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<b>C-File or S</b>	
<b>Street Add</b>	
<b>City, State</b>	

<b>Date:</b> 6/05/2025	<b>ATTN:</b> CEST EP 020
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**Type of Document Submitted:**

<input type="checkbox"/> VAF 20-0995 Suppl. Claim or VAF 20-0996 Higher Level of Review
<input type="checkbox"/> VAF 21-8940/VAF 21-4192 FOR TDIU
<input type="checkbox"/> 38 USC §5103 Notice Acknowledgement
<input checked="" type="checkbox"/> VAF 21-526EZ CLAIM FOR COMPENSATION
<input type="checkbox"/> VAF 21-4138 Statement in Support of Claim
<input type="checkbox"/> Privacy Act / Freedom of Information Act (VAF 3288)
<input type="checkbox"/> Other

Number of Pages Submitted (NOT including this cover sheet): Five (5) Pages

**VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.**



## APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

**IMPORTANT:** Please read the Privacy Act and Respondent Burden on Page 14 before completing the form. Use this form to determine your eligibility for compensation. For more information, you can contact us online through Ask VA: <https://ask.va.gov>. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). If you prefer you may complete and submit the form online at [www.va.gov](http://www.va.gov). VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms).

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. **NOTE:** Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.

FDC PROGRAM  STANDARD CLAIM PROCESS  
 IDES (Select this option **only** if you have been referred to the IDES Program by your Military Service Department)  
 BDD Program Claim (Select this option **only** if you meet the criteria for the BDD Program specified on Instruction Page 5)

### SECTION I: VETERAN'S IDENTIFICATION INFORMATION

(If claim is not an original claim, only Section I, IV (if applicable), V and a signature are required)

**NOTE:** You may either complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill in each applicable check box to help expedite processing of the form.

2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)

11. EMAIL ADDRESS (Optional)  I agree to receive electronic correspondence from VA in regards to my claim.

g o r d o n . g r a h a m @ v a . g o v

12. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX (Includes Work Study/Internship) (If you are not a VA employee skip to Section II, if applicable).

### SECTION II: CHANGE OF ADDRESS

**NOTE:** If you are temporarily or permanently changing your address, complete Items 13A through 13C.

13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)

TEMPORARY  PERMANENT

13B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. &  
Street

Apt/Unit Number City

State/Province Country ZIP Code/Postal Code —

13C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is **temporary**, complete both the beginning and ending date of your temporary address)  
(If your change of address is **permanent**, please enter your effective date in the beginning date only)

Month Day Year

Month Day Year

BEGINNING DATE:

— — —

ENDING DATE:

— — —

## SECTION III: HOMELESS INFORMATION

**IMPORTANT:** The following questions (Items 14A through 14F) should only be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

## 14A. ARE YOU CURRENTLY HOMELESS?

YES (If "Yes," complete Item 14B regarding your living situation)  
 NO

## 14B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

LIVING IN A HOMELESS SHELTER  
 NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)  
 STAYING WITH ANOTHER PERSON  
 FLEEING CURRENT RESIDENCE  
 OTHER (Specify) \_\_\_\_\_

## 14C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

YES (If "Yes," complete Item 14D regarding your living situation)  
 NO

## 14D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

HOUSING WILL BE LOST IN 30 DAYS  
 LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)  
 OTHER (Specify) \_\_\_\_\_

## 14E. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

## 14F. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number  
 (If applicable)

## SECTION IV: EXPOSURE INFORMATION

15A. ARE YOU CLAIMING ANY CONDITIONS RELATED TO TOXIC EXPOSURES? **NOTE:** See Page 4 of the Instructions for further information on the evidence needed to support your claim for presumptive service connection. (You can also refer to the following websites for more information: PACT ACT (<https://www.va.gov/PACT>) and PUBLIC HEALTH MILITARY EXPOSURES (<https://www.publichealth.va.gov/exposures/index.asp>))

YES (If "Yes," complete Items 15B, 15C, 15D and 15E)  NO (If "No," skip to Item 16, Section V: Claim Information)

## 15B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?

Iraq; Kuwait; Saudi Arabia; the neutral zone between Iraq and Saudi Arabia; Bahrain; Qatar; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan; Israel; Egypt; Turkey; Syria; Jordan; Djibouti; Uzbekistan; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; and the Red Sea.

