



# Cuyahoga County Veterans Service Commission

Ph: 216.698.2600 • Fax: 216.698.2650

Email: [vscmail@cuyahogacounty.us](mailto:vscmail@cuyahogacounty.us)

1849 Prospect Avenue • Suite 150 • Cleveland, OH 44115

## SERVICE - CONNECTED BENEFITS

***VA Service - Connected disability is a benefit for service members who became disabled as a direct result of their military service.***

1. What is the Veterans Name? \_\_\_\_\_
2. What is the spouse's / widow's name? \_\_\_\_\_
3. Do you have your DD214? (Circle one answer) YES      NO
4. Provide the Veterans Social Security number. \_\_\_\_\_
5. Provide the spouse/ widow's Social Security number. \_\_\_\_\_
6. Provide the Veterans birth date: \_\_\_\_\_
7. What is the spouse's / widow's birth date? \_\_\_\_\_
8. Please provide the phone number to be used with this application. \_\_\_\_\_
9. Please provide the applicant 's home address:  
  
\_\_\_\_\_
10. When did the applicant move in to this address? \_\_\_\_\_
11. What is your email address? \_\_\_\_\_

If you are not the Veteran, please complete the questions listed below.

1. What is your name? \_\_\_\_\_
2. What is your phone number? \_\_\_\_\_
3. What is your relationship to the Veteran? \_\_\_\_\_

Please use the space below to provide the VSC with the reason for your visit today.

You will receive a call from 216-698-2600 in 24-48 hours from our staff to assist with your SCD application.

# SERVICE- CONNECTED COMPENSATION (SCC)

*Please read the instructions below so that our staff may assist with your request.*

1. If you only require a certified copy of your DD214

- If you retired or were discharged from active duty after the following dates, please complete DPRIS "Consent to Release or Obtain Information" Form located on the last page.

Air Force- October 1, 2004  
Army- October 1, 2002  
Marine Corps- January 1, 1999  
Navy- January 1, 1995

If above dates do not apply see bullet point listed below.

- Please complete the Standard Form 180 (SF 180) enclosed within this package.

### **Filing your Fully Developed Claim**

2. The first step in the VA Claims process is to file an "Informal Claim for Benefits" This allows the VSC to initiate your claim for Service Connection, please follow the step listed below.

- Please complete VA Form 21-0966 (Intent to File) and VA Form 21-22 (Power of Attorney). The Veteran must sign these documents. Please return these two initial documents to the Veterans Service Commission as soon as possible. This will allow the VSC to begin your claim while you are still obtaining the required documents.

3. Preparing your Fully Developed Claim for Service- Connected Compensation:

- After your Informal Claim for VA Benefits has been submitted by the VSC please assist your County Veterans Service Officer by clearly indicating what medical conditions you are requesting to file Service-Connected Compensation and provide all military and private medical records that relate to those conditions.
- This package contains a checklist and instructions that will help you determine what information is necessary to file your claim for Service- Connected benefits.

4. Put the information into the envelope and place into the Drop Box located in our waiting room. A County Veterans Service Officer will contact you within 24-48 Hours to assist you with preparing your Fully Developed Claim . You can also complete this package at home and mail your documents using our prepaid envelopes to:

Cuyahoga County Veterans Service Commission  
1849 Prospect Ave  
Cleveland OH, 44115  
216-698-2600  
vscinfo@cuyahogacounty .us

\*Please contact the front desk staff member to obtain a prepaid envelope.

# VA



**U.S. Department of Veterans Affairs**  
Veterans Benefits Administration

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## **Disability Compensation**

Disability compensation is a benefit paid to Veterans because of injuries or disease that happened during active duty. In some cases, an existing disease or injury was worsened due to active military service. This benefit is also paid to certain Veterans disabled from VA health care. The benefits are tax-free.

### **Who is eligible?**

You may be eligible for disability compensation if:

- You have a service-related disability or illness.
- Your discharge was not dishonorable.

### **How much does VA pay?**

The amount of benefit pay varies depending on your disability. You may be paid additional amounts if:

- You have very severe disability(ies) or loss of limb(s).
- You have a spouse, child(ren) or dependent parent(s).
- You have a seriously disabled spouse.

