PENSION AND FIDUCIARY

PMC VSR Advanced Core Course
Phase 5: Stages of a Claim
Part 1: Determine Eligibility

Phase 5, Part 1(a): Knowledge Check Preparation

Appendix A

April 2020

Phase 5, Part 1(a): Knowledge Check Preparation

Practical Exercise

You are a PMC VSR working claims for Veteran's Pension. You open up the Veteran's eFolder and see the following evidence (see below). Review the forms and answer the following questions.

1. Is the application substantially complete? List the requied elements of a substantially complete application.

2. What is date of claim of the claim for benefits?

3. What date was the ITF received?

4. What are the four ways a clamaint can submit an ITF?

5. Did this Veteran appoint a POA?

6. What form can be used to appoint a POA?

7. Does this claim meet the requirements for any special processing?

8. What VA system would you use to enter a flash?

9. After reviewing the VA systems, you conclude this is the Veteran's first application. What EP should be cested in the system?

10. What VA system should you use to cest this claim?

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

PERSONAL DATA

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. SERVICE NUMBER	3. SOCIAL SECURITY NUMBER
Hernandez, Jésus	TRA-65-9782	TRA-65-9782

4. DEPARTMENT, COMPONENT AND BRANCH OR CLASS	5. GRADE, RATE OR RANK	GRADE	6. DATE OF RANK	DAY	MONTH	YEAR
Army	Sergeant First Class	E-7		28	01	1970

7. U.S. CITIZEN	8. PLACE OF BIRTH *(City and State or Country)*	9. DATE OF BIRTH	DAY	MONTH	YEAR
[X] YES [ ] NO	Aurora		29	11	1938

SELECTIVE SERVICE DATA

10A. SELECTIVE SERVICE NUMBER	b. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, COUNTY, STATE, AND ZIP CODE	c. DATE INDUCTED	DAY	MONTH	YEAR
TRA-65-9782			21	01	1962

TRANSFER OR DISCHARGE DATA

11a. TYPE OF TRANSFER OR DISCHARGE	b. STATION OR INSTALLATION AT WHICH EFFECTED
Discharge	Fort Huachuca

c. REASON AND AUTHORITY	d. EFFECTIVE DATE	DAY	MONTH	YEAR
Completion of required active service		28	01	1970

12. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	13a. CHARACTER OF SERVICE	b. TYPE OF CERTIFICATE ISSUED
	Honorable	

14. DISTRICT, AREA COMMAND OR CORPS TO WHICH RESERVIST TRANSFERRED	15. REENLISTMENT CODE

SERVICE DATA

16. TERMINAL DATE OF RESERVE/ UNITS OBLIGATION	DAY	MONTH	YEAR
	28	01	1971

17. CURRENT ACTIVE SERVICE OTHER THAN BY INDUCTION
a. SOURCE OF ENTRY
[ ] ENLISTED (First Enlistment) [ ] ENLISTED (Prior Service)
[ ] REENLISTED [ ] OTHER

b. TERM OF SERVICE (Years)	c. DATE OF ENTRY	DAY	MONTH	YEAR
8		24	01	1962

18. PRIOR REGULAR ENLISTMENT	19. GRADE, RATE OR RANK AT TIME OF ENTRY INTO CURRENT ACTIVE SVC	20. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City and State)
		Aurora, IL

21. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (Street, RFD, City, County, State and Zip Code)	23a. SPECIALTY NUMBER & TITLE	b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER
32605 West 252 Mile Road, Suite 250, Aurora,	Automated	

22. STATEMENT OF SERVICE		YEARS	MONTHS	DAYS
a. CREDITABLE FOR BASIC PAY PURPOSES	(1) NET SERVICE THIS PERIOD	08	01	06
	(2) OTHER SERVICE	00	00	00
	(3) TOTAL (Line (1) plus (2)	08	01	06
b. TOTAL ACTIVE SERVICE		08	01	06
c. FOREIGN AND/OR SEA SERVICE		00	00	00

24. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDS OR AUTHORZED

25. EDUCATION AND TRAINING COMPLETED
Battalion Aide Surgeon (52 weeks)

VA AND EMP. SERVICE DATA

26a. NON-PAY PERIODS TIME LOST (Preceding Two Years)	b. DAYS ACCRUED LEAVE PAID	27a. INSURANCE IN FORCE (NSLI OR USGLI)	b. AMOUNT OF ALLOTMENT	c. MONTH ALLOTMENT DISCONTINUED
		[ ] YES [ ] NO		

28. VA CLAIM NUMBER	29. SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE
TRA-65-9782	[ ] $10,0000 [ ] $5,000 [ ] NONE

