VFW
VETERANS OF FOREIGN WARS.
California

Post Service Officer Training

Agenda

- Veteran Service Officer (VSO) definition and what they do
- Post Service Officer (PSO) definition and what they do
- VA Forms, Submission & Samples (21-0966, 21-22 & 21-2680)
- VA Benefits/ Service Connection & Compensation
- Code of Conduct for PSO, “12 Rules To Live By”
- Resources for helping Veterans
- Important Reminders

What is a Veteran Service Officer?

VETERANS OF FOREIGN WARS.
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- **VA accredited employees** of the VFW Department of California who **are based out of the VFW Regional Offices**

- Referred to as VSO, Claims Consultant, Department Service Officer (DSO), or Assistant Department Service Officer (ADSO)

- Accredited means they have access to VA systems to help veterans with their claims

Veteran Service Officer Duties

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- Reviews decisions and advocates for the veteran and veteran's family
- Meets with the veteran and assists with collecting evidence
- Answers request for assistance
- Represent veterans at VA hearings

VFW Regional Office Locations

VETERANS OF FOREIGN WARS. California

- VFW VSO offices are located inside VA Regional Offices:

- Los Angeles
- Oakland
- San Diego
- Long Beach – L.A. satellite office
- Sacramento – Oakland satellite office

- Office contact information at **vfwca.org**
  - Go to "Resources" tab
  - Click on "Veterans Benefits & Assistance"

What are Post Service Officers?

- Post Service Officers (PSOs) are **volunteers in their VFW Posts** who help veterans in their local communities
- VFW Posts are the first place many members, veterans, and survivors turn to for assistance
- As a PSO, you share information about veterans' benefits to local communities. (Ex: community centers, nursing homes, places of worship, Veterans Centers, and other community places.)
- Assists veterans and their survivors begin the process of receiving the help they are entitled to/need

Post Service Officer Responsibilities

VETERANS OF FOREIGN WARS. California

- Know VA eligibility rules by established law
- Provide council to Veterans and survivors
- Help Veterans and survivors complete VA forms and direct submission to local office for completion. (DO NOT take possession of any documents, assist and review forms and supporting documents.)
- Stay informed to share knowledge about services offered (Ref: VSO, events, news, info pertaining to local, state, and federal veteran services.)

Why are PSOs so important?

- Knowledge of local benefits and resources
- Housing
- Employment
- Disaster Assistance
- Health Care

A PSO's responsibilities with claims

VETERANS OF FOREIGN WARS.
California

- Assist and review the veteran's claim documents and supporting evidence. (Examples on next slide)
- Must NOT take possession of ANY documents under any circumstance.
- Direct veteran to submit all documents to their respective VFW Regional Office.

VFW Guide for Post Service Officers

VETERANS OF FOREIGN WARS.
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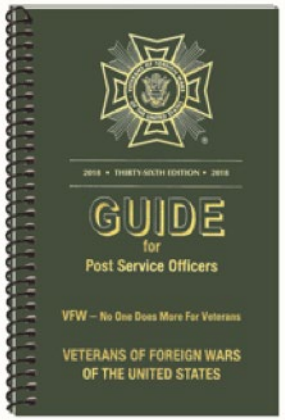
- VFW Manual of Procedure Section 218(a)(12) states in part, "The work of a Service Officer shall be performed in accordance with the instructions contained in the VFW Guide for Service Officers under the general supervision of the Department Service Officer."

- Purchase a copy from the VFW Store: www.vfwstore.org



VA Form 21-22

- Appointment of Veterans Service Organization as Claimants Representative
- Also known as the Power of Attorney (POA) form.* This is necessary for the veteran to get help from the VFW with filing a claim.
- The veteran is giving the VA permission to give VSOs access to the veteran's information in the **VA Benefits system (VBA) –NOT VHA (VA Healthcare System)**.
- Under NO circumstance should any fee or compensation of any nature be charged to anyone for services or representation in connection with any claim with the VFW.

*Note: "POA" is only the word used by the VA to refer to the Veteran Service Organization that has access to the veteran's file. It does NOT give the VSO access or permissions to any of the veterans private, non-VA related documents or information.

SAMPLE VA 21-22

(page 1)

Appointment of Veterans Service Organization as Claimant's Representative

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

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

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

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization please complete VA Form 21-22, *Appointment of Individual as Claimant's Representative*. When completed you can mail ***or*** fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

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

1. VETERAN'S NAME *(First, Middle Initial, Last)*: Joseph B Snuffy

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*: 987 – 65 – 4321

3. VA FILE NUMBER *(If applicable)*: 98765432 — You can leave blank

4. VETERAN'S DATE OF BIRTH: Month 07 – Day 04 – Year 1983

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

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

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

No. & Street: 654 Main St

Apt./Unit Number: #321 City: Los Angeles

State/Province: CA Country: US ZIP Code/Postal Code: 98765 –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*: (310) 999-8877

9. VETERAN'S EMAIL ADDRESS *(Optional)*: JoeBSnuffy@email.com

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

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*: Surviving Spouse = "claimant" Their info goes here

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

No. & Street:

Apt./Unit Number: City:

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

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

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

14. RELATIONSHIP TO VETERAN:

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*: Veterans of Foreign Wars (097)

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*: Lucia Hernandez — Leave this blank -will be completed at the Regional Office by accredited VSO

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A: Department Service Officer (DSO) — Leave Blank

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15: vfw.vbalan@va.gov — Leave blank

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*: 06/22/2020 — Use the same date that the form is signed.

