PENSION AND FIDUCIARY SERVICE

PMC VSR Core Course Phase 5, Part 1(c): Income Eligibility Knowledge Check Preparation

Appendix A: Example Claim 1

12/20/2016

Version 1.0

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: 5/31/2015

Department of Veterans Affairs

INTENT TO FILE A CLAIM FOR COMPENSATIO
OR SURVIVORS PENSION AND/

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

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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CARO
2015 APR 2 PM 2:15 PM

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

SECTION I: 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.*

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

☐ **COMPENSATION** ☒ **PENSION**

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

SECTION II: CLAIMANT'S IDENTIFICATION

1. CLAIMANT'S NAME *(First, middle initial, last)*

Jesus | | Hernandez

2. CLAIMANT'S SOCIAL SECURITY NUMBER

TRA – 65 – 9782

3. VETERAN'S NAME *(First, middle initial, last) (If different from claimant)*

| | |

4. VETERAN'S SOCIAL SECURITY NUMBER

TRA – 65 – 9782

5. VETERAN'S DATE OF BIRTH	6. VETERAN'S SEX	7. HAS THE VETERAN EVER FILED A CLAIM WITH VA?	8. VA FILE NUMBER
Month 11 – Day 29 – Year 1938	☒ MALE ☐ FEMALE	☐ YES ☒ NO *(If "Yes," provide your file number in Item 8)*	

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

Number and Street *or* Rural Route, P.O. Box: 12389 Main View
Apt./Unit Number:

City, State, ZIP Code and Country: Sacramento | CA | 95673

10. PREFERRED TELEPHONE NUMBER *(Include Area Code)*	11. PREFERRED E-MAIL ADDRESS *(If applicable)*
(916)555-5431	

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.

12A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE	12B. DATE SIGNED *(MM,DD,YYYY)*
Jesus Hernandez	03302015

13. 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.)

William Alcares, American Legion VSO Fairfield CA 94533

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. 2900-0321
Respondent Burden: 5 Minutes
Expiration Date: 08/31/2018

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

NOTE - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, "Appointment of Individual as Claimant's Representative." VA Forms are available at www.va.gov/vaforms.

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM.

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER *(Include prefix)*
Hernandez, Jésus	TRA-65-9782

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on reverse side before selecting organization)*

American Legion

3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A *(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)*

William Alcares, VSO

3C. E-MAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A

william.alcares@americanlegion.com

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)	5. INSURANCE NUMBER(S) *(Include letter prefix)*
TRA-65-9782	
6. NAME OF CLAIMANT *(If other than veteran)*	**7. RELATIONSHIP TO VETERAN**

8. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)	9. CLAIMANT'S TELEPHONE NUMBERS *(Include Area Code)*	
	A. DAYTIME	B. EVENING
12389 Main View Sacramento, CA 95673	916-555-5431	916-555-5431
	10. E-MAIL ADDRESS *(If applicable)*	
	11. DATE OF THIS APPOINTMENT	03/30/2015

12. 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 3A 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 above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

14. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 3A to act on my behalf to change my address in my VA records.

☒ I authorize any official representative of the organization named in Item 3A 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 3A is not my appointed fiduciary.

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A 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 12 and 13), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

15. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	16. DATE SIGNED
Jesus Hernandez	03/30/2015
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*	**18. DATE SIGNED**
William Alcares	03/30/2015

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*
	☒ VR&E FILE ☒ EDU FILE ☒ LG FILE ☒ INSURANCE FILE	05/01/2015 MB	05/05/2015 MB	

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.

OMB Control No. 2900-0001
Respondent Burden: 1 hour
Expiration Date: 8/31/2017

Department of Veterans Affairs

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT - Read information and instructions carefully before completing the form. Type, print, or write plainly.

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

RECEIVED
CA RO
2016 Jan 8 PM 3:10

PART I - VETERAN'S INFORMATION

1. FOR WHAT BENEFIT ARE YOU APPLYING?
☐ COMPENSATION ☒ PENSION ☐ BOTH COMPENSATION AND PENSION

2. HAVE YOU PREVIOUSLY APPLIED FOR ANY VA BENEFIT(S)? *(Check applicable box)*
☐ PENSION ☐ COMPENSATION ☐ OTHER *(Specify)* _____

3. FIRST, MIDDLE, LAST NAME OF VETERAN
Jésus Hernandez

4A. VETERAN'S SOCIAL SECURITY NO.	4B. VA FILE NUMBER *(If applicable)*	4C. SPOUSE'S SOCIAL SECURITY NO.
TRA-65-9782	TRA-65-9782	TRA-25-9552

4D. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.

