit Number City  |        |
| State/Province Country ZIP Code/Postal Code -  |        |
| 4. TELEPHONE NUMBER(S) (Include Area Code)   | _      |
| Daytime: — — — — —   |        |
| Cell phone:  |        |
| International Telephone Number (If applicable):  |        |
| 5. E-MAIL ADDRESS (Optional) 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:  |        |
| O WITHDRAW MY APPLICATION FOR CHAPTER 31 BENEFITS  REQUEST TO DISCONTINUE MY CHAPTER 31 PROGRAM AND CLOSE MY CASE  |        |
| ○ REQUEST FOR A REVOLVING FUND LOAN REQUEST FOR SUPPLIES OR EQUIPMENT TO PARTICIPATE IN MY   |        |
| REPROBLEMENT REHABILITATION PROGRAM  |        |
| MITIGATING CIRCUMSTANCES FOR REDUCTION OR COMPLETE WITHDRAWAL FROM TRAINING  MITIGATING CIRCUMSTANCES FOR REDUCTION OR COMPLETE SERVICES   |        |
| OTHER (Specify)  |        |
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