VA FORM FEB 2019 **21-22** SUPERSEDES VA FORM 21-22, AUG 2015. **Page 1**

VFW VETERANS OF FOREIGN WARS. California

SAMPLE VA 21-22

(Page 2)

VETERAN'S SOCIAL SECURITY NUMBER 9 8 7 – 6 5 – 4 3 2 1

SECTION IV: AUTHORIZATION INFORMATION

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

***Box hast to be checked ***

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

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

Must be blank - NO checked boxes here

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

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

Checking is optional

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

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

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

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
Veteran's signature *Joseph B. Snuffy*	06/22/2020
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	**23B. DATE SIGNED** *(MM/DD/YYYY)*
DO NOT SIGN - SIGNED ONLY BY VSO AT REGIONAL OFFICE	06/25/2020

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

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

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

VA FORM 21-22, FEB 2019 Page 2

VFW VETERANS OF FOREIGN WARS. California

VA Form 21-0966 Intent to File

- **Establishes (bookmarks)** the veteran's effective date for receiving benefits.
- Sent to VFW Regional Office immediately by the veteran via mail, fax, or online (electronic upload).
- Form lets the VA know the veteran plans to submit a claim.
- Applies only to **new claims** (never claimed or rating increase)
- **VA gives the veteran or claimant up to 1 year from the date the form was received for them to submit their claim packet.**

VA Form 21-0966 – Cont.

VETERANS OF FOREIGN WARS. California

- The VA give claimants a 1-year period for evidence gathering.
- Supporting evidence means:
  - Medical documents- private medical records, doctor's letters, diagnoses.
  - Military documents- medical records, DD214, ships' logbooks, etc.
  - Other pertinent proof- marriage certificate, death certificate, invoices of medical out-of-pocket expenses, "buddy letters"

VA Form 21-0966 – Cont.

VETERANS OF FOREIGN WARS. California

- Ways that Veterans and Claimants can establish an Intent-to-File date:

1. In person- Preferred method, have Veteran fill out VA 21-0966 form and submit to the VSO at the VFW Regional Office via email/fax.
2. Call the VA directly- call **1-800-827-1000**, verbal "Intent to File" via VA Representative. Do this if the veteran/claimant did not bring a DD-214, marriage, or veteran death certificate when they first contacted you
3. Online/ eBenefits- log in online and begin the process of filing a claim, DO NOT complete the claim. Saving the incomplete claim will trigger an "Intent to File" date. https://www.ebenefits.va.gov/ebenefits/

SAMPLE

VA 21-0966 Intent to File Form

VETERANS OF FOREIGN WARS. California

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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

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

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

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

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*: Joseph B Snuffy

2. CLAIMANT'S SOCIAL SECURITY NUMBER: 987-65-4321

3. VA FILE NUMBER *(If applicable)*: 98765432 1

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY): Month 07 – Day 04 – Year 1983

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)*** --> "Claimant" usually = Surviving Spouse / Veteran's survivor

6. VETERAN'S SOCIAL SECURITY NUMBER: – –

7. VETERAN'S SEX: [X] MALE [ ] FEMALE

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

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

No. & Street: 654 Main St

Apt./Unit Number: #321

City: Los Angeles

State/Province: CA

Country: US

ZIP Code/Postal Code: 98765 –

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? [ ] YES [X] NO

11. TELEPHONE NUMBER *(Include Area Code)*: (310) 999-8888

12. EMAIL ADDRESS *(If applicable)*: JoeBSnuffy@email.com

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: ***(Choose all that apply)***

[X] COMPENSATION [ ] PENSION -> check both boxes if you're not sure whether vet qualifies for compensation

NOTE: Only check the box below if you are a surviving dependent of the veteran.

[ ] SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC) -> Box is for Veteran's Survivor ONLY

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

SECTION III: DECLARATION OF INTENT

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

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE: Veteran/ Veteran's Survivor signs — Joseph B. Snuffy

14B. DATE SIGNED *(MM,DD,YYYY)*: 06/22/2020

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

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

Leave Blank

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

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

VA FORM AUG 2018 **21-0966**

EXISTING STOCK OF VA FORM 21-0966, MAR 2017, WILL BE USED.

