



## PENSION AND FIDUCIARY SERVICE

# PMC VSR Core Course Phase 5, Part 3: Promulgate Non-Rating or Rating Decision Knowledge Check Preparation

## **Appendix A: Example Claim**

[Month Year]

Version 1.0

**For Training Purposes Only**

THIS IS AN IMPORTANT RECORD  
SAFEGUARD IT

PERSONAL DATA	1. LAST NAME - FIRST NAME - MIDDLE NAME Hernandez, Jesús		2. SERVICE NUMBER TRA-65-9782		3. SOCIAL SECURITY NUMBER TRA-65-9782		
	4. DEPARTMENT, COMPONENT AND BRANCH OR CLASS Army		5. GRADE, RATE OR RANK Sergeant First Class	GRADE E-7	6. DATE OF RANK 28 01 1970	DAY MONTH YEAR	
	7. U.S. CITIZEN <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	8. PLACE OF BIRTH (City and State or Country) Aurora		9. DATE OF BIRTH 29 11 1938	DAY MONTH YEAR		
SELECTIVE SERVICE DATA	10a. SELECTIVE SERVICE NUMBER TRA-65-9782	b. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, COUNTY, STATE, AND ZIP CODE			c. DATE INDUCTED 21 01 1962		
	11a. TYPE OF TRANSFER OR DISCHARGE Discharge		b. STATION OR INSTALLATION AT WHICH EFFECTED Fort Huachuca				
TRANSFER OR DISCHARGE DATA	c. REASON AND AUTHORITY Completion of required active service			d. EFFECTIVE DATE 28 01 1970	DAY MONTH YEAR		
	12. LAST DUTY ASSIGNMENT AND MAJOR COMMAND		13a. CHARACTER OF SERVICE Honorable		b. TYPE OF CERTIFICATE ISSUED		
	14. DISTRICT, AREA COMMAND OR CORPS TO WHICH RESERVIST TRANSFERRED				15. REENLISTMENT CODE		
	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 <input type="checkbox"/> ENLISTED (First Enlistment) <input type="checkbox"/> ENLISTED (Prior Service) <input type="checkbox"/> REENLISTED <input type="checkbox"/> OTHER		b. TERM OF SERVICE (Years) 8	c. DATE OF ENTRY DAY MONTH YEAR 24 01 1962	
SERVICE DATA	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) 32605 West 252 Mile Road, Suite 250, Aurora		22. STATEMENT OF SERVICE		YEARS	MONTHS	DAYS
	23a. SPECIALTY NUMBER & TITLE Automated		b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER		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 AUTHORIZED							
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) <input type="checkbox"/> YES <input type="checkbox"/> NO	b. AMOUNT OF ALLOTMENT	c. MONTH ALLOTMENT DISCONTINUED	
			28. VA CLAIM NUMBER TRA-65-9782	29. SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> NONE			
REMARKS	30. REMARKS						
AUTHENTICATION	31. PERMANENT ADDRESS FOR MAILING PURPOSES AFTER TRANSFER OR DISCHARGE (Street, R.F.D., City, County, State and Zip Code) 32605 West 252 Mile Road, Suite 250 Aurora, IL 60456 (US)			32. SIGNATURE OF PERSON BEING TRANSFERRED OR DISCHARGED <i>Jésus Hernandez</i>			
	33. TYPE NAME, GRADE AND TITLE OF AUTHORIZING OFFICER Capt. Samuel D. Hawkins ADMINO			34. SIGNATURE OF OFFICE AUTHORIZING TO SIGN <i>Samuel D. Hawkins</i>			

**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



Department of Veterans Affairs

**RECEIVED**

Mar 30 2015

AMERICAN LEGION  
VSO Sacramento CaVA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)**RECEIVED****CARO**

2015 APR 2 PM 2:15 PM

**INTENT TO FILE A CLAIM FOR COMPENSATION  
OR SURVIVORS PENSION AND/OR DEPENDENCY**

(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: 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](http://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

Month Day Year  
11 - 29 - 1938

6. VETERAN'S SEX

 MALE  FEMALE

7. HAS THE VETERAN EVER FILED A CLAIM WITH VA?

 YES  NO (If "Yes," provide your file number in Item 8)

8. VA FILE NUMBER

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 NumberCity, State, ZIP Code and Country  
Sacramento CA 95673

10. PREFERRED TELEPHONE NUMBER (Include Area Code)

(916)555-5431

11. PREFERRED E-MAIL ADDRESS (If applicable)

**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

Jesus Hernandez

12B. DATE SIGNED (MM,DD,YYYY)

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](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.