YES  NO

FROM: \_\_\_\_\_ TO: \_\_\_\_\_

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)

Note: Please provide an approximate time frame (month and year).

## 15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCATIONS?

Republic of Vietnam to include the 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimoit or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a C-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves).

Please list other location(s) where you served, if not listed above:

YES  NO

FROM: \_\_\_\_\_ TO: \_\_\_\_\_

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)

Note: Please provide an approximate time frame (month and year).

## 15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply)

ASBESTOS  MUSTARD GAS  RADIATION  
 SHAD (Shipboard Hazard and Defense)  MILITARY OCCUPATIONAL SPECIALTY (MOS)-related toxin  CONTAMINATED WATER AT CAMP LEJEUNE  
 OTHER (Specify) \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_

WHEN WERE YOU EXPOSED? (MM-YYYY)

Note: Please provide an approximate time-frame (month and year).

? - , 1 9 9 1 -

## 15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATES AND LOCATIONS OF POTENTIAL EXPOSURE

SECTION V: CLAIM INFORMATION  
 (For additional space, use Section XIII: Claim Information (Addendum))

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability: confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)

NOTE: List your claimed conditions below. See the following three examples for guidance on how to complete Section V.

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATES TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

**SECTION V: CLAIM INFORMATION (Continued)**  
**(For additional space, use Section XIII: Claim Information (Addendum))**

CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENERED
1. Entitlement to aid and attendance under §3.350(b)(3) due solely to	100% SC condition	§3.350(b)(3) administrative	2023
2. §4.130DC9413-8045 Anxiety Disorder with TBI			
3. Entitlement to aid and attendance under §3.350(b)(3) due solely to	SC Condition	§3.350(b)(3) administrative	2024
4. §4.97 DC 6602 Asthma to include COPD			
5. Entitlement to aid and attendance under §3.350(b)(3) due solely to	100% combined SC	§3.350(b)(3) administrative	2020
6. §4.71a DC 5009 Psoriatic Arthritis with residuals			
7. ***M-21 VIII.iv.4.A.1.i states that a 2680 isn't required***			
8. Although VA Form 21-2680 may be accepted as a prescribed form adequate to claim			
9. entitlement to SMC, this form is not required to develop a claim for, or grant, entitlement to			
10. SMC. Additional development for VA Form 21-2680 should not be routinely undertaken when the form is not received with a claim." M-21 VIII.iv.4.A.1.i			
11.			
12.			
13.			
14.			
15.			

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.

**NOTE:** If treatment began from 2005 to present, you **do not** need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
Wilmington DE VAMC	—	<input checked="" type="checkbox"/> Don't have date
	—	<input checked="" type="checkbox"/> Don't have date
	—	<input checked="" type="checkbox"/> Don't have date

**NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW. (VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms))**

For:	Required Form(s):
Supplemental Claims	VA Form 20-0995
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Mental Health Condition(s)	VA Form 21-0781 (recommended, not required)
Specially Adapted Housing or Special Home Adaptation	VA Form 28-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