REMARKS

30. REMARKS

AUTHENTICATION

31. PERMANENT ADDRESS FOR MAILING PURPOSES AFTER TRANSFER OR DISCHARGE *(Street., R.F.D., City, County, City, State and Zip Code)*	32. SIGNATURE OF PERSON BEING TRANSFERRED OR DISCHARGED
32605 West 252 Mile Road, Suite 250 Aurora, IL 60456 (US)	Jésus Hernandez

33. TYPE NAME, GRADE AND TITLE OF AUTHORIZING OFFICER	34. SIGNATURE OF OFFICE AUTHORIZING TO SIGN
Capt. Samuel D. Hawkins ADMINO	Samuel D. Hawkins

DD FORM 1 JUL 66 **214** PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE EFFECTIVE 1 JAN 67 * GPO:1969-351-112 ARMED FORCES OF THE UNITED STATES REPORT OF TRANSFER OR DISCHARGE

For Training Purposes Only

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)*: Jesus Hernandez

2. CLAIMANT'S SOCIAL SECURITY NUMBER: TRA – 45 – 6789

3. VA FILE NUMBER *(If applicable)*: TRA456789

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY): Month 11 – Day 29 – Year 1938

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***: Jesus Hernandez

6. VETERAN'S SOCIAL SECURITY NUMBER: TRA – 45 – 6789

7. VETERAN'S SEX: ☐ 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: 12389 Main View

Apt./Unit Number:

City: Sacramento

State/Province: CA

Country:

ZIP Code/Postal Code: 95673 –

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?
☐ YES ☒ 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.** 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: Jesus Hernandez

14B. DATE SIGNED *(MM,DD,YYYY)*: 02/20/2020

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.)

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. 2900-0002
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 9 before completing the form.

SECTION I: VETERAN'S PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, First, Middle)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (MM,DD,YYYY)
Jesus Hernandez	TRA-45-6789	11/29/1938

4. HAVE YOU EVER FILED A CLAIM WITH VA?	5. VA FILE NUMBER
☐ YES ☒ NO (If "Yes," provide your file number in Item 5)	TRA-45-6789

6A. MAILING ADDRESS	6B. TELEPHONE NUMBERS (Include Area Code)
12389 Main View Street address, rural route, or P.O. Box — Apt. number Sacramento — CA — 95673 City — State — ZIP Code — Country	DAYTIME (916) 555-5431 EVENING ( ) CELL PHONE ( )

7A. PREFERRED E-MAIL ADDRESS (If applicable)	7B. ALTERNATE E-MAIL ADDRESS (If applicable)
jesus0@my-claim.com	

8. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

A. DISABILITY(IES)	B. DATE DISABILITY(IES) BEGAN

9. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT
Sacramento VA Medical Center	05/04/1985 02/02/1989

SECTION II: VETERAN'S SERVICE INFORMATION (*MUST COMPLETE*)

10A. DID YOU SERVE UNDER ANOTHER NAME?	10B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER
☐ YES (If "Yes," complete Item 10B) ☒ NO (If "No," skip to Item 11A)	

11A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	11B. BRANCH OF SERVICE	11C. RELEASE DATE FROM ACTIVE SERVICE
01/24/1962	Army	01/28/1970

11D. SERVICE NUMBER	11E. PLACE OF LAST SEPARATION
TRA-65-9782	Fort Huachuca

12A. HAVE YOU EVER BEEN A PRISONER OF WAR?	12B. DATES OF CONFINEMENT ON (MM,DD,YYYY)
☒ YES ☐ NO (If "Yes," complete Item 12B) (If "No," skip to Item 13A)	From: 03/15/1965 To: 06/22/1965

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)*

NOTE: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

13A. WHAT DISABILITY(IES) PREVENT YOU FROM WORKING?	13B. WHEN DID THE DISABILITY(IES) BEGIN? (MM, DD, YYYY)

14A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?	14B. ARE YOU NOW OR HAVE YOU RECENTLY BEEN HOSPITALIZED OR GIVEN OUTPATIENT OR HOME CARE DUE TO THE DISABILITY(IES) LISTED IN ITEM 13A?
☒ YES ☐ NO (If "Yes," complete and attach with this application, VA Form 21-2680, *Exam for Housebound Status or Permanent Need for Regular Aid and Attendance.* Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS.))	☐ YES ☒ NO

15A. DATE(S) OF RECENT HOSPITALIZATION OR CARE	15B. NAME AND MAILING ADDRESS OF FACILITY OR DOCTOR

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)* CONTINUED

NOTE: In the table below, tell us about all of your employment, including self-employment, for **one** year before you became disabled to the present.