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](http://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

Hernandez, Jesús

2. VA FILE NUMBER (Include prefix)

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)

TRA-65-9782

5. INSURANCE NUMBER(S) (Include letter prefix)

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)

12389 Main View  
Sacramento, CA 95673

9. CLAIMANT'S TELEPHONE NUMBERS (Include Area Code)

A. DAYTIME

916-555-5431

B. EVENING

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)

Jesus Hernandez

16. DATE SIGNED

03/30/2015

17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B (Do Not Print)

William Alcares

18. DATE SIGNED

03/30/2015

**VA  
USE  
ONLY**

COPY OF VA FORM 21-22 SENT TO:

 VR&E FILE EDU FILE LG FILE INSURANCE FILE

DATE SENT

05/01/2015 MB

ACKNOWLEDGED  
(Date)

05/05/2015 MB

REVOKED (Reason and date)

**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.



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)

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

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

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**CA RO**  
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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)  
 A. DAYTIME (916) 555-5431  
 B. EVENING  
 C. CELL

7. E-MAIL ADDRESS (If applicable)  
 jesus0@my-case.com

8A. DATE OF BIRTH (Month, day, year) 11/29/1938  
 8B. PLACE OF BIRTH Aurora  
 9. SEX  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)  
 YES  NO (If "Yes," complete Items 10B & 10C)

10B. WHEN WAS THE CLAIM FILED? (Mo., day, yr.)  
 10C. FOR WHAT DISABILITY ARE YOU RECEIVING BENEFITS?

**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  
 Sacramento VA Medical Center  
 10535 Hospital Way  
 Mather, CA 95655

13A. HAVE YOU EVER BEEN A PRISONER OF WAR?  
 YES  NO (If "Yes," complete Items 13B and 13C)

13B. NAME OF COUNTRY Viet Nam

13C. DATES OF CONFINEMENT  
 FROM 3/15/1965 TO 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 <i>(Reserve, National Guard)</i>	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  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO BRANCH _____	22B. RESERVE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RESERVE OBLIGATION <input type="checkbox"/> INACTIVE
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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? <i>(If "Yes," complete Items 23C &amp; 23D)</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	23B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? <i>(If "Yes," explain, i.e. Future Reserve/National Guard Retirement, Pending MEB/PEB)</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____	23C. BRANCH OF SERVICE	23D. MONTHLY AMOUNT  \$
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24. RETIRED STATUS <input type="checkbox"/> RETIRED <input type="checkbox"/> TEMPORARY DISABILITY RETIRED LIST <input type="checkbox"/> DISABLED RETIRED LIST	25. NO, I DO NOT WANT VA COMPENSATION IN LIEU OF MILITARY RETIRED PAY <i>(Check box, if applicable)</i> <input type="checkbox"/>
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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 <i>(If married, complete Items 27B thru 29D)</i> <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED <i>(If never married, skip to Item 30)</i>	27B. SPOUSES'S BIRTHDATE <i>(Mo., day, yr.)</i>  08/30/1942
--	---

27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED <i>(To include current marriage)</i> 1	27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED <i>(To include current marriage)</i> 1	27E. IS YOUR SPOUSE ALSO A VETERAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>(If "Yes," complete Item 27F)</i>	27F. SPOUSE'S VA FILE NUMBER <i>(If any)</i>  C- TRA-25-9552
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27G. DO YOU LIVE TOGETHER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "No," complete Items 27H thru 27J)</i>	27H. REASON FOR SEPARATION <i>(For example, marital problems, job requirements, health, etc.)</i>	27I. PRESENT ADDRESS OF SPOUSE
---	---	--------------------------------