5. MAILING ADDRESS *(Number and street or rural route, city or P.O., State and ZIP Code)*
12389 Main View, Sacramento, CA 95673

6. TELEPHONE NUMBER(S) *(Include Area Code)*			7. E-MAIL ADDRESS *(If applicable)*
A. DAYTIME	B. EVENING	C. CELL	
(916) 555-5431			jesus0@my-case.com

8A. DATE OF BIRTH *(Month, day, year)*	8B. PLACE OF BIRTH	9. SEX
11/29/1938	Aurora	☒ MALE ☐ FEMALE

10A. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? *(Formerly the U.S. Bureau of Employees Compensation)*	10B. WHEN WAS THE CLAIM FILED? *(Mo., day, yr.)*	10C. FOR WHAT DISABILITY ARE YOU RECEIVING BENEFITS?
☐ YES ☒ NO *(If "Yes," complete Items 10B & 10C)*		

PART II - NATURE AND HISTORY OF SERVICE-RELATED DISABILITY(IES) *(If you need more space please use Item 45, "Remarks")*

11. PLEASE PROVIDE NATURE OF SICKNESS, DISEASE, OR INJURIES FOR WHICH THIS CLAIM IS MADE; DATE EACH BEGAN; AND PLACE OF TREATMENT

A. LIST DISABILITY(IES)	B. DATE BEGAN	C. PLACE OF TREATMENT

12A. ARE YOU NOW OR HAVE YOU RECEIVED TREATMENT OR DOMICILIARY CARE AT A VA MEDICAL FACILITY?
☒ YES ☐ NO *(If "Yes,"complete Items 12B &12C)*

12B. DATES OF TREATMENT/CARE

Month	Day	Year
05	04	1985
02	02	1989

12C. NAME AND ADDRESS OF VA MEDICAL FACILITY *(If you need more space use Item 45, "Remarks")*
Sacramento VA Medical Center
10535 Hospital Way
Mather, CA 95655

13A. HAVE YOU EVER BEEN A PRISONER OF WAR?	13B. NAME OF COUNTRY	13C. DATES OF CONFINEMENT	
		FROM	TO
☒ YES ☐ NO *(If "Yes," complete Items 13B and 13C)*	Viet Nam	3/15/1965	6/22/1965

14. ARE YOU CLAIMING A DISABILITY RELATED TO AGENT ORANGE OR OTHER HERBICIDE EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☒ NO

15. ARE YOU CLAIMING A DISABILITY RELATED TO ASBESTOS EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☒ NO

16. ARE YOU CLAIMING A DISABILITY RELATED TO MUSTARD GAS EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☒ NO

17. ARE YOU CLAIMING A DISABILITY RELATED TO IONIZING RADIATION EXPOSURE? *(If 'Yes," list disability(ies) below)*
☐ YES ☒ NO

18. ARE YOU CLAIMING A DISABILITY RELATED TO AN ENVIRONMENTAL HAZARD EXPOSURE DURING THE GULF WAR? *(If "Yes," list disability(ies) below)*
☐ YES ☒ NO

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART III - ACTIVE DUTY SERVICE INFORMATION

NOTE: Please complete the information for each period of active duty. Attach DD214 or other separation papers for all periods of active duty. If you do not have your DD214 form or other separation papers, check the box. ☐

19A. ENTERED INTO SERVICE		19B. SERVICE NUMBER	19C. SEPARATED FROM SERVICE		19D. BRANCH OF SERVICE	19E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		
01/24/1962		TRA-65-9782	01/28/1970	Fort Huachuca	Army	Sergeant First Class

PART IV - RESERVE AND NATIONAL GUARD SERVICE INFORMATION

NOTE: Enter complete information for each period of Reserves and National Guard service. Attach any separation papers you have.