VA Form 21-2680
Aid & Attendance or Housebound

VETERANS OF FOREIGN WARS.
California

- Needs another person to help perform daily activities like eating, bathing, dressing, etc.
- Is bedridden or spends a significant amount of time in bed due to illness.
- In a nursing home due to physical or mental disability.
- Limited vision= 5/200 or less in both eyes; concentric contraction of visual field to 5 degrees or less despite using corrective lenses.
- Housebound-spends majority of time home due to a permanent disability.
- **A physician/physician's assistant or medical specialist are the only people who can fill out the VA 21-2680.** The only part of the form that is filled out by the veteran or claimant is **Section I.**

SAMPLE

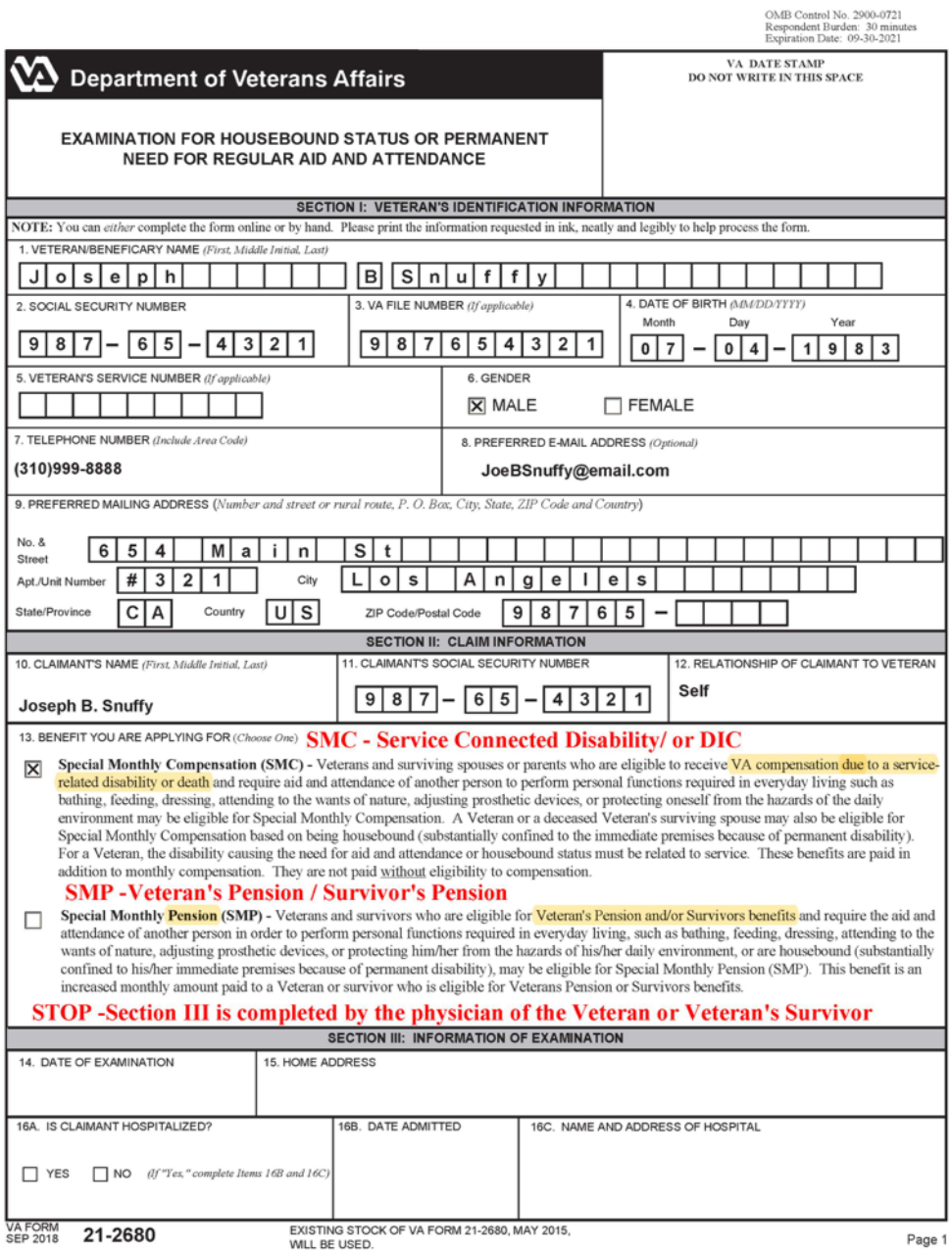
VA 21-2680

Aid & Attendance

or

Housebound

(page 1)



OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*: Joseph B Snuffy

2. SOCIAL SECURITY NUMBER: 987-65-4321

3. VA FILE NUMBER *(If applicable)*: 987654321

4. DATE OF BIRTH *(MM/DD/YYYY)*: Month 07 – Day 04 – Year 1983

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

6. GENDER: ☒ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*: (310)999-8888

8. PREFERRED E-MAIL ADDRESS *(Optional)*: JoeBSnuffy@email.com

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

No. & Street: 654 Main St
Apt./Unit Number: #321
City: Los Angeles
State/Province: CA
Country: US
ZIP Code/Postal Code: 98765 –