27J. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S MONTHLY SUPPORT  \$	27K. HOW WERE YOU MARRIED? <input checked="" type="checkbox"/> CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL <input type="checkbox"/> TRIBAL <input type="checkbox"/> OTHER <i>(Explain)</i> <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> PROXY _____
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**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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Michael Hernandez	08/19/1980 (Month, day, year) Place: San Diego, CA	TRA-50-6519	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	 (Month, day, year) Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," complete Items 34B thru 34D)	34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY	34C. HAVE YOU APPLIED FOR MEDICAID? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> APPLIED - NOT RECEIVED DECISION	34E. ARE YOU RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSI BUT NO DECISION HAS BEEN MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 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) <i>(Provide the first, middle initial, and last name)</i>		
				NAME Bianca L Cruz	NAME Michael Hernandez	NAME
35A.	Social Security	712.00	712.00	0	656.00	
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 <i>(Interest, dividends, or one-time payments)</i>	185.00 Interest Annually	121.00 Interest 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?  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36B. WILL YOU RECEIVE ANY INCOME FROM THE OPERATION OF A FARM WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36C. DO YOU THINK YOUR INCOME WILL CHANGE IN THE NEXT 12 MONTHS? <i>(If "Yes," explain below)</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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) <i>(Provide the first, middle initial, and last name)</i>		
				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 <i>(CDs)</i>	0	0	0	0	
37C.	Retirement accounts <i>(IRAs, Keogh Plans, etc.)</i>	0	0	0	0	
37D.	Stocks, bonds, and mutual funds	42,725	0	0	0	
37E.	Value of business assets	0	0	0	0	
37F.	Real property <i>(not your home)</i>	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)
		Hospital charge	Sacramento Regional Hospital	Self
6,356.00	04/2015			
		Prescription	Walgreens	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			
		Medicare deduction	Medicare	self
524.00	05/2015			
		Medicare deduction	Medicare	spouse
524.00	05/2015			
		Prescription	Sacramento Regional Hospital	self
876.00	06/2015			
		CT Scan with contrast	Sacramento Radiology Associates	self
4864.00	04/2015			

**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](http://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)

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

SAVINGS \_\_\_\_\_  
(Account Number)

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 ( <i>Do not print</i> ) ( <i>Please sign in ink</i> )  <i>Jésus Hernandez</i>	42B. VETERAN'S PRINTED NAME  Jésus Hernandez	42C. DATE SIGNED  12/29/2015
43A. SIGNATURE OF WITNESS ( <i>Do not print</i> )	43B. PRINTED NAME AND ADDRESS OF WITNESS	
44A. SIGNATURE OF WITNESS ( <i>Do not print</i> )	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, being the parent(s) of Bianca Cruz,  
NAME OF PARENT(S) NAME OF CHILD

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

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


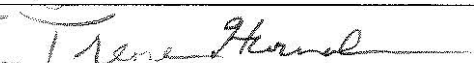
I/We understand that this child will not be considered to have been placed for adoption until the prospective adoptive parent(s), the Adoption Service Provider (ASP) and I/we have signed this placement agreement.

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. These rights  
DATE 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 	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).

<small>SIGNATURE OF INDIVIDUAL SERVING AS AN ASP</small> <u>Barbara Jones</u>	<small>DATE</small> 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.*

<small>SIGNATURE OF NOTARY</small>	<small>DATE</small> 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:

<small>NAME OF CDSS ADOPTION OFFICE/DELEGATED COUNTY ADOPTION AGENCY</small> California Family Service	
<small>ADDRESS</small> 1867 Northern shore Sacramento, CA	<small>TELEPHONE NUMBER</small> (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

 <b>Department of Veterans Affairs</b>		<b>EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE</b>		
1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN <p style="text-align: center;">Jésus Hernandez</p>		2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT <p style="text-align: center;">Michael Hernandez</p>		3. RELATIONSHIP OF CLAIMANT TO VETERAN <p style="text-align: center;">child</p>
4A. VETERAN'S SOCIAL SECURITY NUMBER <p style="text-align: center;">TRA-65-9782</p>	4B. CLAIMANT'S SOCIAL SECURITY NUMBER <p style="text-align: center;">TRA-50-6519</p>		5. CLAIM NUMBER <p style="text-align: center;">TRA-65-9782</p>	
6. DATE OF EXAMINATION <p style="text-align: center;">02152015</p>		7. HOME ADDRESS <p style="text-align: center;">12389 Main View Sacramento, CA 95673</p>		
8A. IS CLAIMANT HOSPITALIZED?  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 8B and 9)		8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL	
<b>NOTE: EXAMINER PLEASE READ CAREFULLY</b> 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 <p style="text-align: center;">36</p>	11B. SEX <p style="text-align: center;">M</p>	12. WEIGHT ACTUAL: LBS. 175 ESTIMATED: LBS.		13. HEIGHT FEET: 5 INCHES: 8
14. NUTRITION <p style="text-align: center;">Patient is alert and well nourished; no signs for concern.</p>				15. GAIT kness, Spasticity, Balance and sensory d
16. BLOOD PRESSURE <p style="text-align: center;">115/60</p>	17. PULSE RATE <p style="text-align: center;">80</p>	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?	
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)  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Unable to hold utensils in hands.				
22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? (If "No," provide explanation)  <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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)  <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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)  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24B. CORRECTED VISION LEFT EYE                      RIGHT EYE	
25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
26. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? (If "Yes," provide explanation)  <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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)  <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 Dr. Dennis Voyt	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN <b>Dr. Dennis Voyt</b>	35C. DATE SIGNED 02/15/2015
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36A. NAME AND ADDRESS OF MEDICAL FACILITY Primary Care 3842 Boston Way Sacramento, CA 93245	36B. TELEPHONE NUMBER OF MEDICAL FACILITY <i>(Include Area Code)</i>  916-458-9631
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**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.



