OMB Control No. 2900-0321
Respondent Burden: 5 Minutes
Expiration Date: 08/31/2018

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

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

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

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER *(Include prefix)*
Caprio Jr., Johnny A.	TRA-08-4095

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

Disabled American Veterans

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)*

Balmer, James P

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

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)	5. INSURANCE NUMBER(S) *(Include letter prefix)*
TRA-07-9541	
6. NAME OF CLAIMANT *(If other than veteran)*	**7. RELATIONSHIP TO VETERAN**
Caprio, Ruby Sue R.	spouse
8. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	**9. CLAIMANT'S TELEPHONE NUMBERS** *(Include Area Code)*
22580 Free Street, Hartford, CT 06074 (US)	A. DAYTIME: (860) 555-0191 / B. EVENING:
	10. E-MAIL ADDRESS *(If applicable)*: johnny0@my-case.com
	11. DATE OF THIS APPOINTMENT: 04/01/2017

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

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

☒ I authorize any official representative of the organization named in Item 3A to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 3A is not my appointed fiduciary.

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

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

15. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	16. DATE SIGNED
Ruby Sue R. Caprio	04/01/2017
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*	**18. DATE SIGNED**
James P Balmer	04/01/2017

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

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.

VA FORM AUG 2015 **21-22**

SUPERSEDES VA FORM 21-22, OCT 2014, WHICH WILL NOT BE USED.

RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
AMVETS
American Ex-Prisoners of War, Inc.
American GI Forum, National Veterans Outreach Program
Armed Forces Services Corporation
Army and Navy Union, USA
Associates of Vietnam Veterans of America
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
Military Order of the Purple Heart
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc.
National Association for Black Veterans, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
The Veterans Assistance Foundation, Inc.
The Veterans of the Vietnam War, Inc. & The Veterans Coalition
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America
West Virginia Department of Veterans Assistance
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims.

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

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 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 and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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 responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 01/31/2018

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: 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 and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The 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 maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO.
Johnny A. Caprio Jr.	TRA-08-4095	C/CSS - TRA-08-4095

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

I have been the physician for John since birth. John has been diagnosis of mental retardation and an autism spectrum disorder since age 3. I do not expect his prognosis to change and he will require care and assistance throughout their lifetime.

If any questions, please do not hesitate to contact me.

Eugene Sampleton, MD

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED
Ruby Sue R. Caprio	04/01/2017

ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING
22580 Free Street, Hartford, CT 06074 (US)	(860) 555-0191	

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.

VA FORM JAN 2015 **21-4138**

SUPERSEDES VA FORM 21-4138, AUG 2011, WHICH WILL NOT BE USED.

CONTINUE ON REVERSE

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: 07/31/2018

Department of Veterans Affairs

APPLICATION FOR DIC, DEATH PENSION, AND/OR ACCRUED BENEFITS

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

04/01/2017

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, first, middle)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
Caprio Jr., Johnny A.	TRA-08-4095	06/20/1981

4. VETERAN'S SEX	5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
☒ MALE ☐ FEMALE	☐ YES ☒ NO (If "Yes," provide the file number in Item 6)	TRA-08-4095

7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?	8. WHAT IS THE VETERAN'S DATE OF DEATH? (MM,DD,YYYY)
☐ YES ☒ NO	03/10/2017

9. WHAT IS YOUR NAME? (First, middle, last name)	10. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
Caprio, Ruby Sue R.	☒ SURVIVING SPOUSE ☐ PARENT ☐ CHILD ☐ CUSTODIAN FILING FOR CHILD

11. WHAT IS YOUR SOCIAL SECURITY NUMBER?	12. WHAT IS YOUR DATE OF BIRTH? (MM,DD,YYYY)	13. ARE YOU A VETERAN?
TRA-07-9541	09/02/1980	☐ YES ☒ NO

14A. WHAT IS YOUR ADDRESS?	14B. YOUR TELEPHONE NUMBER(S) (include Area Code)
22580 Free Street Street address, rural route, or P.O. Box — Apt. number Hartford, CT 06074 (US) City — State — ZIP Code — Country	DAYTIME ( ) EVENING ( ) CELL PHONE ( )

15A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)	15B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)
johnny0@my-case.com	

16. WHAT ARE YOU CLAIMING? (Check all that apply)

☒ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☒ DEATH PENSION ☒ ACCRUED BENEFITS