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*: Joseph B. Snuffy

11. CLAIMANT'S SOCIAL SECURITY NUMBER: 987-65-4321

12. RELATIONSHIP OF CLAIMANT TO VETERAN: Self

13. BENEFIT YOU ARE APPLYING FOR *(Choose One)* **SMC - Service Connected Disability/ or DIC**

☒ **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

SMP -Veteran's Pension / Survivor's Pension

☐ **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

STOP -Section III is completed by the physician of the Veteran or Veteran's Survivor

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED? ☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

VA FORM SEP 2018 **21-2680** EXISTING STOCK OF VA FORM 21-2680, MAY 2015, WILL BE USED.

Page 1

VETERANS OF FOREIGN WARS. California

SAMPLE

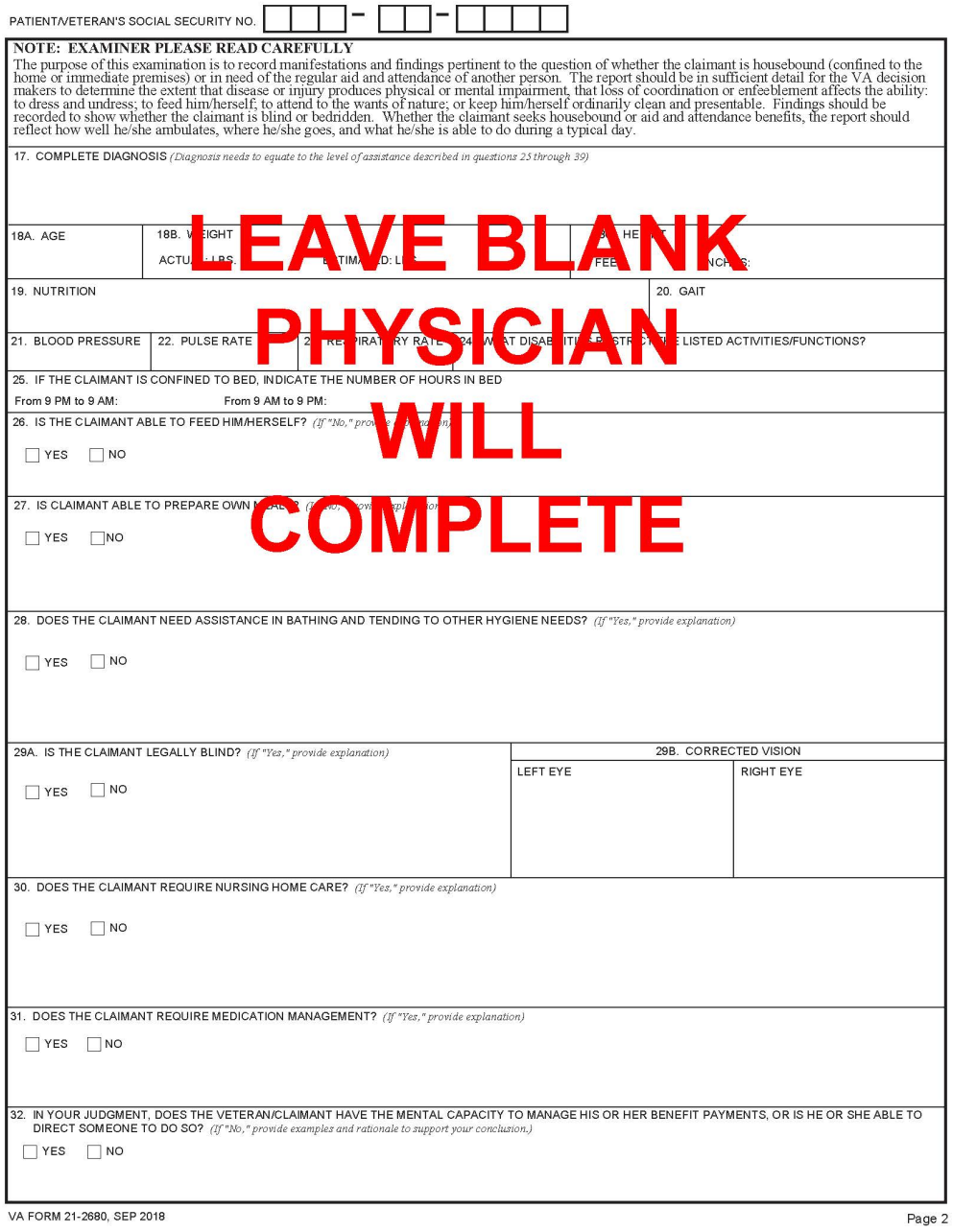
VA 21-2680

Aid & Attendance

or

Housebound

(page 2)



PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ - ☐☐ - ☐☐☐☐

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 25 through 39)*

18A. AGE | 18B. WEIGHT ACTUAL: LBS. ESTIMATED: LBS. | HEIGHT FEET: INCHES:

19. NUTRITION | 20. GAIT

21. BLOOD PRESSURE | 22. PULSE RATE | 23. RESPIRATORY RATE | 24. WHAT DISABILITIES REGISTER IN THE LISTED ACTIVITIES/FUNCTIONS?