DEPARTMENT OF VETERANS AFFAIRS

February 15, 2016

MR. JESUS HERNANDEZ  
12389 MAIN VIEW  
SACRAMENTO, CA 95673

In reply, refer to:  
310/PMC/PMC  
File Number: TRA-65-9782  
JESUS HERNANDEZ

**IMPORTANT -- reply needed**

Dear Mr. Hernandez:

We are working on your claim for Disability Pension Benefits.

This letter tells you what we will do with your claim and what you can do to help us. Please read the enclosure to this letter entitled, "Veteran Claims Assistance Act (VCAA)." The enclosure explains how we obtain evidence related to your claim and the legal requirements for supporting your claim.

**What Do We Still Need from You?**

We need additional evidence from you. *Please put your VA file number on the first page of every document you send us.*

- In support of your claim for special monthly pension, we need a doctor's statement and/or medical report showing at least one of the following: you need the aid and attendance of another person in performing your activities of daily living; are severely visually impaired; or are permanently housebound. Any statements you provide should address the following issues: number of hours in bed; posture and general appearance; restriction of use of lower and upper extremities; restrictive use of spine, trunk and neck; effects of advancing age: (such as loss of memory or balance, which affect ability to perform self-care, ambulate or travel beyond home or ward); and what your activities are during a typical day.
- Send us any treatment records related to your claimed condition(s). This includes reports or statements from doctors, hospitals, laboratories, medical facilities, mental health clinics, x-rays, physical therapy records, surgical reports, etc. These should include the dates of treatment, findings, and diagnoses. If you want us to try to obtain any doctor, hospital or medical reports on your behalf, please complete and return the attached *VA Form 21-4142, Authorization and Consent to Release Information*.

File Number: TRA-65-9782

Jesus Hernandez

- If you have received treatment at a Department of Veterans Affairs (VA) facility or treatment authorized by VA, please tell us the dates and places of treatment. We will then obtain the necessary records if you give us enough information to locate them.
- You may also send us your own statement, or statements from people who have witnessed how your claimed disabilities affect you. All statements submitted on your behalf should conclude with the following certification: "I hereby certify that the information I have given is true to the best of my knowledge and belief."
- **We have enclosed a "VCAA Notice Response." We encourage you to return this document, as it may expedite a decision on your claim.**

### **Where Should You Send What We Need?**

**Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website.** Just visit [www.eBenefits.va.gov](http://www.eBenefits.va.gov) to register. Please also refer to the 'What is eBenefits?' section of this letter for more information.

Please send what we need to this address:

You can send what we need to the appropriate address listed on the attached Where to Send Your Written Correspondence chart.

### **How Soon Should You Send What We Need?**

- We strongly encourage you to send any information or evidence as soon as you can. If we do not hear from you, we may make a decision on your claim after 30 days. However, you have up to one year from the date of this letter to submit the information and evidence necessary to support your claim. If we decide your claim before one year from the date of this letter, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.

## What is eBenefits?

eBenefits provides electronic resources in a self-service environment to Servicemembers, Veterans, and their families. Use of these resources often helps us serve you faster! Through the eBenefits website you can:

- Submit claims for benefits and/or upload documents directly to the VA
- Request to add or change your dependents
- Update your contact and direct deposit information and view payment history
- Request a Veterans Service Officer to represent you
- Track the status of your claim or appeal
- Obtain verification of military service, civil service preference, or VA benefits
- And much more!

Enrolling in eBenefits is easy. Just visit [www.eBenefits.va.gov](http://www.eBenefits.va.gov) for more information. If you submit a claim in the future, consider filing through eBenefits. Filing electronically, especially if you participate in our fully developed claim program, may result in a faster decision than if you submit your claim through the mail.

## How Can You Contact Us?

If you are looking for general information about benefits and eligibility, you should visit our web site at <http://www.va.gov>. Otherwise, you can contact us in several ways. Please give us your VA file number, **TRA-65-9782**, when you do contact us.