SECTION II: VETERAN'S SERVICE INFORMATION *(COMPLETE ONLY IF THE VETERAN WAS NOT RECEIVING VA COMPENSATION OR PENSION BENEFITS AT THE TIME OF DEATH)*

(Skip to Section III if the veteran was receiving VA compensation or pension benefits at the time of his or her death)

17A. DID THE VETERAN SERVE UNDER ANOTHER NAME?	17B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:
☐ YES ☒ NO (If "Yes," complete Item 17B) (If "No," skip to Item 18A)	

18A. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	18B. BRANCH OF SERVICE	18C. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)
05/26/2005	Coast Guard	05/26/2009

18D. DID THE VETERAN SERVE IN A COMBAT ZONE SINCE 9-11-2001?	18E. PLACE OF LAST SEPARATION
☐ YES ☒ NO	

19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?	19B. DATE OF ACTIVATION (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," answer Items 19B, 19C and 19D)	

19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?	19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)
	( )

20A. WAS THE VETERAN EVER A PRISONER OF WAR?	20B. DATES OF CONFINEMENT
☐ YES ☒ NO (If "Yes," complete Item 20B) (If "No," skip to Section III)	FROM: TO:

SECTION III- MARITAL INFORMATION *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)*

*(Skip to Section IV if you are **NOT** claiming benefits as the surviving spouse of the veteran)*

TELL US ABOUT THE VETERAN'S MARRIAGES

21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)?

1

21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	21C. TO WHOM MARRIED (first, middle, last name)	21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21E. HOW MARRIAGE TERMINATED (death, divorce)	21F. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)
09/13/2000 Hartford, CT	Caprio, Ruby Sue R.	ceremonial	death	03/10/2017 Hartford, CT

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

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

☐ YES ☒ NO

22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

1

22C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	22D. TO WHOM MARRIED (first, middle, last name)	22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22F. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	22G. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)
09/13/2000 Hartford, CT	Caprio Jr., Johnny A.	ceremonial	death	03/10/2017 Hartford, CT

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

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

☒ YES ☐ NO

24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

☐ YES ☒ NO

25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

☒ YES ☐ NO (If "No," complete Item 26)

26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

☐ YES ☒ NO (If "Yes," provide explanation):

SECTION IV: DEPENDENT CHILDREN *(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)*

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)*

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
Caprio, John	02/24/1999 Newport, RI (US)	TRA-04-9428	☒	☐	☐	☐	☒	☐	☐
Caprio, Joseph M.	07/18/2003 Redmond, WA (U	TRA-28-3241	☐	☐	☒	☐	☐	☐	☐
Caprio, Ann R.	06/05/1998 Norridge, IL (US)	TRA-78-7198	☒	☐	☐	☒	☐	☐	☐

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who ***do not*** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION V: VETERAN'S PARENT *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)*

*(Skip to Section VI if you are **NOT** claiming benefits as the parent of a veteran)*

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE

☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION ***(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)***

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?

31D. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO (If "Yes," complete Item 31E)	31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)

32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF *MAJORITY* (AGE 18 IN MOST STATES)? ☐ YES ☐ NO (If "Yes," skip to Item 34)	32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control) (MM DD YYYY) *to* (MM DD YYYY) (MM DD YYYY) *to* (MM DD YYYY)

32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B

A. NAME (FIRST, MIDDLE, LAST)	B. ADDRESS
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country

34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE OF DEATH.

A. NAME (FIRST, MIDDLE, LAST)	B. DATE OF DEATH (MM,DD,YYYY)

SECTION VI: DIC *(COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))*

*(Skip to Section VII if you are **NOT** claiming DIC)*

35. WHAT BENEFIT ARE YOU CLAIMING?

☒ DIC ☐ DIC under 38 U.S.C. 1151 (RARE)

36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION VII: NET WORTH *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

37. **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. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your net worth and the child's net worth, if any.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$ 200.00	Self	REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$ 0.00	Self
INTEREST-BEARING BANK ACCOUNTS	$ 0.00	Self	OTHER PROPERTY *(Provide source)* N/A	$ 0.00	Self
IRA'S, KEOGH PLANS, ETC.	$ 0.00	Self	OTHER PROPERTY *(Provide source)* N/A	$ 0.00	Self
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$ 0.00	Self	OTHER *(Provide source)* N/A	$ 0.00	Self

SECTION VIII: GROSS MONTHLY INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

