



PENSION AND FIDUCIARY SERVICE

PMC VSR Core Course
Phase 5: Stages of Claim
Part 4: Prepare Decision Notice

Prepare Decision Notice Knowledge Check

Appendix A: Catherine Abel Claim
(TRA-57-6817)

May 18, 2017

Version 1.0

For Training Purposes Only

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

1. LAST NAME - FIRST NAME -MIDDLE NAME Abel, Catherine R.			2. SEX F	3. SOCIAL SECURITY NUMBER TRA 57 6817		4. DATE OF BIRTH YEAR MONTH DAY 49 04 19
5. DEPARTMENT, COMPONENT AND BRANCH OR CLASS Marine Corps			6a. GRADE, RATE OR RANK Captain		6b. PAY GRADE O-3	7. DATE OF RANK YEAR MONTH DAY 78 07 17
8a. SELECTIVE SERVICE NUMBER		b. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, STATE AND ZIP CODE		c. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (Street, RFD, City, State and Zip Code) 57251 Serene Blvd, Van Nuys, CA 91411 (US)		
9a. TYPE OF SEPERATION Discharge			b. STATION OR INSTALLATION AT WHICH EFFECTED Camp Pendleton California			
c. AUTHORITY AND REASON					d. EFFECTIVE DATE YEAR MONTH DAY 78 08 31	
e. CHARACTER OF SERVICE Honorable				f. TYPE OF CERTIFICATE ISSUES		10. REENLISTMENT CODE
11. LAST DUTY ASSIGNMENT AND MAJOR COMMAND Camp Pendleton			12. COMMAND TO WHICH TRANSFERRED			
13. TERMINAL DATE OF RESERVE/ MSS OBLIGATION YEAR MONTH DAY		14. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City, State and ZIP Code) Van Nuys, CA			15. DATE ENTERED ACTIVE DUTY THIS PERIOD YEAR MONTH DAY 72 08 31	
16a. PRIMARY SPECIALTY NUMBER AND TITLE 0802 - Field Artillery Officer (5 years)		b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER Logistics		18. RECORD OF SERVICE		
				(a) NET ACTIVE SERVICE THIS PERIOD YEARS MONTHS DAYS 06 01 01		
				(b) PRIOR ACTIVE SERVICE 00 00 00		
17a. SECONDARY SPECIALTY NUMBER AND TITLE		b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER		(c) TOTAL ACTIVE SERVICE (a & b) 06 01 01		
				(d) PRIOR INACTIVE SERVICE 00 00 00		
				(e) TOTAL SERVICE FOR PAY (c & d) 06 01 01		
				(f) FOREIGH AND/OR SEA SERVICE THIS PERIOD 00 00 00		
19. INDOCHINA OR KOREA SERVICE SINCE AUGUST 5, 1964			20. highest education level successfull completed (In Years) SECONDARY/HIGH SCHOOL ____ YRS (1-12 grades) COLLEGE ____ YRS			
21. TIME LOST (Preceeding Two Yrs)	22. DAYS ACCRUED LEAVE PAID	23. SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> NONE		24. DISIBILITY SEVERANCE PAY <input type="checkbox"/> NO <input type="checkbox"/> YES AMOUNT _____		25. PERSONNEL SECURITY INVESTIGATION a. TYPE b. DATE COMPLETED
26. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBINS AWARDED OR AUTHORIZED Joint Service Commendation Medal 03/31/1973 Marine Corps Achievement Medal with 1 Oak Leaf Cluster 09/03/1972 Marine Corps Commendation Medal with 1 Gold Star 06/01/1974 Marine Corps Good Conduct Medal with 1 Bronze Star 10/05/1975						
27. REMARKS						
28. MAILING ADDRESS AFTER SEPERATION (Street, RFD, City, County, State, ZIP) 57251 Serene Blvd Van Nuys, CA 91411 (US)				29. SIGNATURE OF PERSON BEING SEPARATED Catherine R. Abel		
30. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER SAMUEL D. HAWKINS, CAPT. ADMIN OFFICER				31. SIGNATURE OF OFFICER AUTHORIZED TO SIGN Samuel D. Hawkins		

DD FORM 1 NOV 72 214

PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT.

REPORT OF SEPARATION FROM ACTIVE DUTY

SECTION IV: MARITAL STATUS (MUST COMPLETE)

18A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

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

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

18B. HOW MANY TIMES HAVE YOU BEEN MARRIED (including current marriage)?