### **How can you apply?**

Fill out VA Form 21-526, "Veterans Application for Compensation and/or Pension," located at <https://www.vba.va.gov/pubs/forms/VBA-21-526-ARE.pdf>. You may also use VA Form 21-526EZ, "Fully Developed Claim (Compensation)," located at <https://www.vba.va.gov/pubs/forms/VBA-21-526EZ-ARE.pdf>.

If you have any of the following documents, please attach them to your application:

- Discharge or separation papers (DD214 or equivalent)

- Dependency records (marriage license and children's birth certificates)
- Medical evidence (doctor or hospital reports and records)

You can also apply online using eBenefits at

<https://www.ebenefits.va.gov/ebenefits/about/feature?feature=disability-compensation>.

## **Related Benefits**

- Priority medical care: <https://www.va.gov/HEALTHBENEFITS/apply/index.asp>
- Vocational rehabilitation: <https://www.benefits.va.gov/vocrehab/index.asp>
- Clothing allowance: [https://www.benefits.va.gov/COMPENSATION/claims-special-clothing\\_allowance.asp](https://www.benefits.va.gov/COMPENSATION/claims-special-clothing_allowance.asp)
- Grants for Specially Adapted Housing:  
<https://www.benefits.va.gov/homeloans/adaptedhousing.asp>
- Automobile Grant and Adaptive Equipment:  
<https://www.benefits.va.gov/COMPENSATION/claims-special-auto-allowance.asp>
- Service-Disabled Veterans Insurance: <https://www.benefits.va.gov/insurance/s-dvi.asp>
- Federal Employment Preference: [https://www.va.gov/JOBS/hiring\\_programs.asp](https://www.va.gov/JOBS/hiring_programs.asp)
- State/local Veterans benefits: <https://www.va.gov/statedva.htm>
- Military exchange and community privileges:  
<https://www.shopmyexchange.com/>



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## **Service-Connected Compensation** **CHECKLIST**

Thank you for contacting the Cuyahoga County Veterans Service Commission. Please bring with you the items checked below so your claim can be processed completely and efficiently.

- Military Discharge Document - DD214 or WD AGO (Original if available)
  
- Marriage Certificate and information on all prior marriages (divorce decrees, annulments etc.)
  
- Spouse and dependents social security numbers and dates of birth: Include birth certificates for children under the age of 18 and 18-23 yrs old that are full time students.
  
- Provide all military medical and private medical records that relate to the condition you wish to file for.
  
- Direct Deposit Information (ex. voided check)

Please bring these documents with you when you come into file for Service Connected Compensation.

**REMEMBER APPLYING FOR VA BENEFITS IS ALWAYS FREE**



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

**INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION,  
OR SURVIVORS PENSION AND/OR DIC**  
**(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)**

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

**SECTION I: CLAIMANT/VETERAN IDENTIFICATION**

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

1. CLAIMANT'S NAME (First, Middle Initial, Last)		
2. CLAIMANT'S SOCIAL SECURITY NUMBER		3. VA FILE NUMBER (If applicable)
4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY) Month Day Year		
5. VETERAN'S NAME (First, Middle Initial, Last) (If different from claimant)		
6. VETERAN'S SOCIAL SECURITY NUMBER	7. VETERAN'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	8. VETERAN'S SERVICE NUMBER (If applicable)
9. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)		
No. & Street		
Apt./Unit Number City		
State/Province Country ZIP Code/Postal Code		
10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. TELEPHONE NUMBER (Include Area Code)	12. EMAIL ADDRESS (If applicable)

**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)**

COMPENSATION  PENSION

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

SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

**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 at [www.va.gov](http://www.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	14B. DATE SIGNED (MM,DD,YYYY)
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15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (Please Print)  
(NOTE: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

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

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

**APPOINTMENT OF VETERANS SERVICE ORGANIZATION  
 AS CLAIMANT'S REPRESENTATIVE**

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

**NOTE:** If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. 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](http://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)