38. **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. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your income and the child's income, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$ 358.00	Self	SERVICE RETIREMENT/ SURVIVOR BENEFIT PLAN (SBP) ANNUITY	$ 0.00	Self
SOCIAL SECURITY	$ 150.00	Caprio, John	SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	$ 0.00	Self
U.S. CIVIL SERVICE	$ 0.00	Self	OTHER *(Provide source)* N/A	$ 0.00	Self
U.S. RAILROAD RETIREMENT	$ 0.00	Self	OTHER *(Provide source)* N/A	$ 0.00	Self
BLACK LUNG BENEFITS	$ 0.00	Self	OTHER *(Provide source)* N/A	$ 0.00	Self

SECTION IX: EXPECTED INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

39. **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 12 month period following the veteran's death. If the claim is filed more than one year after the veteran died, report the expected total household income for the 12 month period from the date you sign this application. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report ***your expected income*** and the ***child's expected income***, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$ 0.00	Self	OTHER INCOME EXPECTED *(Provide source)* N/A	$ 0.00	Self
GROSS WAGES AND SALARY	$ 0.00	Self	OTHER INCOME EXPECTED *(Provide source)* N/A	$ 0.00	Self
TOTAL DIVIDENDS AND INTEREST	$ 0.00	Self	OTHER INCOME EXPECTED *(Provide source)* N/A	$ 0.00	Self

SECTION X: MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension or parents DIC)*

40. MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any continuing family medical expenses such as the monthly Medicare deduction or nursing home costs you pay. 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 veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim.

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yyyy)	PURPOSE (Medicare deduction, nursing home costs, burial expenses, etc.)	PAID TO (Name of nursing home, hospital, funeral home, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
$ 3500.00	03/16/2017	Funeral Expenses	Schmitts Funeral	Spouse
$				
$				
$				
$				

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 41, 42, and 43 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.

41. 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.: _____

42. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	43. 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 except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.*

I certify I have enclosed all 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 44, 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.

44. 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 box below **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.

45A. CLAIMANT'S SIGNATURE **(REQUIRED)**	45B. DATE SIGNED
Ruby Sue R. Caprio	03/27/2017

SECTION XIII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")*

46A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	46B. PRINTED NAME AND ADDRESS OF WITNESS
47A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	**47B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or 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.

SSA Inquiry
Profile (S01)

Input Section

SSN	TRA-08-4095	CAN		BIC		Vet Reference No	TRA-08-4095	Reference	
Name	CAPRIO JR., JOHNNY A.							DOB	06/20/1981

Ver SSN	TRA-08-4095	Ver Code		Title II Status		Title XVI Status	
Title II CAN		BIC		BIC Applies To			
First Name	Johnny	MI	A.	Last Name	Johnny	Sex Code	M

Name and Address

Johnny A. Caprio Jr.
22580 Free Street
Hartford, CT 06074 (US)

Proof of Age		Person's Own Ver SSN	
Date of Birth	06/20/1981		
Date of Death	03/10/2017	SSN Correction Indicator	
Date of Death Source Code			
Direct Deposit			

Marital Status	Married
Phone Number	(860) 555-0191

Verify SSN's	Other SSN's

For Training Purposes Only

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO 333444555 STATE FILE NO. 666777888

NAME OF DECEDENT
For use by physician or institution
To Be Completed/ Verified By: FUNERAL DIRECTOR:

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last): Johnny A. Caprio Jr.
2. SEX: M
3. SOCIAL SECURITY NUMBER: TRA-08-4095
4a. AGE-Last Birthday (Years)
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF BIRTH (Mo/Day/Yr): 06/20/1981
6. BIRTHPLACE (City and State or Foreign Country): Hartford, CT
7a. RESIDENCE-STATE: Connecticut
7b. COUNTY: Jackson
7c. CITY OR TOWN: Hartford
7d. STREET AND NUMBER: 22580 Free Street
7e. APT. NO.:
7f. ZIP CODE: 06074
7g. INSIDE CITY LIMITS? [X] Yes [ ] No
8. EVER IN US ARMED FORCES? [X] Yes [ ] No
9. MARITAL STATUS AT TIME OF DEATH: [X] Married [ ] Married, but separated [ ] Widowed [ ] Divorced [ ] Never Married [ ] Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage): Ruby Sue De La Riva
11. FATHER'S NAME (First, Middle, Last): Saul Caprio
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Vicky Lamata
13a. INFORMANT'S NAME: Caprio, Ruby Sue R.
13b. RELATIONSHIP TO DECEDENT: Spouse
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 22580 Free Street
14. PLACE OF DEATH (Check only one: see instructions)
IF DEATH OCCURRED IN A HOSPITAL: [ ] Inpatient [ ] Emergency Room/Outpatient [X] Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: [ ] Hospice facility [ ] Nursing home/Long term care facility [X] Decedent's home [ ] Other (Specify):
15. FACILITY NAME (If not institution, give street & number): Hartford General Hospital
16. CITY OR TOWN , STATE, AND ZIP CODE: Hartford, CT 06074 (US)
17. COUNTY OF DEATH: Jackson
18. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): Smith Funeral Home
20. LOCATION-CITY, TOWN, AND STATE: Hartford, CT 06074 (US)
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: Smith Funeral Home, 123 40th St,Hartford, CT 06074 (US)
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: Kenneth Durst
23. LICENSE NUMBER (Of Licensee): 1234