1

19A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country)	19B. TO WHOM MARRIED (first, middle, last name)	19C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	19D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	19E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country)
05/20/1965 Memphis, TN	Pat Abel	ceremonial	divorce	03/27/1973

19F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 19C, PLEASE EXPLAIN:

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

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

20. HOW MANY TIMES HAS YOUR SPOUSE BEEN MARRIED (including current marriage)?

1

21A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country)	21B. TO WHOM MARRIED (first, middle, last name)	21C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	21E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country)
05/20/1965 Memphis, TN	Abel, Catherine R.	ceremonial	divorce	03/27/1973

21F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21C, PLEASE EXPLAIN:

22A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (month, day, year)	22B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	22C. IS YOUR SPOUSE ALSO A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	22D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (if any)?
22E. DO YOU LIVE WITH YOUR SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If "Yes," skip to Section VI) (If "No," complete Items 22F - 22H)</small>		22F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O., State, ZIP Code and country)	
22G. TELL US THE REASON WHY YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e.; illness, work, etc.)		22H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? \$	

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

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

23A. NAME OF DEPENDENT CHILD (First, middle initial, last)	23B. DATE AND PLACE OF BIRTH (city, state or country)	23C. SOCIAL SECURITY NUMBER	<i>(Check all that apply)</i>						
			23D. BIOLOGICAL	23E. ADOPTED	23F. STEPCHILD	23G. 18-23 YEARS OLD (in school)	23H. SERIOUSLY DISABLED	23I. CHILD MARRIED	23J. CHILD PREVIOUSLY MARRIED
Sunil Abel	01/04/1967 Houston, TX	TRA-01-1776	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note - In Items 24A through 24D, tell us about the children listed in Item 23A who **do not** live with you.

24A. NAME OF DEPENDENT CHILD (First, middle initial, last)	24B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	24C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	24D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			\$
			\$
			\$

SECTION VII: INCOME VERIFICATION - NET WORTH (MUST COMPLETE)

25. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. You must report your net worth and the net worth of your dependents (spouse, child, etc.), if any. Identify the **specific** owner for each net worth source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	\$ 100	Veteran	REAL PROPERTY (Not your home, vehicle, furniture, or clothing)	\$ 0	
INTEREST-BEARING BANK ACCOUNTS	\$ 0		ALL OTHER PROPERTY (Please write source)	\$ 0	
IRA'S, KEOGH PLANS, ETC.	\$ 0		ALL OTHER PROPERTY (Please write source)	\$ 0	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	\$ 0		OTHER (Provide source)	\$ 0	

SECTION VIII: INCOME VERIFICATION - MONTHLY INCOME (MUST COMPLETE)

26. **GROSS MONTHLY INCOME** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. You must report your income and the income of your dependents (spouse, child, etc.), if any. Identify the **specific** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	\$ 455.00	Veteran	SERVICE RETIREMENT	\$ 0	
SOCIAL SECURITY	\$ 0		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	\$ 0	
U.S. CIVIL SERVICE	\$ 0		OTHER (Provide source) State Retirement	\$ 93.50	Veteran
U.S. RAILROAD RETIREMENT	\$ 0		OTHER (Provide source)	\$ 0	
BLACK LUNG BENEFITS	\$ 0		OTHER (Provide source)	\$ 0	

SECTION IX: EXPECTED INCOME (MUST COMPLETE)

27. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the next 12 months. You must report your expected income and the expected income of your dependents (spouse, child, etc.), if any. Identify the **specific** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	\$ 0		OTHER INCOME EXPECTED (Provide source)	\$ 0	
GROSS WAGES AND SALARY	\$ 0		OTHER INCOME EXPECTED (Provide source)	\$ 0	
TOTAL DIVIDENDS AND INTEREST	\$ 0		OTHER INCOME EXPECTED (Provide source)	\$ 0	

SECTION X: MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES (MUST COMPLETE)

28. **MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES** (IF NONE WRITE "0" OR "NONE")

Report your family medical expenses and certain other expenses actually paid by you that may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. 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 deduct them from the disability benefits for the year in which the expenses are paid. **Do not include any expenses for which you were reimbursed.**

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yy)	PURPOSE (Doctor's fees, hospital charges, attorney fees, tuition, education materials, etc.)	PAID TO (Name of doctor, hospital, pharmacy, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
\$ 106.00	monthly	Medicare Part B Premium	Social Security	Veteran
\$ 585.00	monthly	Private Medical Insurance Premium	AETNA	Veteran
\$				
\$				

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

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 29, 30, and 31 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.

