OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 09/30/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS *(Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. (See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)*

- ○ FULLY DEVELOPED CLAIM (FDC) PROGRAM
- ○ STANDARD CLAIM PROCESS
- ○ IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- ○ BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

SECTION I: IDENTIFICATION AND CLAIM INFORMATION
(If claim is not an original claim, only Section I, IV, and a signature are required)

NOTE: You may *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.

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*

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

4. HAVE YOU EVER FILED A CLAIM WITH VA? ○ YES ○ NO *(If "Yes," provide your file number in Item 5)*

5. VA FILE NUMBER

6. DATE OF BIRTH *(MM-DD-YYYY)* – –

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

8. GENDER YOU CURRENTLY IDENTIFY WITH ○ MALE ○ FEMALE ○ OTHER

9. BDD CLAIMS ***ONLY:*** **PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** *(MM-DD-YYYY)* – –

10. TELEPHONE NUMBER *(Optional) (Include Area Code)* – –

Enter International Phone Number *(If applicable)*

11. 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 –

12. EMAIL ADDRESS *(Optional)* ○ I agree to receive electronic correspondence from VA in regards to my claim.

○ 13. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX *(Includes Work Study/Internship)? (If you are not a VA employee skip to Section II, if applicable)*

SECTION II: CHANGE OF ADDRESS

NOTE: If you are temporarily or permanently changing your address, complete Items 14A through 14C.

14A. TYPE OF ADDRESS CHANGE *(Complete if applicable) (Check only one box)*

○ TEMPORARY ○ PERMANENT

14B. NEW 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 –

14C. EFFECTIVE DATE(S) OF NEW ADDRESS *(If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)*

	Month	Day	Year		Month	Day	Year
BEGINNING DATE:	–	–		**ENDING DATE:**	–	–	

VETERANS SOCIAL SECURITY NO. ___ – ___ – ____

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 15A through 15F) should ***only*** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

15A. ARE YOU CURRENTLY HOMELESS?

- ○ YES *(If "Yes," complete Item 15B regarding your living situation)*
- ○ NO

15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ○ LIVING IN A HOMELESS SHELTER
- ○ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)
- ○ STAYING WITH ANOTHER PERSON
- ○ FLEEING CURRENT RESIDENCE
- ○ OTHER (Specify)

15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

- ○ YES *(If "Yes," complete Item 15D regarding your living situation)*
- ○ NO

15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ○ HOUSING WILL BE LOST IN 30 DAYS
- ○ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)
- ○ OTHER (Specify)

15E. POINT OF CONTACT *(Name of person VA can contact in order to get in touch with you)*

15F. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*

___ – ___ – ____

Enter International Phone Number *(If applicable)*

SECTION IV: CLAIM INFORMATION

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY *(If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)*

NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section IV.**

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

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

VETERANS SOCIAL SECURITY NO. ___ - ___ - ____

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.

NOTE: If treatment began from 2005 to present, you ***do not*** need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
	__ - ____	○ Don't have date
	__ - ____	○ Don't have date
	__ - ____	○ Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW. (VA forms are available at **www.va.gov/vaforms**)

For:	***Required Form(s):***
Supplemental Claims	VA Form 20-0995, *Decision Review Request: Supplemental Claim*
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 or 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION V: SERVICE INFORMATION

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

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

19A. BRANCH OF SERVICE
○ ARMY ○ NAVY ○ MARINE CORPS
○ AIR FORCE ○ COAST GUARD ○ SPACE FORCE
○ NOAA ○ USPHS

19B. COMPONENT
○ ACTIVE ○ RESERVES ○ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES *(MM,DD,YYYY)*

	Month	Day	Year
ENTRY DATE:	__ -	__ -	____
EXIT DATE:	__ -	__ -	____

20B. PLACE OF LAST OR ANTICIPATED SEPARATION

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
○ YES ○ NO

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

	Month	Day	Year
From:	__ -	__ -	____
To:	__ -	__ -	____

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
○ YES *(If "Yes," complete Items 21B thru 21F)*
○ NO *(If "No," skip to Item 22A)*

21B. COMPONENT
○ NATIONAL GUARD
○ RESERVES

21C. OBLIGATION TERM OF SERVICE

	Month	Day	Year
From:	__ -	__ -	____
To:	__ -	__ -	____

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
○ YES ○ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
○ YES *(If "Yes," complete Items 22B & 22C)*
○ NO

22B. DATE OF ACTIVATION:
Month __ - Day __ - Year ____

22C. ANTICIPATED SEPARATION DATE:
Month __ - Day __ - Year ____

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
○ YES *(If "Yes," complete Item 23B)*
○ NO

23B. DATES OF CONFINEMENT

From: Month	Day	Year	To: Month	Day	Year
__ -	__ -	____	__ -	__ -	____
__ -	__ -	____	__ -	__ -	____

VETERANS SOCIAL SECURITY NO. ___ - ___ - ____

SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?

○ YES *(If "Yes," complete Items 24C and 24D)*

○ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?

○ YES *(If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)*

○ NO

24C. BRANCH OF SERVICE

○ ARMY ○ NAVY ○ MARINE CORPS

○ AIR FORCE ○ COAST GUARD ○ SPACE FORCE

○ NOAA ○ USPHS

24D. MONTHLY AMOUNT

$ ___,___.00

25. RETIRED STATUS

○ RETIRED ○ PERMANENT DISABILITY RETIRED LIST

○ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):

Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26**.

Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

○ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:

VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which ***may*** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

○ YES *(If "Yes," complete Items 27B through 27D)*

○ NO

27B. DATE PAYMENT RECEIVED *(MM-DD-YYYY)*

__ - __ - ____

27C. BRANCH OF SERVICE

○ ARMY ○ NAVY ○ MARINE CORPS

○ AIR FORCE ○ COAST GUARD ○ SPACE FORCE

○ NOAA ○ USPHS

27D. AMOUNT RECEIVED *(Provide pre-tax amount)*

$ ___,___.00

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:

You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

○ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

SECTION VII: DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

○ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT *(If you check this box skip to Section VIII)*

30. ACCOUNT NUMBER *(Check only **one** box below and provide the account number)*

Account No.: ○ CHECKING ○ SAVINGS

31. NAME OF FINANCIAL INSTITUTION *(Provide the name of the bank where you want your direct deposit)*

32. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

VETERANS SOCIAL SECURITY NO. [ ] [ ] [ ] – [ ] [ ] – [ ] [ ] [ ] [ ]

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**)	33B. DATE SIGNED *(MM-DD-YYYY)* [ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION IX: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS *(Sign in ink)* ***(Note**: Only sign if veteran signed in Item 33A using an "X")*	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS *(Sign in ink)* ***(Note**: Only sign if veteran signed in Item 33A using an "X")*	35B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

NOTE: An alternate signer signature **will not** be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**)	36B. DATE SIGNED *(MM-DD-YYYY)* [ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE (NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual As Claimant's Representative,* indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	37B. DATE SIGNED *(MM-DD-YYYY)* [ ][ ] – [ ][ ] – [ ][ ][ ][ ]

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

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. 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. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 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.