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr): 03/10/2017
25. TIME PRONOUNCED DEAD: 2:15pm
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable): Dr. Stone
27. LICENSE NUMBER: 56789
28. DATE SIGNED (Mo/Day/Yr): 03/10/2017
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month): 03/10/2017
30. ACTUAL OR PRESUMED TIME OF DEATH: 2:15pm
31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? [ ] Yes [X] No

CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events --diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition --------> resulting in death)	a. CARDIAC ARREST	Immediate
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? [ ] Yes [X] No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? [ ] Yes [X] No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? [ ] Yes [ ] Probably [X] No [ ] Unknown
36. IF FEMALE: [ ] Not pregnant within past year [ ] Pregnant at time of death [ ] Not pregnant, but pregnant within 42 days of death [ ] Not pregnant, but pregnant 43 days to 1 year before death [ ] Unknown if pregnant within the past year
37. MANNER OF DEATH: [X] Natural [ ] Homicide [ ] Accident [ ] Pending Investigation [ ] Suicide [ ] Could not be determined
38. DATE OF INJURY (Mo/Day/Yr) (Spell Month): 03/10/2017
39. TIME OF INJURY: 2:00pm
40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area): HOME
41. INJURY AT WORK? [ ] Yes [X] No
42. LOCATION OF INJURY: State: Connecticut City or Town: Hartford Street & Number: 22580 Free Street Apartment No.: Zip Code: /*postalcode*/
43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: [ ] Driver/Operator [ ] Passenger [ ] Pedestrian [ ] Other (Specify)
45. CERTIFIER (Check only one):
[X] Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
[ ] Pronouncing & Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
[ ] Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
Signature of certifier: Dr. Stone
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): Hartford, CT 06074 (US)
47. TITLE OF CERTIFIER: MD
48. LICENSE NUMBER: 123456
49. DATE CERTIFIED (Mo/Day/Yr): 03/10/2017
50. **FOR REGISTRAR ONLY**- DATE FILED (Mo/Day/Yr): 03/10/2017

