Cuyahoga County
Veterans Service Commission

Ph: 216.698.2600 • Fax: 216.698.2650
Email: 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? _____

<u>If you are not the Veteran, please complete the questions listed below.</u>

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 thispackage.

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.

U.S. Department of Veterans Affairs
Veterans Benefits Administration

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
- 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
- State/local Veterans benefits: https://www.va.gov/statedva.htm
- Military exchange and community privileges: https://www.shopmyexchange.com/

Cuyahoga County
Veterans Service Commission

Ph: 216.698.2600 • Fax: 216.698.2650
Email: vscmail@cuyahogacounty.us
1849 Prospect Avenue • Suite 150 • Cleveland, OH 44115

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

OMB Control No. 2900-0826
Respondent Burden: 5 minutes
Expiration Date: 02/28/2026

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. This form is used to notify VA of your intent to file for the general benefit(s). For more information, contact us online through ASK VA: **https://ask.va.gov/**. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at **www.va.gov/vaforms**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable check box to expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER

3. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 4)
☐ NO

4. VA FILE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY)

6. VETERAN'S SERVICE NUMBER (If applicable)

7. MAILING ADDRESS (If applicable) (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. TELEPHONE NUMBER (Include Area Code)
Enter International Phone Number (If applicable)

9. E-MAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY if the claimant is NOT the veteran)

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

11. SOCIAL SECURITY NUMBER

12. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 13)
☐ NO

13. VA FILE NUMBER (If applicable)

14. RELATIONSHIP TO VETERAN (Check one)
☐ SPOUSE ☐ CHILD ☐ FIDUCIARY ☐ VETERAN SERVICE OFFICER ☐ ALTERNATE SIGNER
☐ THIRD-PARTY ☐ OTHER (Specify)

15. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)

16. MAILING ADDRESS (If applicable) (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

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

18. E-MAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III: 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.

19. 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**. 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 (VA Form 21-0966) for each general benefit. Please complete as much of this form as possible, as VA cannot process this form if we cannot identify the claimant and/or veteran.

SECTION IV: DECLARATION OF INTENT AND SIGNATURE

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.

20. SIGNATURE OF VETERAN/CLAIMANT/AUTHORIZED AGENT **(REQUIRED)**	21. DATE SIGNED (MM/DD/YYYY)
	☐☐ – ☐☐ – ☐☐☐☐

22. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (VSO) (Please Print)

NOTE: This form may only be completed by a VSO, attorney, or agent if a valid power of attorney has been completed.

Where to Send Correspondence - After completing this form, mail to:

Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444

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

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as 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. 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 the intent of the claimant 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 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **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. 2900-0321
Respondent Burden: 5 minutes
Expiration Date:7/31/2026

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

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)*

2. SOCIAL SECURITY NUMBER *(SSN)* – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* Month – Day – Year

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

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

7. 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. TELEPHONE NUMBER *(Include Area Code)*

9. EMAIL ADDRESS *(Optional)*

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

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

11A. CLAIMANT'S DATE OF BIRTH Month – Day – Year

11B. RELATIONSHIP TO VETERAN

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

13.TELEPHONE NUMBER *(Include Area Code)*

14. EMAIL ADDRESS *(Optional)*

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)*

American Legion (AmLeg) 074

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)*

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

Accredited CVSO

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

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

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

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.

☒ 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

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

☐ 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.

☒ 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 20.6. *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 **(Required)**	22B. DATE SIGNED *(MM/DD/YYYY)*
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (Required)	**23B. DATE SIGNED *(MM/DD/YYYY)***

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: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*

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.

Authorized for local reproduction
Previous edition unusable

OMB No. 3095-0029 Expires 5/31/2027

REQUEST PERTAINING TO MILITARY RECORDS

Requests can be submitted online using eVetRecs at https://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.)*

COMPONENT	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE # (If unknown, write "unknown")	DOD ID / EDIPI # (If unknown, write "unknown")
a. ACTIVE				☐	☐		
b. RESERVE				☐	☐		
c. NATIONAL GUARD				☐	☐		

6. PLEASE LIST LAST DUTY STATION(S) _____

7. IS THIS PERSON DECEASED? ☐ **NO** ☐ **YES - MUST provide date of death if veteran is deceased:** _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ **NO** ☐ **YES**

9. HAS THIS PERSON FILED A CLAIM WITH THE VA? ☐ **NO** ☐ **YES – if known, please provide VA Claim/File #** _____

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 (Date of Separation): _____

This form contains information used to verify military service. **An UNDELETED DD Form 214 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. Please note - recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records

An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.

☐ I request inpatient/hospitalization records from _____ (facility), last treated in _____ (year). **(NOTE: Fields are required)**

If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

2. PURPOSE: (Required unless the request is from the veteran, government agencies under routine use, or for information releasable under FOIA. In all cases, it may help to provide the best possible response and ensure a faster reply.)

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

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. RELATIONSHIP TO VETERAN: _____

3. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)

☐ 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): _____

4. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name _____

Street Address _____ Apt. # _____

City _____ State _____ ZIP Code _____

Daytime Phone _____ Fax Number _____

Email Address _____

5. 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 3 is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on the accompanying instructions 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**

* This form is available at https://www.archives.gov/veterans/military-service-records/standard-form-180.html on the National Archives and Records Administration (NARA) website. *

Department of Veterans Services

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***