20A. ENTERED INTO SERVICE		20B. SERVICE NUMBER	20C. SEPARATED FROM SERVICE		20D. SERVICE STATUS *(Reserve, National Guard)*	20E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

21. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE

22A. ARE YOU NOW A MEMBER OF THE RESERVES OR NATIONAL GUARD? IF SO, GIVE THE BRANCH OF SERVICE

☐ YES ☐ NO BRANCH _____

22B. RESERVE STATUS

☐ ACTIVE ☐ RESERVE OBLIGATION

☐ INACTIVE

22C. NAME, ADDRESS AND PHONE NO. OF RESERVE OR NATIONAL GUARD UNIT *(If additional space is needed, use Item 45 "Remarks")*

PART V - MILITARY RETIRED/SEVERANCE PAY

IMPORTANT - Unless you check the box in Item 25 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. If you receive both military retired pay and VA compensation, some of the amount you receive may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

23A. ARE YOU RECEIVING MILITARY RETIRED PAY? *(If "Yes," complete Items 23C & 23D)*

☐ YES ☒ NO

23B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? *(If "Yes," explain, i.e. Future Reserve/National Guard Retirement, Pending MEB/PEB)*

☐ YES ☒ NO _____

23C. BRANCH OF SERVICE

23D. MONTHLY AMOUNT

$

24. RETIRED STATUS

☐ RETIRED ☐ TEMPORARY DISABILITY RETIRED LIST ☐ DISABLED RETIRED LIST

25. NO, I DO NOT WANT VA COMPENSATION IN LIEU OF MILITARY RETIRED PAY *(Check box, if applicable)* ☐

26. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE/SEPARATION PAY, OR ANY OTHER LUMP SUM PAYMENT FROM THE ARMED FORCES? *(If "Yes," list type, amount, date it was received, and the branch of service below)*

☐ YES ☒ NO _____

PART VI - MARITAL AND DEPENDENCY INFORMATION

27A. MARITAL STATUS *(If married, complete Items 27B thru 29D)*

☒ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NEVER MARRIED *(If never married, skip to Item 30)*

27B. SPOUSES'S BIRTHDATE *(Mo., day, yr.)*

08/30/1942

27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED *(To include current marriage)*

1

27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED *(To include current marriage)*

1

27E. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☒ NO *(If "Yes,"complete Item 27F)*

27F. SPOUSE'S VA FILE NUMBER *(If any)*

C- TRA-25-9552

27G. DO YOU LIVE TOGETHER?

☒ YES ☐ NO *(If "No,"complete Items 27H thru 27J)*

27H. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*

27I. PRESENT ADDRESS OF SPOUSE

27J. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S MONTHLY SUPPORT

$

27K. HOW WERE YOU MARRIED?

☒ CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL ☐ TRIBAL ☐ OTHER *(Explain)*

☐ COMMON-LAW ☐ PROXY _____

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VI - MARITAL AND DEPENDENCY INFORMATION - CONTINUED *(If you need additional space, use Item 45 "Remarks")*

FURNISH THE FOLLOWING INFORMATION ABOUT EACH OF YOUR MARRIAGES *(IF NOT APPLICABLE, WRITE "N/A")*

28A. DATE AND PLACE OF MARRIAGE		28B. TO WHOM MARRIED	28C. TERMINATED *(Death, Divorce)*	28D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE
09,1961	San Diego, CA	Irene Hernandez			

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE *(IF NOT APPLICABLE, WRITE "N/A")*

29A. DATE AND PLACE OF MARRIAGE		29B. TO WHOM MARRIED	29C. TERMINATED *(Death, Divorce)*	29D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

DEPENDENCY - Dependent Children Information *(If you need additional space, use Item 45 "Remarks")*

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN

30A. NAME OF CHILD *(First, middle initial, last)*	30B. DATE & PLACE OF BIRTH *(City, state or country)*	30C. SOCIAL SECURITY NUMBER	30D. CHECK EACH APPLICABLE CATEGORY					
			BIOLOGICAL	ADOPTED	STEPCHILD	18-23 YRS. OLD AND IN SCHOOL	SERIOUSLY DISABLED BEFORE AGE 18	CHILD PREVIOUSLY MARRIED
Bianca L Cruz	10/12/2005 *(Month, day, year)* Place: Sacramento	TRA-90-8980	☐	☒	☐	☐	☐	☐
Michael Hernandez	08/19/1980 *(Month, day, year)* Place: San Diego, CA	TRA-50-6519	☒	☐	☐	☐	☒	☐
	(Month, day, year) Place:		☐	☐	☐	☐	☐	☐

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN WHO DO NOT LIVE WITH YOU

31A. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	31B. NAME AND ADDRESS OF PERSON HAVING CUSTODY	31C. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		$
		$

PART VII - NON-SERVICE CONNECTED PENSION *(If you need additional space use Item 45 "Remarks")*

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.

32. WHAT DISABILITIES PREVENT YOU FROM WORKING? *(List below)*	33. DO YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON OR ARE YOU GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?
	☒ YES ☐ NO

NURSING HOME INFORMATION

NOTE: You may submit a statement by 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.