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*

☐ YES ☐ NO

29B. CORRECTED VISION

LEFT EYE	RIGHT EYE

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? *(If "No," provide examples and rationale to support your conclusion.)*

☐ YES ☐ NO

VA FORM 21-2680, SEP 2018 Page 2

LEAVE BLANK

PHYSICIAN

WILL

COMPLETE

VETERANS OF FOREIGN WARS.

California

SAMPLE

VA 21-2680

Aid & Attendance

or Housebound

(page 3)

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ - ☐☐ - ☐☐☐☐

33. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, RANGE OF MOVEMENTS AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE AND ABILITY TO CONTINENT SUFFICIENT ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES ☐ NO *(If "YES," give distance) (Check applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. 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 pate at http://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 21-2680, SEP 2018 Page 3

LEAVE BLANK

PHYSICIAN WILL COMPLETE

Check that the #s 40A - 41B are completed
VA will return the form if these #s are blank

VETERANS OF FOREIGN WARS. California

Service-Connection and Compensation

VETERANS OF FOREIGN WARS.
California

- Service-Connection and Compensation
- O% = Service Connection the veteran's disability is rated 0%, they receive free medical/ mental health treatment at a VA facility (hospital or clinic). No compensation is paid, because the disability is considered minor.
- 10% or more = Compensation payments are given monthly if a veteran is disabled due to military service.

Non-Service-Connected Pension

- Non-Service-Connected Pension qualification requirements:
  - Age 65 or older, if under 65, are permanently 100% disabled, have limited or no income.
  - **Served the minimum time-in-service requirement on <u>active duty</u> with <u>at least 1 day served during an eligible wartime period</u>.**
  - Seriously disabled veterans may qualify for Aid and Attendance (A&A) benefits.

VA Healthcare Benefits & Services

VETERANS OF FOREIGN WARS.
California

- Hospital, outpatient medical, dental, pharmacy and prosthetic services
- Domiciliary, nursing home and community base residential care
- Mental health treatment (inpatient and outpatient)
- Specialized health care for women veterans (includes prenatal care)
- Health and rehabilitation programs for homeless Veterans
- Readjustment counseling– Vet Centers (for Combat and MST only)
- Alcohol and drug dependency treatment
- Registries - Medical evaluation for disorders related to service in the Gulf Wars (Desert Shield/Storm, Iraq, Afghanistan, Kuwait). exposure to Agent Orange, burn pits, radiation, and other environmental hazards.

Education Benefits

VETERANS OF FOREIGN WARS.
California

- VA administers education benefits for active duty troops, veterans, reservists, and qualifying dependents.
- Post 9/11 GI Bill (Chapter 33) and Montgomery GI Bill (Chapter 30) for active duty veterans.
- MGIB Selected Reserve (Section 1606) for Reservists.
- Dependents Educational Assistance (Chapter 35) for dependents.

- For more info visit:

http://explore.va.gov/education-training

Veteran Readiness and Employment (VR&E)

VETERANS OF FOREIGN WARS. California

- Commonly referred to or known as “Voc Rehab”

- Purpose is to aid Veterans with service-connected disabilities to prepare for, obtain, and maintain suitable employment, by providing job training, employment accommodations, resume development, and job seeking skills.

- For more info visit:

http://www.benefits.va.gov/vocrehab/

VA Home Loans

VETERANS OF FOREIGN WARS.
California

- Several VA home loan services are available to eligible veterans, some military personnel, and certain surviving spouses (DIC).
- Types of VA loans:
  - Guaranteed Loans
  - Purchase or Refinance
  - Special Grants

- For more info visit:

https://www.benefits.va.gov/homeloans/

Life Insurance

- Service-Disabled Veterans Insurance (SDVI)
  - For Veterans with service-connected disabilities. Veterans **must apply within 2 years of getting service connected** for **any new** disability.
- Veterans Group Life Insurance (VGLI)
  - Renewable term life insurance for veterans who want to convert their SGLI up to an amount not to exceed the coverage they had when separated from service. Must apply within a year & a half from their discharge date.