## SECTION VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?			18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:		
<input type="checkbox"/> YES (If "Yes," complete Item 18B) <input checked="" type="checkbox"/> NO (If "No," skip to Item 19A)					
19A. BRANCH OF SERVICE			19B. COMPONENT		
<input checked="" type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS			<input checked="" type="checkbox"/> ACTIVE <input type="checkbox"/> RESERVES <input type="checkbox"/> NATIONAL GUARD		
20A. MOST RECENT ACTIVE SERVICE DATES			20B. PLACE OF LAST OR ANTICIPATED SEPARATION		
ENTRY DATE: Month Day Year 1 0 - 2 7 - 1 9 8 0			F t D i x N J 0 8 6 4 0		
EXIT DATE: Month Day Year 0 8 - 3 1 - 1 9 9 6					
20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?			20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable)		
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			Month Day Year FROM: — — — TO: — — —		
21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?			21B. COMPONENT 21C. OBLIGATION TERM OF SERVICE		
<input checked="" type="checkbox"/> YES (If "Yes," complete Items 21B through 21F) <input type="checkbox"/> NO (If "No," skip to Item 22A)			Month Day Year FROM: — — — TO: — — —		
21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:			21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)		21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
					<input type="checkbox"/> YES <input type="checkbox"/> NO
22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?		22B. DATE OF ACTIVATION:		22C. ANTICIPATED SEPARATION DATE:	
<input type="checkbox"/> YES (If "Yes," complete Items 22B & 22C) <input checked="" type="checkbox"/> NO		Month Day Year — — —		Month Day Year — — —	
23A. HAVE YOU EVER BEEN A PRISONER OF WAR?		23B. DATES OF CONFINEMENT			
		FROM: Month Day Year — — —		TO: Month Day Year — — —	
		Month Day Year — — —		Month Day Year — — —	
SECTION VII: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)					
24A. ARE YOU RECEIVING MILITARY RETIRED PAY?		24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?			
<input type="checkbox"/> YES (If "Yes," complete Items 24C and 24D) <input type="checkbox"/> NO		<input checked="" type="checkbox"/> YES (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)) SEE EP 298 CRSC/CRDP Processing 10/25/2024 <input type="checkbox"/> NO			
24C. BRANCH OF SERVICE			24D. MONTHLY AMOUNT		25. RETIRED STATUS
<input checked="" type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS			\$ , .00		<input checked="" type="checkbox"/> RETIRED <input type="checkbox"/> PERMANENT DISABILITY <input type="checkbox"/> TEMPORARY DISABILITY <input type="checkbox"/> RETIRED LIST

## IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):

Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time *may* result in an overpayment, which *may* be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in Item 26.

Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.

**IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.**

26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.

VETERAN'S SOCIAL SECURITY NO. [REDACTED]

**IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:**

VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which may be subject to collection.

**27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?**

YES (If "Yes," complete Items 27B through 27D)  
 NO

27B. DATE PAYMENT RECEIVED (MM-DD-YYYY)	27C. BRANCH OF SERVICE	27D. AMOUNT RECEIVED (Provide pre-tax amount)
1 - [REDACTED] - [REDACTED]	<input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS	\$ [REDACTED].00

**IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:**

You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in Item 28, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which may be subject to collection.

**IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.**

28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.

**SECTION VII: DIRECT DEPOSIT INFORMATION**

(Note: If you have already signed up for direct deposit, skip to Section IX)

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, and attach either a voided personal check or a deposit slip. If you do not have a bank account, please visit <https://www.benefits.va.gov/benefits/banking.asp>. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT (If you check this box skip to Section IX)

**30. ACCOUNT NUMBER (Check only one box below and provide the account number)**

Account No.: [REDACTED]  CHECKING  SAVINGS

**31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit)**

Established

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

[REDACTED]

**SECTION IX: CLAIM CERTIFICATION AND SIGNATURE****VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE**

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. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not discloseable.

I certify I have received the notice attached to this application titled, *Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation 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 1, on page 9, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

**33B. DATE SIGNED (MM-DD-YYYY)**

[REDACTED]

**X: WITNESSES TO SIGNATURE****34A. SIGNATURE OF WITNESS (Note: Only sign if veteran signed in Item 33A using an "X")****34B. PRINTED NAME AND ADDRESS OF WITNESS****35A. SIGNATURE OF WITNESS (Note: Only sign if veteran signed in Item 33A using an "X")****35B. PRINTED NAME AND ADDRESS OF WITNESS**