- Call us at 1-800-827-1000 or 1-877-294-6380. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711 (international number is 1-800-829-4833).
- Send us an inquiry using the Internet at <https://iris.va.gov>.

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File Number: TRA-65-9782

Jesus Hernandez

We look forward to resolving your claim in a fair and timely manner.

Sincerely yours,

*RO Director*

RO Director

VA Regional Office

Enclosures:     VA Form 21-4138  
                  VA Form 21-4142  
                  VA Form 21-2680  
                  Where to Send Your Written Correspondence  
                  Veterans Claims Assistance Act (VCAA)  
                  What the Evidence Must Show - NSC Live Pension  
                  What the Evidence Must Show – SMP  
                  What the Evidence Must Show - Helpless Child

cc: DISABLED AMERICAN VETERANS

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## Veterans Claims Assistance Act (VCAA)

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### What the Evidence Must Show for Nonservice-Connected Pension Benefits

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To support a claim for non service-connected pension, the evidence must show:

1. You met certain minimum requirements regarding active service during a period of war.

Generally, those requirements involve:

- 90 days of consecutive service, at least one day of which was during a period of war; OR
- 90 days of combined service during at least one period of war;

*(Note: If your service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligation.)*

- OR, any length of active service during a period of war with a discharge due to a service-connected disability.

2. You are age 65 or older or are permanently and totally disabled. You are considered permanently and totally disabled if medical evidence shows you are:

- A patient in a nursing home for long-term care; OR
- Receiving Social Security disability benefits; OR
- Unemployable due to a disability reasonably certain to continue throughout your lifetime; OR
- Suffering from a disability that is reasonably certain to continue throughout your lifetime that would make it impossible for an average person to follow a substantially gainful occupation; OR
- Suffering from a disease or disorder that VA determines causes persons who have that disease or disorder to be permanently and totally disabled.

3. Your net worth and income do not exceed certain requirements.

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### What the Evidence Must Show for Special Monthly Pension Benefits

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To support your claim for increased disability pension benefits based on the need for aid and attendance, the evidence must show:

- You have corrected vision of 5/200 or less in both eyes; OR
- You have contraction of the concentric visual field to 5 degrees or less; OR
- You are a patient in a nursing home due to mental or physical incapacity; OR
- You require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment; OR

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Jesus Hernandez

- You are bedridden, in that your disability requires that you remain in bed apart from any prescribed course of convalescence or treatment.

To support your claim for increased disability pension benefits based on being housebound, the evidence must show:

- You have a single permanent disability evaluated as 100 percent disabling; AND due to such disability, you are permanently and substantially confined to your immediate premises; OR
- You have significant additional disability (rated 60% or higher) in addition to any disability necessary to establish pension eligibility.

### **What the Evidence Must Show for a Helpless Child**

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To support a claim for benefits based on a veteran's child being helpless, the evidence must show that the child, before his or her 18<sup>th</sup> birthday, became permanently incapable of self-support due to a mental or physical disability.

#### **VA is Responsible for Getting the Following Evidence:**

- Relevant records that you adequately identify and authorize VA to obtain from any Federal agency. These may include records from the military, VA medical centers (including private facilities where VA authorized treatment), or the Social Security Administration.
- VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your compensation claim.

#### **On Your Behalf, VA Will Make Reasonable Efforts to Get the Following Evidence:**

Relevant records not held by a Federal agency that you adequately identify and authorize VA to obtain. These may include records from State or local governments, private doctors and hospitals, or current or former employers.

**How Can You Help:** If you have any information or evidence that you have not previously told us about or given to us, please tell us or give us that evidence now. If the evidence is not in your possession, you must give us enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to us, asks for a fee to provide it, or VA otherwise cannot get the evidence, we will notify you. *It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.*

File Number: TRA-65-9782

Jesus Hernandez

**How VA Determines the Effective Date:** If we grant your claim, the beginning date of your entitlement will generally be based on when we received your claim.

Higher levels of nonservice-connected pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Higher levels of pension may be effective from the date the medical evidence first shows entitlement.

File Number: TRA-65-9782  
Jesus Hernandez

## VCAA NOTICE RESPONSE

**Date of Claim: January 8, 2016**

We provided a notice to you about the evidence and information VA needs to support your claim for benefits. At this time, you may choose to indicate whether you intend to submit additional information or evidence that would help support your claim.