- For more info visit:

https://www.va.gov/life-insurance/options-eligibility/

Dependency and Indemnity Compensation (DIC)

VETERANS OF FOREIGN WARS. California

- Payable to certain survivors of:
  - **Veterans whose deaths were caused by service-connected illness or injury**. This includes disabilities that can be proven to be service-connected. In other words, Vet did not have to be receiving disability benefits before death (i.e. AO exposure presumptive).
  - **Veterans who were 100% P&T.** One of the qualifying factors must be met:
    1. 10 yrs. before their death; or,
    2. Released from active duty for at least 5 yrs. before death; or,
    3. At least 1yr before their death, was a prisoner of war who died after Sept. 30, 1999
  - **Service-members who died on active duty, active duty for training, or inactive-duty training.**
  - For more info visit:

https://www.va.gov/disability/dependency-indemnity-compensation/

Survivors Pension

VETERANS OF FOREIGN WARS. California

- Widow who has not remarried; OR
- Unmarried child who is under 18, permanently disabled before 18, or Age 18-23 and enrolled in an approved educational institution
- **Meets low income and net worth requirements**
- May qualify for Aid and Attendance (A&A) benefits even if they don't meet Pension income requirements

For the Survivor to qualify for Pension, the Deceased veteran must have:

- Other than dishonorable military discharge, AND
- **Served the minimum time-in-service requirement on <u>active duty</u>, with <u>at least 1 day served during an eligible war time period.</u>**

Death Benefits
(VA National Cemetery Administration)

VETERANS OF FOREIGN WARS.
California

- Burial Benefits - VA burial benefits can help service members, Veterans, and their family members plan and pay for a burial or memorial service in a VA national cemetery.
- Headstones and Markers - VA can provide a monument to mark the grave of an eligible veteran.
- Presidential Memorial Certificate - A Presidential Memorial Certificate (PMC) is a certificate signed by the President of the United States. It is given to honor the memory of a Veteran in recognition of their military service. Note: Vet must have an Honorable discharge to qualify.
- **VBA Burial Benefits-** Reimbursement for some funeral costs
- For more info visit: https://www.va.gov/burials-memorials/

Code of Conduct for Post Service Officers

VETERANS OF FOREIGN WARS.
California

“The 12 VFW Rules to Live By”

Code of Conduct for Post Service Officers

VETERANS OF FOREIGN WARS.
California

1. Will perform their duties under the supervision of the Department Service Officer (DSO) and their respective VFW Regional Office.

2. Shall assist members of the Post, their widows and orphans and other Veterans in obtaining rightful benefits from the federal and state governments.

3. Will never release confidential information, such as what conditions were claimed or address of the claimant, etc. to parties other than the claimant or VFW accredited representatives.

Code of Conduct for Post Service Officers

VETERANS OF FOREIGN WARS. California

4. Should keep members informed of Veterans' entitlements and benefits offered and administered by federal, state, and local governments.
5. Assist Veterans and survivors free of charge; under no circumstances, shall they request, demand or accept cash or any other form of payment for such assistance, etc.
6. Shall not refuse to assist any Veteran or survivor unless the claimant is considered fraudulent. Shall not refuse to assist any Veteran or survivor because they do not feel the Veteran or survivor is eligible for the benefit sought. The VFW Regional Office will make the final decision as to whether the VFW will provide representation in all cases.

Code of Conduct for Post Service Officers

VETERANS OF FOREIGN WARS. California

7. Inform the veterans (preferably in writing) that all application forms, evidence, etc., in connection with claims should be submitted to the Department Service Officer. Since VA Awards benefits are based on the date of the claim, it is vital the claims be sent to the VFW Regional Office IMMEDIATELY upon receipt.
8. Shall NOT keep original documents provided to them in connection with claims. The claimant will transmit copies to the DSO/ VFW Regional Office who will submit them to the VA on their behalf.
9. Shall refrain from the use of racial, religious, age related, sexual or ethnic epithets, innuendos, slurs or jokes in the workplace.

Code of Conduct for Post Service Officers

VETERANS OF FOREIGN WARS. California

10. Must conduct themselves in a professional manner and refrain from sexual advances, verbal or physical conduct of a sexual nature, or request for sexual favors.
11. Should have access to current VA forms. Contact your VFW Regional Office or DSO if forms are not available in your office or visit https://www.va.gov/find-forms/
12. Should attend all Post Service Officer Training

Resource Links

VETERANS OF FOREIGN WARS. California

- VA Healthcare: http://www.va.gov/healthbenefits/apply/veterans.asp
- Access VA Benefits & Healthcare: www.VA.gov
- eBenefits:
  - https://www.ebenefits.va.gov/ebenefits/homepage
- VFW Service Offices:
- https://vfwca.org/di/vfw/v2/default.asp?pid=74108

Resource Links

- National Archives -DD214, Military Medical Records and Training Records: http://www.archives.gov
  - Note: must be connected to a printer when making the request

- Cal-Vets & DMV - "Veteran" designation on CA License or ID :

http://www.calvet.ca.gov/VetServices/Pages/Veteran-Designation-on-California-Driver-License-and-ID-Card.aspx
  - Note: must file with County VSO –bring DD-214 and ID/License

- Cal-Vets College Fee Waiver:
  - http://www.calvet.ca.gov/VetServices/Pages/College-Fee-Waiver.aspx
  - Note: must file with County VSO or Cal-Vets Regional Office VSO

Important Reminders!