16A. ARE YOU NOW EMPLOYED?	16B. WHEN DID YOU LAST WORK? (MM,DD,YYYY)	16C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED?
☐ YES ☒ NO		☐ YES ☐ NO (If "Yes," complete Items 16D and 16E)

16D. WHAT KIND OF WORK DID YOU DO?	16E. ARE YOU STILL SELF-EMPLOYED?	16F. WHAT KIND OF WORK DO YOU DO NOW?
	☐ YES ☐ NO (If "Yes," complete Item 16F)	

17A. ARE YOU NOW IN A NURSING HOME?	17B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?
☐ YES ☒ NO (If "Yes," complete Items 17B and 17C and submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.)	

17C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?	17D. HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☐ NO (If "No," complete Item 17D)	☐ YES ☐ NO

18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	18B. WHAT WAS YOUR JOB TITLE?	18C. WHEN DID YOUR JOB BEGIN?	18D. WHEN DID YOUR JOB END?	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					$
					$

SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

19A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☒ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED (Skip to Section VI if never married)

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

19B. HOW MANY TIMES HAVE ***YOU*** BEEN MARRIED (Including current marriage)?

1

20A. DATE (Month, Day, Year) AND PLACE OF MARRIAGE (City and State or Country)	20B. TO WHOM MARRIED (First, Middle, Last Name)	20C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)	20D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)	20E. DATE (Month, Day, Year) AND PLACE MARRIAGE ENDED (City and State or Country)
09/01/1961 San Diego, CA	Irene Hernandez	Ceremonial	n/a	

20F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 20C, PLEASE EXPLAIN:

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

21. HOW MANY TIMES HAS ***YOUR SPOUSE*** BEEN MARRIED (Including current marriage)?

1

22A. DATE (Month, Day, Year) AND PLACE OF MARRIAGE (City and State or Country)	22B. TO WHOM MARRIED (First, Middle, Last Name)	22C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)	22D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)	22E. DATE (Month, Day, Year) AND PLACE MARRIAGE ENDED (City and State or Country)

22F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22C, PLEASE EXPLAIN:

23A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (Month, Day, Year)	23B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	23C. IS YOUR SPOUSE ALSO A VETERAN?	23D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (If any)?
08/30/1942	TRA259552	☐ YES ☒ NO (If "Yes," complete Item 23D)	

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)* CONTINUED

23E. DO YOU LIVE WITH YOUR SPOUSE?	23F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O., State, ZIP Code and country)
☒ YES ☐ NO (If "Yes," skip to Section VI) (If "No," complete Items 23F, 23G and 23H)	
23G. TELL US THE REASON YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e.; illness, work, etc.)	23H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? $

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

Note - Skip to Section VII if you have no dependent children.

24A. NAME OF DEPENDENT CHILD (First, Middle initial, Last)	24B. DATE AND PLACE OF BIRTH (City and State or Country)	24C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 24D. BIOLOGICAL	24E. ADOPTED	24F. STEPCHILD	24G. 18-23 YEARS OLD (in school)	24H. SERIOUSLY DISABLED	24I. CHILD MARRIED	24J. CHILD PREVIOUSLY MARRIED
Bianca Cruz	10/12/2005 Sacramento CA	TRA908980	☐	☒	☐	☐	☐	☐	☐
Michael Hernandez	08/19/1980 San Diego CA	TRA506519	☐	☐	☐	☐	☒	☐	☐
			☐	☐	☐	☐	☐	☐	☐

Note - In Items 25A through 25D, tell us about the children listed in Item 24A who ***do not*** live with you.

25A. NAME OF DEPENDENT CHILD (First, middle initial, last)	25B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	25C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS *(If you need more space, attach a separate sheet.)*

26. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☒ YES ☐ NO (If "Yes," complete Items A and B) (If "No," skip to Item 27)

A. SOCIAL SECURITY RECIPIENT	B. GROSS MONTHLY AMOUNT
Michael Hernandez	$ 787.00
Irene Hernandez	$ 634.00
Jesus Hernandez	$ 1587.00
	$
	$

27. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

☒ YES ☐ NO (If "Yes," complete Items 28A and 28B) (If "No," skip to Item 29A)

28A. WHAT IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS?	28B. COULD ANY PART OF THE LOT BE SOLD *WITHOUT SELLING THE RESIDENCE*?
6000 Square feet	☐ YES ☒ NO (If "Yes," also complete VA Form 21P-0969, *Income and Asset Statement*)

IMPORTANT: VA matches income information reported with Federal tax information. Report all income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, *Income and Asset Statement,* if appropriate.