Your signed response will let us know whether to decide your claim without waiting 30 days, or whether we should give you the full 30 days from the date of the letter sent with this notice response before deciding your claim.

Your signature on this response will not affect:

- Whether or not you are entitled to VA benefits;
- The amount of benefits to which you may be entitled;
- The assistance VA will provide you in obtaining evidence to support your claim; or
- The date any benefits will begin if your claim is granted.

## RESPONSE

**I elect *one* of the following:** (Whichever box you check, you have one year from the date of the notice to give VA any other information or evidence you think will support your claim.)

I have enclosed all the remaining information or evidence that will support my claim, or I have no other information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

I will send more information or evidence to VA to support my claim. VA will wait the full 30 days from the date of the letter sent with this notice response before deciding my claim.

\_\_\_\_\_  
Claimant/Representative Signature

\_\_\_\_\_  
Date





**DEPARTMENT OF VETERANS AFFAIRS  
DEPARTMENT OF VETERANS AFFAIRS REGIONAL OFFICE  
5000 WISSAHICKON AVENUE  
PO BOX 8079  
PHILADELPHIA PA 19101**

**JESUS HERNANDEZ**

**VA File Number  
TRA-65-9782**

**Rating Decision  
April 15, 2016  
INTRODUCTION**

The records reflect that you are a Veteran of the Vietnam War. You served in the Army from January 24, 1962 to January 28, 1970. You filed an original claim for disability pension on January 8, 2016. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

**DECISION**

1. Jesus Hernandez is not entitled to Aid and Attendance or Housebound benefits.
2. Permanent incapacity for self-support is established for Michael Hernandez.

**EVIDENCE**

- VA Form 21-526, Application for Compensation and/or Pension, received January 8, 2016
- VA Form 21-22 Appointment of Veterans Service Organization as Claimant's Representative, Received March 30, 2015
- Marriage Certificate, received January 8, 2016
- Independent Adoption Placement Agreement, received January 8, 2016
- VA Form 21-2680 Examination for Housebound Status or Permanent Need for Regular Aid and Attendance, received January 8, 2016
- DD Form 214, received January 8, 2016
- VCAA 5103 Notice sent February 15, 2016

## **REASONS FOR DECISION**

### **1. Entitlement to Aid and Attendance or Housebound benefits for Jesus Hernandez.**

Aid and attendance may be awarded when the claimant is blind in both eyes having visual acuity of 5/200 or less, or has contraction of the visual field to 5 degrees or less; is a patient in a nursing home because of mental or physical incapacity; or, when the evidence shows aid and attendance is required to perform routine activities of daily living. The routine activities of daily living are basic self-care tasks which include such things as the ability to dress or undress one's self, to keep one's self ordinarily clean and presentable, ability to feed one's self, the ability to attend to the needs of nature, or the ability to protect one's self from the hazards or dangers incident to his or her daily environment. Special monthly entitlement based on the need for aid and attendance is not established because none of these requirements have been met. A special monthly entitlement based on being housebound is met when the veteran is substantially confined to his or her home or immediate premises by reason of a disability or disabilities which are reasonably certain will remain throughout the surviving spouse's lifetime. Special monthly entitlement on this basis is not established by the evidence of record. {38 CFR 3.351}

A development letter was sent February 15, 2016 requesting medical evidence to support your claim for special monthly pension benefits. No response has been received regarding this request.

Therefore, entitlement to special monthly pension based on housebound status or the need for aid and attendance is denied.

### **2. Permanent incapacity for self-support of Michael Hernandez.**

For purposes of establishing entitlement to VA benefits, a child over 18 years of age must be shown to be permanently incapable of self-support by reason of mental or physical disability by the age of 18. The evidence establishes that Michael Hernandez became permanently incapable of self-support prior to (his or her) 18th birthday due to a physical or mental disability diagnosed as multiples sclerosis. The cited evidence reports that Michael Hernandez's diagnosis of multiple sclerosis severely limits (his or her) ability to care for their daily needs. The cited treatment report from Dr. Voyt indicates Michael is unable to communicate his needs and he will require daily care. The evidence shows Michael Hernandez became incapable of self- support prior to (his or her) 18th birthday. Therefore, entitlement as a helpless child for VA purposes is granted effective January 8, 2016 the date the veteran's claim for pension benefits was received.

### **REFERENCES:**

Title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief contains the regulations of the Department of Veterans Affairs which govern entitlement to all Veteran benefits. For additional information regarding applicable laws and regulations, please consult your local library, or visit us at our web site, [www.va.gov](http://www.va.gov).