34A. ARE YOU NOW IN A NURSING HOME?	34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY	34C. HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☒ NO *(If "YES," complete Items 34B thru 34D)*		☐ YES ☒ NO

34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION?	34E. ARE YOU RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSI BUT NO DECISION HAS BEEN MADE?
☐ YES ☒ NO ☐ APPLIED - NOT RECEIVED DECISION	☐ YES ☒ NO ☐ APPLIED - NOT RECEIVED DECISION

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VIII - INCOME INFORMATION *(Provide the income you received from all sources)*

NOTE: Report the total income before deductions for taxes, insurance, etc. If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space. If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid. Payments from any source will be counted, unless the law says that they don't need to be counted.

MONTHLY INCOME - Provide the income that you and your dependents receive every month. For items 35A-35F, if none, write "0" or "NONE." Do not leave blank spaces.

ITEM NO.	SOURCES OF RECURRING MONTHLY INCOME	VETERAN	SPOUSE	CHILD(REN) *(Provide the first, middle initial, and last name)* NAME Bianca L Cruz	NAME Michael Hernandez	NAME
35A.	Social Security	2032.00	2032.00	0	838.00	
35B.	U.S. Civil Service	0	0	0	0	
35C.	U.S. Railroad Retirement	0	0	0	0	
35D.	Military Retired Pay	0	0	0	0	
35E.	Black Lung Benefits	0	0	0	0	
35F.	Other *(Interest, dividends, or one-time payments)*	185.00 Annually	121.00 Annually	0	0	

36A. WILL YOU RECEIVE ANY INCOME FROM RENTAL PROPERTY OR FROM THE OPERATION OF A BUSINESS WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?

☐ YES ☒ NO

36B. WILL YOU RECEIVE ANY INCOME FROM THE OPERATION OF A FARM WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?

☐ YES ☒ NO

36C. DO YOU THINK YOUR INCOME WILL CHANGE IN THE NEXT 12 MONTHS? *(If "Yes," explain below)*

☐ YES ☒ NO

PART IX - NET WORTH *(Provide specific information about the net worth of you and your dependents)*

NET WORTH is the market value of all interest and rights in any kind of property after subtracting any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal items such as your vehicle, clothing, and furniture.

NOTE: For Items 37A-37F provide amounts. If none, write "0" OR "NONE." Do not leave blank spaces.

ITEM NO.	SOURCE	VETERAN	SPOUSE	CHILD(REN) *(Provide the first, middle initial, and last name)* NAME Bianca L Cruz	NAME Michael Hernandez	NAME
37A.	Cash, non-interest bearing bank accounts	0	0	0	0	
37B.	Interest bearing bank accounts, certificates of deposit *(CDs)*	0	0	0	0	
37C.	Retirement accounts *(IRAs, Keogh Plans, etc.)*	0	0	0	0	
37D.	Stocks, bonds, and mutual funds	82,725	0	0	0	
37E.	Value of business assets	0	0	0	0	
37F.	Real property *(not your home)*	0	0	0	0	

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART X - MEDICAL, LEGAL, OR OTHER EXPENSES

IMPORTANT - Complete items 38A through 38E only if you are applying for non service connected pension.

MEDICAL, LEGAL OR OTHER EXPENSES - Family medical expenses you actually paid (out-of-pocket) may be deducted from your income. Show the amount of unreimbursed medical expenses you paid for dependents you are under an obligation to support. Also, show medical, legal, or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to increase benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Be sure to include the Medicare deduction. If more space is needed, you may use Item 45, "Remarks" or attach a separate sheet.

38A. AMOUNT YOU PAID	38B. DATE PAID (*Month, year*)	38C. PURPOSE (*Doctor's fees, hospital charges, attorney fees, etc.*)	38D. PAID TO (*Name of doctor, hospital, pharmacy, attorney, etc.*)	38E. PERSON FOR WHOM EXPENSE PAID (*Self, spouse, child*)
6,356.00	04/2015	Hospital charge	Sacramento Regional Hospital	Self
143.00	05/2015	Prescription	Walgreens	self
143.00	06/2015	Prescription	Walgreens	self
143.00	04/2015	Prescription	Walgreens	self
143.00	08/2015	Prescription	Walgreens	self
524.00	05/2015	Medicare deduction	Medicare	self
524.00	05/2015	Medicare deduction	Medicare	spouse
876.00	06/2015	Prescription	Sacramento Regional Hospital	self
4864.00	04/2015	CT Scan with contrast	Sacramento Radiology Associates	self

PART XI - DIRECT DEPOSIT

The Department of 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 39, 40 and 41 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 Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

39. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

☒ CHECKING 125846982 (Account Number)

☐ SAVINGS _____ (Account Number)

☒ I certify that I do not have an account with a financial institution or certified payment agent

40. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit to go)*

First California Federal Credit Union

41. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check or savings deposit slip)*

6593568

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART XII - CERTIFICATION, AUTHORIZATION, AND SIGNATURE(S)

I certify that the statements in this document are true and complete to the best of my knowledge and belief. 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.