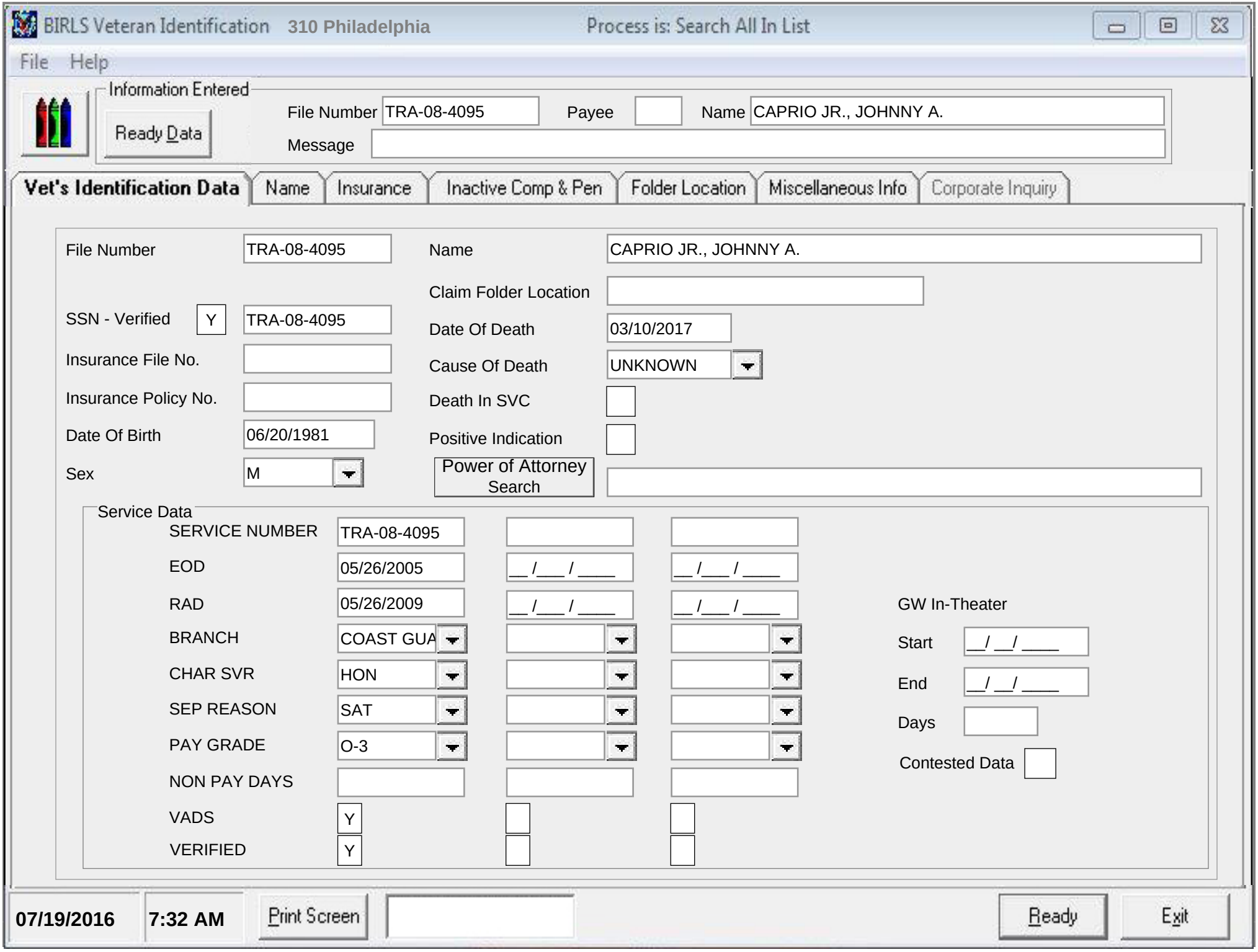
To Be Completed By: FUNERAL DIRECTOR

51. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.
[ ] 8th grade or less
[ ] 9th - 12th grade; no diploma
[ ] High school graduate or GED completed
[ ] Some college credit, but no degree
[ ] Associate degree (e.g., AA, AS)
[ ] Bachelor's degree (e.g., BA, AB, BS)
[X] Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
[ ] Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
[X] No, not Spanish/Hispanic/Latino
[ ] Yes, Mexican, Mexican American, Chicano
[ ] Yes, Puerto Rican
[ ] Yes, Cuban
[ ] Yes, other Spanish/Hispanic/Latino (Specify)

53. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
[X] White
[ ] Black or African American
[ ] American Indian or Alaska Native (Name of the enrolled or principal tribe)
[ ] Asian Indian
[ ] Chinese
[ ] Filipino
[ ] Japanese
[ ] Korean
[ ] Vietnamese
[ ] Other Asian (Specify)
[ ] Native Hawaiian
[ ] Guamanian or Chamorro
[ ] Samoan
[ ] Other Pacific Islander (Specify)
[ ] Other (Specify)

54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED): Storekeeper
55. KIND OF BUSINESS/INDUSTRY: Storekeeper


BIRLS Veteran Identification 310 Philadelphia
Process is: Search All In List
File Help
Information Entered
Ready Data
File Number TRA-08-4095
Payee
Name CAPRIO JR., JOHNNY A.
Message
Vet's Identification Data
Name
Insurance
Inactive Comp & Pen
Folder Location
Miscellaneous Info
Corporate Inquiry
File Number TRA-08-4095
Name CAPRIO JR., JOHNNY A.
Claim Folder Location
SSN - Verified Y TRA-08-4095
Date Of Death 03/10/2017
Insurance File No.
Cause Of Death UNKNOWN
Insurance Policy No.
Death In SVC
Date Of Birth 06/20/1981
Positive Indication
Sex M
Power of Attorney Search
Service Data
SERVICE NUMBER TRA-08-4095
EOD 05/26/2005
RAD 05/26/2009
BRANCH COAST GUA
CHAR SVR HON
SEP REASON SAT
PAY GRADE O-3
NON PAY DAYS
VADS Y
VERIFIED Y
GW In-Theater
Start __/__/____
End __/__/____
Days
Contested Data
07/19/2016
7:32 AM
Print Screen
Ready
Exit