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

CHECKING

SAVINGS

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

Account No.: _____ Account No.: _____

30. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

31. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension Benefits*.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 32, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

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

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

33A. VETERAN'S SIGNATURE (REQUIRED)

Catherine R. Abel

33B. DATE SIGNED

03/03/2017

SECTION XIII: WITNESSES TO SIGNATURE (MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 33A WITH AN "X")

34A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

34B. PRINTED NAME AND ADDRESS OF WITNESS

35A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

35B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

File Help



Information Entered

Ready Data

File Number Payee Name
 Message

Vet's Identification Data

- Name
- Insurance
- Inactive Comp & Pen
- Folder Location
- Miscellaneous Info
- Corporate Inquiry

File Number Name
 SSN - Verified Claim Folder Location
 Insurance File No. Date Of Death
 Insurance Policy No. Cause Of Death
 Date Of Birth Death In SVC
 Sex Positive Indication
 Power of Attorney Search

Service Data

SERVICE NUMBER	<input type="text" value="TRA-4485460"/>	<input type="text"/>	<input type="text"/>
EOD	<input type="text" value="08/31/1972"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>
RAD	<input type="text" value="08/31/1978"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>
BRANCH	<input type="text" value="MARINE CO"/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>
CHAR SVR	<input type="text" value="HON"/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>
SEP REASON	<input type="text" value="SAT"/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>
PAY GRADE	<input type="text" value="O-3"/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>	<input type="text" value=""/> <input type="text"/>
NON PAY DAYS	<input type="text"/>	<input type="text"/>	<input type="text"/>
VADS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VERIFIED	<input type="text" value="Y"/>	<input type="text"/>	<input type="text"/>

GW In-Theater

Start
 End
 Days
 Contested Data

7:32 AM

Print Screen

Ready

Exit

Current/Proposed Award Screen

No Current Award	Proposed Award - Net Effect \$0.00
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Enhanced View **Benefit:** Improved Pension

	Effective ▲	Awd Gross ◆	Awd Net ◆	IVAP ◆	MAPR ◆	S ◆	Svc Pd ◆	Dis Level ◆	A
<input checked="" type="radio"/>	04/01/2017	\$1,075.00	\$1,075.00	\$0.00	\$12,907.00		Vietnam Era	PT	

Financial Data Screen

Current Effective Date Set

Select	Financial Decision Effective Date	IVAP	Post- Award Audit	Potential Fraud	No Family Income	Net Worth is a bar	Improved Pension Family Net Worth Amount
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New Effective Date Set

Select	Status	Financial Decision Effective Date	IVAP	Post- Award Audit	Potential Fraud	No Family Income	Net Worth is a bar	Improved Pension Family Net Worth Amount
<input checked="" type="radio"/>	Added	04/01/2017	\$0.00	N	N	N	N	\$100.00

Financial Decision Screen

Financial Decision

Effective Date: Post- Award Audit No Family Income Entitlement Date: Potential Fraud Net Worth is a Bar

Improved Pension Family Net Worth Amount:

Proposed 04/01/2017 Decisions

Select	Person	Award Status	Income/Expense Type	Other Income Description	Income/Expense Amount	Exclusion Type	Exclusion Amount	Decision Date
<input type="radio"/>	CATHERINE R. ABEL	Primary Beneficiary	State Annuity/Retirement Monthly		\$93.50			03/09/2017
<input type="radio"/>			Social Security Monthly		\$455.00			03/09/2017
<input type="radio"/>			Medical		\$8,292.00			03/09/2017

Award Print Information

Claim Information

Date of Claim	Type of Claim	End Product	POA	Claimant	Claim Jurisdiction
03/05/2017	Initial Live Pension	180		Catherine R Abel	Chicago (328)

Miscellaneous Data

Net Effect of Award as of Generation	Cross Reference	Employable	Competent Status	Fiduciary Status	PGF Loc
\$0.00		Y	Competent	Pay Direct	

Verified Service

Name	Branch	Duty	EOD	RAD	Char Disch
Catherine R Abel	Marine Corps	Active Duty	08/31/1972	08/31/1978	Honorable

Primary Beneficiary Information

Mailing Address

CATHERINE R ABEL
 57251 SERENE BLVD
 VAN NUYS CA
 USA
 91411

Payment Address

CATHERINE R ABEL
 57251 SERENE BLVD
 VAN NUYS CA
 USA
 91411

Eff Date	Reason	Gross	MAPR	Total W/H	Allot W/H	Net	Dis Lvl	S	M	H	S	P
								C	C	C	C	
04/01/2017	Original Award	1,075.00	12,907.00			1,075.00	PT					