- NEVER hold on to any veteran's documents (copies or originals)
- Don't sign VA 21-22 –the form will be signed at the Regional Office by DSO
- Ensure veterans submit docs to the VFW Regional Office
- Submit form 21-0966 immediately to establish an effective date – even if the veteran or claimant doesn't have DD-214, Marriage or Death Certificate
- Stay Informed
- Refer to DSOs with any questions you may have –contact information is found in vfwca.org website
- Alternative VA Contact and Information Sheet provided in your training packet
- Get current VA Forms and Information at https://www.va.gov/ or https://www.vfw.org/

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

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

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization please complete VA Form 21-22, *Appointment of Individual as Claimant's Representative.* When completed you can mail ***or*** fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

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

1. VETERAN'S NAME *(First, Middle Initial, Last)*: Joseph B Snuffy

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*: 987-65-4321

3. VA FILE NUMBER *(If applicable)*: You can leave blank — 98765432 1

4. VETERAN'S DATE OF BIRTH: Month 07 – Day 04 – Year 1983

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

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

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

No. & Street: 654 Main St
Apt./Unit Number: #321
City: Los Angeles
State/Province: CA
Country: US
ZIP Code/Postal Code: 98765 –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*: (310)999-8877

9. VETERAN'S EMAIL ADDRESS *(Optional)*: JoeBSnuffy@email.com

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

10. CLAIMANT'S NAME *(First, Middle Initial, Last)* Surviving Spouse = "claimant" Their info goes here

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

No. & Street:
Apt./Unit Number:
City:
State/Province:
Country:
ZIP Code/Postal Code: –

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

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

14. RELATIONSHIP TO VETERAN:

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*: Veterans of Foreign Wars (097)

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*: Lucia Hernandez — Leave this blank -will be completed at the Regional Office by accredited VSO

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A: Department Service Officer (DSO) — Leave Blank

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15: vfw.vbalan@va.gov — Leave blank

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*: 06/22/2020 — Use the same date that the form is signed.

VETERAN'S SOCIAL SECURITY NUMBER 9 8 7 – 6 5 – 4 3 2 1

SECTION IV: AUTHORIZATION INFORMATION

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

***Box hast to be checked ***

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

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

Must be blank - NO checked boxes here

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

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

Checking is optional

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

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

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

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
Veteran's signature Joseph B. Snuffy	06/22/2020
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*
DO NOT SIGN - SIGNED ONLY BY VSO AT REGIONAL OFFICE	06/25/2020

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

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

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

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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

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

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

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

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*: Joseph B Snuffy

2. CLAIMANT'S SOCIAL SECURITY NUMBER: 987-65-4321

3. VA FILE NUMBER *(If applicable)*: 987654321

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY): Month 07 – Day 04 – Year 1983

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)*** --> "Claimant" usually = Surviving Spouse / Veteran's survivor

6. VETERAN'S SOCIAL SECURITY NUMBER:

7. VETERAN'S SEX: [X] MALE [ ] FEMALE

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

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

No. & Street: 654 Main St

Apt./Unit Number: #321

City: Los Angeles

State/Province: CA

Country: US

ZIP Code/Postal Code: 98765 –

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?
[ ] YES [X] NO

11. TELEPHONE NUMBER *(Include Area Code)*: (310) 999-8888

12. EMAIL ADDRESS *(If applicable)*: JoeBSnuffy@email.com

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: ***(Choose all that apply)***

[X] **COMPENSATION** [ ] **PENSION** -> check both boxes if you're not sure whether vet qualifies for compensation

NOTE: Only check the box below if you are a surviving dependent of the veteran.

[ ] **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)** -> Box is for Veteran's Survivor ONLY

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

SECTION III: DECLARATION OF INTENT

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

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE: Veteran/ Veteran's Survivor signs — Joseph B. Snuffy

14B. DATE SIGNED *(MM,DD,YYYY)*: 06/22/2020

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

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

Leave Blank

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

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

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*: Joseph B Snuffy

2. SOCIAL SECURITY NUMBER: 987-65-4321

3. VA FILE NUMBER *(If applicable)*: 987654321

4. DATE OF BIRTH *(MM/DD/YYYY)*: Month 07 – Day 04 – Year 1983

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

6. GENDER: ☒ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*: (310)999-8888

8. PREFERRED E-MAIL ADDRESS *(Optional)*: JoeBSnuffy@email.com

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

No. & Street: 654 Main St
Apt./Unit Number: #3211
City: Los Angeles
State/Province: CA
Country: US
ZIP Code/Postal Code: 98765 –

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*: Joseph B. Snuffy

11. CLAIMANT'S SOCIAL SECURITY NUMBER: 987-65-4321

12. RELATIONSHIP OF CLAIMANT TO VETERAN: Self

13. BENEFIT YOU ARE APPLYING FOR (*Choose One*) **SMC - Service Connected Disability/ or DIC**

☒ **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

SMP -Veteran's Pension / Survivor's Pension

☐ **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

STOP -Section III is completed by the physician of the Veteran or Veteran's Survivor