29A. ***OTHER THAN SOCIAL SECURITY***, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

☐ YES ☒ NO

29B. ***OTHER THAN SOCIAL SECURITY***, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

☐ YES ☒ NO

29C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000 IN ASSETS? (**Note**: Assets are all the money and property you or your dependents own. Assets do ***not*** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation).

☐ YES ☒ NO

29D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust.)

☐ YES ☒ NO

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS (If you need more space, attach a separate sheet) CONTINUED

29E. DID YOU ANSWER "YES" TO **ANY** OF THE ITEMS IN 29A - 29D?

☐ YES ☒ NO (If "Yes," you ***must*** also complete VA Form 21P-0969, *Income and Asset Statement*)

SECTION VIII: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself, dependents you are under obligation to support, or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you or your dependents were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 10 and 11.

30. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

☐ YES ☒ NO (If "No," skip to Section IX)

A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	B. PAID TO (Name of Provider, Insurance company, Nursing home, etc.)	C. PURPOSE (Medicare premiums, Nursing Home,etc.)	D. DATE PAID (Month, Day, Year)	E. HOURLY RATE/ HOURS (In-home Provider Only)	F. AMOUNT YOU PAY
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

SECTION IX: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 31, 32, and 33 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. 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.

31. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☒ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:_____ Account No.:_____

32. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	33. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION X: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

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 and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension 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 34, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

34. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

35A. VETERAN'S SIGNATURE (**REQUIRED**)	35B. DATE SIGNED
Jesus Hernandez	March 4, 2020

SECTION XI: WITNESSES TO SIGNATURE *(MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 35A WITH AN "X")*

36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	36B. PRINTED NAME AND ADDRESS OF WITNESS
37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	**37B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension 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 Vocational Rehabilitation 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 pension. 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.

Office Of The Clerk Of The Circuit Court

Certificate Of Marriage

I Hereby Certify *, that a* MARRIAGE LICENSE *was issued to*

Jesus Hernandez *and* Irene Bergen

on the 11th *day of* September

in the year 1961 *, as appears*

by the Record of Marriage Licenses of this office.

In Testimony Whereof *, I hereunto subscribe my name and affix the seal of the Circuit Court for County, on* _____

/s/ Lawrence W.

County's Clerk of the Circuit Court

INDEPENDENT ADOPTION PLACEMENT AGREEMENT

This form MUST be signed after the Statement of Understanding (SOU AD 926) AND Declaration of Mother (AD 880) forms have been completed and signed. This Independent Adoption Placement Agreement WILL NOT be valid if it is signed prior to the SOU AD 926 and AD 880.

PLACING PARENT SECTION

Note to placing parent: *This form will become a permanent and irrevocable consent to adoption. Do not sign this form unless you want the prospective adoptive parent(s) named below to adopt your child.*

I/We, Natalia Hernandez and Juan Cruz (NAME OF PARENT(S)), being the parent(s) of Bianca Cruz (NAME OF CHILD),

(Gender: ☐ M ☑ F) born on 10/12/2005 (DATE OF BIRTH) in Sacramento, California (CITY AND STATE OF BIRTH),

place him/her with Irene Hernandez and Jesus Hernadez (FULL NAME(S) OF PROSPECTIVE ADOPTIVE PARENT(S)) for the purpose of an independent adoption.

I/We understand that I/we may revoke this Independent Adoption Placement Agreement **ONLY DURING THE THIRTY (30) DAY PERIOD** beginning on the date I/we sign this agreement AND **ONLY IF I/WE HAVE NOT WAIVED MY/OUR RIGHT TO REVOKE THE AGREEMENT.**

If I/we take no further action, this placement agreement will become a permanent and irrevocable consent to the adoption on the 31st day after I/we sign it.

I/We further understand that with the signing of the order of adoption by the court, I/we shall give up all my/our rights of custody, services, and earnings of this child and I/we may not reclaim this child.

The person(s) named above have my/our permission to care for this child in his/her/their home.

I/We have chosen the person(s) named above to be the parent(s) of my/our child based on my/our personal knowledge about him/her/them.

I/We have been informed of the basic health and social history of the person(s) named above.

I/We understand that this child will not be considered to have been placed for adoption until the prospective adoptive parent(s), the Adoption Service Provider (ASP) and I/we have signed this placement agreement.

The person(s) named above have my/our permission to make any provisions for medical and surgical care for this child, including anesthesia, which may be deemed necessary or advisable by any licensed physician, **for a period not to exceed one year from the date this agreement is signed.**

I/We understand that if this child is found to be subject to the Indian Child Welfare Act (ICWA), this placement agreement WILL NOT be valid.