	□	
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2. VETERAN'S SOCIAL SECURITY NUMBER (SSN)

□□□□	-	□□□□	-	□□□□□□
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3. VA FILE NUMBER (If applicable)

□□□□□□□□
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4. VETERAN'S DATE OF BIRTH

Month □□	-	Day □□	-	Year □□□□
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5. VETERAN'S SERVICE NUMBER (If applicable)

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

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

No. & Street										
Apt./Unit Number	□□□□□□	City								
State/Province	□□	Country	□□	ZIP Code/Postal Code	□□□□□□	-	□□□□□□			

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

□□□□□□□□
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9. VETERAN'S EMAIL ADDRESS (Optional)

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

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

	□	
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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)

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

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14. RELATIONSHIP TO VETERAN

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**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)

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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)

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

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17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

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

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# REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>  
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

## SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much information as possible.)

1. NAME USED DURING SERVICE (last, first, full middle)		2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH		
5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)						
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
b. RESERVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
c. STATE NATIONAL GUARD	-			<input type="checkbox"/>	<input type="checkbox"/>	

6. IS THIS PERSON DECEASED?  NO  YES - *MUST* provide Date of Death if veteran is deceased: \_\_\_\_\_

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE?  NO  YES

## SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

### 1. CHECK THE ITEM(S) YOU ARE REQUESTING:

**DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: \_\_\_\_\_  
This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.  
*An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box:*  I want a DELETED copy.

**Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. *IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:* \_\_\_\_\_

**Other (Specify):** \_\_\_\_\_

### 2. PURPOSE: (Providing information about the purpose of the request is strictly voluntary; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

- Benefits (explain)  Employment  VA Loan Programs  Medical  Genealogy  Correction  Personal  Other (explain)

Explain here: \_\_\_\_\_

## SECTION III - RETURN ADDRESS AND SIGNATURE

### 1. REQUESTER NAME:

2.  I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

I am the DECEASED VETERAN'S NEXT-OF-KIN (*MUST submit Proof of Death. See item 2a on instruction sheet.*)  
\_\_\_\_\_  
(Relationship to deceased veteran)

I am the VETERAN'S LEGAL GUARDIAN (*MUST submit copy of Court Appointment*) or AUTHORIZED REPRESENTATIVE (*MUST submit copy of Authorization Letter or Power of Attorney*)

OTHER  
\_\_\_\_\_  
(Specify type of Other)

### 3. SEND INFORMATION/DOCUMENTS TO:

(Please print or type. See item 4 on accompanying instructions.)

Name \_\_\_\_\_

Street \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

4. **AUTHORIZATION SIGNATURE:** I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. (See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)

Signature Required - Do not print \_\_\_\_\_ Date \_\_\_\_\_

Daytime phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Email address \_\_\_\_\_

\* This form is available at <http://www.archives.gov/veterans/military-service-records/standard-form-180.html> on the National Archives and Records Administration (NARA) web site. \*

# DPRIS APPLICATION



## Consent to Release or Obtain Information Form

This is consent for release of information about: \_\_\_\_\_  
(Name of Veteran)

\_\_\_\_\_  
(Serial Number/Social Security Number) (Branch of Service) (Date of Birth)

I authorize \_\_\_\_\_  
(Name of Provider Agency)

to release or obtain my **Military Personnel Records** from the Defense Personnel Records Information System (DPRIS).

This information may be used only in support of applications for benefits from the United States Department of Veteran Affairs.

I understand I have the right to see this information at any time. I understand that I can revoke this consent in writing to both the person giving and the person receiving the information. Any information already released may be used as stated on the consent. I understand the requested or provided information is to be used to support applications for Veteran benefits.

This consent is valid only until: \_\_\_\_\_  
(Date Consent Expires)

This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked in writing sooner. By my signature below, I affirm that I have read this release or it has been read to me, and I understand its content.

\_\_\_\_\_  
Veteran's Signature (Date)

\_\_\_\_\_  
Veteran's address

***Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit further disclosure without specific written consent from the person to who it pertains. Enclosure 3***