IMPORTANT - If you sign with an "X", then you must have 2 people witness your signature. They must then print their names and addresses and sign the form.

42A. VETERAN'S SIGNATURE *(Do not print) (Please sign in ink)*	42B. VETERAN'S PRINTED NAME	42C. DATE SIGNED
Jésus Hernandez	Jésus Hernandez	12/29/2015

43A. SIGNATURE OF WITNESS *(Do not print)*	43B. PRINTED NAME AND ADDRESS OF WITNESS

44A. SIGNATURE OF WITNESS *(Do not print)*	44B. PRINTED NAME AND ADDRESS OF WITNESS

PART XIII - REMARKS

(Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension)

45. REMARKS *(If you need more space you may attach a separate sheet of paper)*

$253 7/2015 Prescriptions Walgreen's for spouse

$253 8/2015 Prescriptions Walgreen's for spouse

$253 9/2015 Prescriptions Walgreen's for spouse

$253 10/2015 Prescriptions Walgreen's for spouse

$253 11/2015 Prescriptions Walgreen's for spouse

$253 12/2015 Prescriptions Walgreen's for spouse

$676 9/2015 Outpatient clinic Dr. Kenneth Copal for spouse

$121 8/2015 School Physical $121 Dr. Jennifer Niles for child

$35 8/2015 Prescriptions Walgreen's for child

$3954 10/2015 MRI Sacramento Radiology Associates for child

$587 10/2015 X-Rays Sacramento Radiology Associates for child

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.

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON THIS PAGE.

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

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 5-31-2018

Department of Veterans Affairs

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT	3. RELATIONSHIP OF CLAIMANT TO VETERAN
Jésus Hernandez	Michael Hernandez	child

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER
TRA-65-9782	TRA-50-6519	TRA-65-9782

6. DATE OF EXAMINATION	7. HOME ADDRESS
02152015	12389 Main View Sacramento, CA 95673

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☒ NO *(If "Yes," complete Items 8B and 9)*		

NOTE: EXAMINER PLEASE READ CAREFULLY

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

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*
Multiple Sclerosis diagnoses since age 12. Unable to walk or hold objects without assistance. Disability is anticipated to be lifelong and he will need daily care.

11A. AGE	11B. SEX	12. WEIGHT	13. HEIGHT
36	M	ACTUAL: LBS. 175 ESTIMATED: LBS.	FEET: 5 INCHES: 8

14. NUTRITION	15. GAIT
Patient is alert and well nourished; no signs for concern.	kness, Spasticity, Balance and sensory d

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
115/60	80		

20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED
From 9 PM to 9 AM: From 9 AM to 9 PM:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*
☐ YES ☒ NO Unable to hold utensils in hands.

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*
☐ YES ☒ NO Unable to hold objects in hand for prolonged periods.

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*
☒ YES ☐ NO Unable to bath without assistance from caregiver. Needs daily assistance with all personal hygiene needs

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☒ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*
☐ YES ☒ NO

26. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*
☒ YES ☐ NO Unable to safely administer personal medications without assistance

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*
☐ YES ☒ NO Unable to calculate expenses without assistance

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

36 y/o male assisted by mother for check up. Shows signs of weakness and spasticity in the left leg. Right hand is shows signs of Dupuytren's Contracture. Alert, well nourished.

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

Right hand is shows signs of Dupuytren's Contracture.

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

Shows signs of weakness and spasticity in the left leg.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

No restrictions of the spine, trunk and nect

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

Patient is minimally able to perform activities of daily living without assistance. Patient's mother is primary caregiver and assists him with most tasks.

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

Patient is unable to leave home or immediate premises without supervision. Patient is under the care and assistance of his mother who is his primary caregiver.

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

☒ YES

☐ NO *(If "YES," give distance) (Check applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* 3-4 steps

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED
Dr. Dennis Voyt	Dr. Dennis Voyt	02/15/2015

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*
Primary Care 3842 Boston Way Sacramento, CA 93245	916-458-9631

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

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet pate at **http://www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.