I/We was/were advised of my/our rights in this independent adoption process on 11/15/2013 (DATE). These rights are summarized on the attached SOU (AD 926) which I/we have read and signed.

I/We have decided to place my/our child for adoption with the person(s) named above, and I/we am/are signing this freely and willingly.

SIGNATURE OF PARENT	DATE SIGNED
	12/12/2013
SIGNATURE OF PARENT Irene Hernandez	DATE SIGNED 12/12/2013

ADOPTION SERVICE PROVIDER SECTION
(advising and witnessing signature of birth parent(s))

I have advised the placing parent(s) as required by Family Code Section 8801.5.

☑ The advisement occurred at least ten (10) days before the signing of this placement agreement, **or**

☑ Due to the attached exigent circumstances, the advisement occurred fewer than ten (10) days before the signing of this placement agreement:

I, Barbara Jones (NAME OF INDIVIDUAL SERVING AS AN ASP), have witnessed the signing of this Independent Adoption Placement Agreement by Irene and Jesus Hernandez (PLACING PARENT(S)) on 12/12/2013 (DATE) in Sacramento, California (CITY AND STATE WHERE SIGNED).

I am:

☐ A representative of _____ (NAME OF AGENCY), a California licensed private adoption agency.

☐ An individual California ASP.

☑ A representative of California Family Services (NAME OF AGENCY), an adoption agency licensed or otherwise approved under the laws of the state of California (NAME OF STATE), the state where the Independent Adoption Placement Agreement is being signed.

☐ An individual licensed or otherwise certified as a clinical social worker under the laws of _____ (NAME OF STATE), the state where the Independent Adoption Placement Agreement is being signed.

☐ Independent counsel for the placing parent(s) serving as an ASP, pursuant to Family Code Section 8502(b) and 8801.5(e).

SIGNATURE OF INDIVIDUAL SERVING AS AN ASP	DATE
Barbara Jones	12/12/2013

WHEN SIGNED OUT OF CALIFORNIA and the identification of the birth parent(s) is being questioned, then this form must also be signed in front of a Notary.

The Notary Public must staple the Acknowledgement document to this form and sign and date below.

SIGNATURE OF NOTARY	DATE
	12/12/2013

ADOPTION AGENCY INVESTIGATING THIS ADOPTION
(to be completed by representative or ASP)

The adoption agency which will investigate this proposed independent adoption is:

NAME OF CDSS ADOPTION OFFICE/DELEGATED COUNTY ADOPTION AGENCY	
California Family Service	
ADDRESS	TELEPHONE NUMBER
1867 Northern shore Sacramento, CA	(916) 458-1965

PROSPECTIVE ADOPTIVE PARENT(S) SECTION

I/We, the prospective adoptive parent(s) listed on page one, accept the placement of

Bianca Cruz (NAME OF CHILD) by Irene and Jesus Hernandez (PLACING PARENT(S))

into my/our home with the intent of adoption.

☑ I/We agree to file a petition to adopt this child within ten (10) working days after signing this placement agreement with the Superior Court in Sacramento (NAME OF COUNTY) County, the county where:

- ☑ I/we reside.
- ☑ The child was born or resides at the time of filing.
- ☑ The placing birth parent(s) resided when the Independent Adoption Placement Agreement was signed.
- ☑ The placing birth parent(s) resided when the petition was filed.

I/We agree that if, during the time period specified on the first page of this agreement, the placing parent(s) sign(s) and delivers to the investigating adoption agency a statement revoking this placement agreement and requesting that the child be returned, I/we must immediately return the child to the custody of the placing parent(s).

I/We agree that until the adoption is granted by the court:

A. I/We must place the child under the care of a licensed physician and follow his/her recommendations for health care for the child, including immunization.

B. I/We must not take the child from the county named above for a period of more than thirty (30) days without the approval of the court. I/We understand that the court may issue an order which prevents me/us from taking the child out of the county at all.

C. I/We must not conceal the child from the placing parent(s), the investigating adoption agency, or the court.

D. I/We must inform the investigating agency of any changes in my/our family or place of residence.

E. I/We must assume responsibility for board, lodging, maintenance, medical care, and any other care for this child, and for any damages resulting therefrom.

I/We understand that if this child is found to be subject to the ICWA, this placement agreement will not be valid.

I/We have been informed of the basic health and social history of the placing parent(s).

SIGNATURE OF PROSPECTIVE ADOPTIVE PARENT	DATE SIGNED
	12/12/2013
SIGNATURE OF PROSPECTIVE ADOPTIVE PARENT	DATE SIGNED
	12/12/2013