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)
11/06/2017

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
Francis Waltherson

4A. VETERAN'S SOCIAL SECURITY NO.	4B. VA FILE NUMBER *(If applicable)*	4C. SPOUSE'S SOCIAL SECURITY NO.
TRA-32-8360	TRA-32-8360	

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)*
444 BLENNER RD

6. TELEPHONE NUMBER(S) *(Include Area Code)*			7. E-MAIL ADDRESS *(If applicable)*
A. DAYTIME	B. EVENING	C. CELL	
(555) 555-5555			

8A. DATE OF BIRTH *(Month, day, year)*	8B. PLACE OF BIRTH	9. SEX
02/08/1962	PARKERSBURG	☒ 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
Knees	in service	
Severe DDD of my back due to knees	1989	Lincoln, NE VAMC
Headaches due to back	Aug 1990	St. Cloud, MN VAMC
Wrist condition	Sept 1990	Dr. Jones, What Do The 5 Fingers Say medical group

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
01	01	1989
12	31	1990

12C. NAME AND ADDRESS OF VA MEDICAL FACILITY *(If you need more space use Item 45, "Remarks")*
Lincoln, NE
St. Cloud, MN

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

13B. NAME OF COUNTRY
United States

13C. DATES OF CONFINEMENT

FROM	TO

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		
08/19/1986		TRA-32-8360	08/19/1988	Travis Air Force Base	Air Force	Major General

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.)*

27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED *(To include current marriage)*	27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED *(To include current marriage)*	27E. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO *(If "Yes,"complete Item 27F)*	27F. SPOUSE'S VA FILE NUMBER *(If any)* **C-**

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

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
	_____ *(Month, day, year)* Place:		☐	☐	☐	☐	☐	☐
	_____ *(Month, day, year)* Place:		☐	☐	☐	☐	☐	☐
	_____ *(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)*
Knees, back, sinusitis and headache

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?
☐ YES ☒ NO *(If "YES," complete Items 34B thru 34D)*

34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY

34C. HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☐ NO

34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION?
☐ YES ☐ NO ☐ 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?
☐ 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	NAME	NAME
35A.	Social Security	0.0	0.0			
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)*	0.0	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?	36B. WILL YOU RECEIVE ANY INCOME FROM THE OPERATION OF A FARM WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM?	36C. DO YOU THINK YOUR INCOME WILL CHANGE IN THE NEXT 12 MONTHS? *(If "Yes," explain below)*
☐ YES ☒ NO	☐ YES ☒ NO	☐ 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	NAME	NAME
37A.	Cash, non-interest bearing bank accounts	15,000	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	0.0	0.0			
37E.	Value of business assets	0.0	0.0			
37F.	Real property *(not your home)*	0.0	0.0			

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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*)
156.00	10/7/2017	Nasal sprays	Walgreens	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 _____ (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)*	41. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check or savings deposit slip)*

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
Francis Waltherson	Francis Waltherson	09/27/2017

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)*

I also had chronic sinusitis in service, which I still have today.

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.