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED? ☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

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

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 25 through 39)*

18A. AGE	18B. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.	HEIGHT FEET INCHES:

19. NUTRITION	20. GAIT

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? *(If "No," provide examples and rationale to support your conclusion.)*

☐ YES ☐ NO

LEAVE BLANK PHYSICIAN WILL COMPLETE

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

33. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE WITH STABILITY, CONDITION OF SKIN, SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES
☐ NO

(If "YES," give distance) (Check applicable box or specify distance)

☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

LEAVE BLANK

PHYSICIAN WILL COMPLETE

Check that the #s 40A - 41B are completed
VA will return the form if these #s are blank

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. 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 pate at **http://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 Environmental Health Coordinators

-Schedule registry evaluations (physical exam to be added to a registry)
-Health concerns related to military exposures (environmental, chemical, etc.)

California	Environmental Health Coordinators
San Francisco VA Medical Center 4150 Clement Street San Francisco, CA 94121	**Luis Matos-Boneta** (415) 221-4810 x25911 Luis.Matos-Boneta@va.gov Fax: (415) 750-2249
VA Central California Health Care System **Fresno VA Medical Center** 2615 E. Clinton Avenue Fresno, CA 93703	**Ebony Turner** (559) 225-6100 x6950 Ebony.Turner2@va.gov Fax: (559) 228-6990
VA Greater Los Angeles Healthcare System **West Los Angeles Medical Center** 11301 Wilshire Blvd Los Angeles, CA 90073	**Jody L. Conn** (818) 895-9528 VHAGLARegistryCoordinators@va.gov Fax: (310) 268-4980
VA Loma Linda Healthcare System 11201 Benton Street Loma Linda, CA 92357	**William E. Carson** (909)825-7084 x2288 William.Carson@va.gov Fax: (909) 796-1370
VA Long Beach Healthcare System 5901 East 7th Street Long Beach, CA 90822	**Emilita Monfiero** (562) 826-8000 x3042 Emilita.Monfiero@va.gov
VA Palo Alto Health Care System **Palo Alto Division** 3801 Miranda Avenue Palo Alto, CA 94304	**Luis San Gabriel** (650) 493-5000 x65409 Luis.SanGabriel@va.gov Fax: (650) 858-8900
VA San Diego Healthcare System 3350 La Jolla Village Dr. San Diego, CA 92161	**Dale Willoughby** (858) 642-3995 Dale.Willoughby@va.gov Fax: (858) 642-6488
VA Northern California Health Care System **McClellan Outpatient Clinic** 3401 Beech St., Bldg #949, Room 204 McClellan, CA 95652	**Jacqueline Johnson** (916) 640-8485 Jacqueline.Johnson5@va.gov Fax: (916) 640-8470

U.S. Department of Veterans Affairs
Veterans Benefits Administration

Alternative VA Contact and Information:

Ask any question on-line https://iris.custhelp.va.gov/

(Claim Status, Benefit Verification Letters and more …)

Note: **Some Benefit Verification Letters** such as GI Bill eligibility, Loan Certificate of Eligibility, and VA Benefits (commissary letters, to prove income or disability rating) **can be downloaded directly from your VA.gov account**. You can download the letter and print it at home. It takes approximately 15-20 minutes. It is a quicker option than waiting for the VA to mail you the letter.

Phone Numbers

Benefits (National Call Center)	1-800-827-1000	- Claim Status, Benefit Letters etc.
Debt Management Center	1-800-827-0648	- Debt issues, Waivers, Payment Plans
Education (GI Bill, Chapter 35)	1-888-442-4551	- All education issues, GI Bill, Chapter 35
Health Care	1-877-222-8387	- All health Care, hospital issues, records etc.
Homeless Veterans	1-877-424-3838	- Homeless and Housing Issues and Assistance
Pension Management Center	1-877-294-6380	- Pension and Survivors Benefits
Veterans Crisis Line	1-800-273-8255	- Immediate Need Issues
Home Loans	1-888-827-3702	- Certificate of Eligibility – Loan Inquiries
Vocational Rehab & Education	1-310-235-7722	- Claim Status and Inquiries
Claims Intake - FAX Number	1-844-531-7818	- Submit a Claim, evidence or Correspondence

Web Sites

VA Home Page	www.va.gov
eBenefits	www.ebenefits.va.gov
My HealtheVet	www.myhealth.va.gov
Home Loan Guaranty	www.homeloans.va.gov
Education Benefits	www.gibill.va.gov
Forms - VA forms	www.va.gov/vaform
Homeless Veterans	www.va.gov/homeless
Records, (military)	www.archives.gov/st-louis/military-personnel
State Departments of Veterans Affairs	www.va.gov/statedva.htm