Department of Veterans Affairs

INFORMATION AND INSTRUCTIONS TO HELP YOU COMPLETE THE AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

GENERAL INFORMATION

At VA, we recognize and respect the importance of privacy. Personal information that we collect is kept confidential to the extent provided by law. In accordance with the Privacy Act and applicable confidentiality statutes, VA will only disclose the information in its custody or control in the following circumstances: where the individual identifies the particular information and consents to its use; where disclosure of the information is required by law; or where the disclosure is otherwise legally permitted, including release for a purpose compatible with the purpose for which it was collected.

By law, VA must have your written permission (an "authorization") to use or give out your claim or benefit information for any purpose that is not permitted by all applicable legal authorities. You may revoke your written permission at any time, except if VA has already acted based on your permission.

SPECIFIC INSTRUCTIONS

Questions 1 - 5
In this section, give us the veteran's identification information to include name, social security number, VA file number, date of birth and the veteran's service number, if applicable.

Questions 6 - 9
In this section provide the beneficiary/claimant's identification information.

Questions 10 - 13 ONE FAMILY MEMBER OR FRIEND
This section tells VA the duration of your consent. If you do not want your authorization to be effective indefinitely, tell us when to stop releasing your personal benefit or claim information to your authorized third party in Item 12. Check the box that applies and fill in dates, if applicable.

In Item 13 VA will give your personal benefit or claim information to the person or organization you fill in here. You may select only ***one person*** or ***one organization***. If you designate an organization, you must also identify one or more individuals in that organization to whom VA may disclose your benefit or claim information. This form ***cannot*** be used to disclose federal tax information to third parties.

Important: The information provided in Item 6, "Name of Beneficiary/Claimant Who Is Not the Veteran" cannot be the same information provided in Item 13.

Question 14
Select the security question you would like us to ask your designated third party and provide the answer. This question will be asked each time your designated third party contacts our office.

Where Do I Send My Completed Form?
You can obtain the VA mailing address to send your completed, signed authorization by accessing our Internet website at http://www.va.gov/directory or in the government pages of your telephone book under "United States Government, Veterans."

You should make a copy of your signed authorization for your records before mailing it to VA. You can only have one active VA Form 21-0845 on file with VA at a time.

WHAT IF I CHANGE MY MIND?
If you change your mind and do not want VA to give out your personal benefit or claim information, you may notify us in writing, or by telephone at 1-800-827-1000 or electronically via the Internet at https://iris.va.gov. Upon notification from you VA will no longer give out benefit or claim information (except for the information VA has already given out based on your permission).

OMB Approved No. 2900-0736
Respondent Burden: 5 minutes
Expiration Date: 09/30/2019

Department of Veterans Affairs

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs permission to release your personal beneficiary or claim information to a third party. This form may not be executed by any beneficiary recognized as incompetent for VA purposes, nor can VA accept this form from any beneficiary recognized as incompetent for VA purposes.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly, and legibly to help process the form.

1. NAME OF VETERAN *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS NOT THE VETERAN *(First, Middle Initial, Last)*

7. ADDRESS OF BENEFICIARY/CLAIMANT *(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

8. PREFERRED PHONE NUMBER *(Include Area Code)*

9. PREFERRED EMAIL ADDRESS *(Optional)*

SECTION III - CONTACT INFORMATION

10. I (beneficiary/claimant) authorize the Department of Veterans Affairs (VA) to contact the person or organization listed below for the purposes of providing the following information pertaining to my VA record. *(Check only one box below to tell VA the specific benefit or claim information you want disclosed)*

☐ Any Information *(Go to Item 12)*
☐ Limited Information *(Go to Item 11)*

11. IF YOU SELECTED "LIMITED INFORMATION", CHECK ALL THAT APPLY

☐ Status of pending claim or appeal
☐ Current benefit and rate
☐ Payment history
☐ Amount of money owed VA
☐ Request a benefit payment letter
☐ Change of address or direct deposit
☐ Other _____

12. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

☐ One time only
☐ From the date of signing below until _____
(Specify date - month, day, year)
☐ Ongoing until written notice is given to VA to terminate

13. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION AS SPECIFIED ABOVE TO THE PERSON OR ORGANIZATION LISTED BELOW.
NOTE: IF AUTHORIZATION IS FOR AN ORGANIZATION, PLEASE PROVIDE THE FIRST AND LAST NAME OF THE ORGANIZATION'S REPRESENTATIVE.

A. NAME OF PERSON OR ORGANIZATION	B. ADDRESS OF PERSON OR ORGANIZATION

VETERAN'S SSN ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III - CONTACT INFORMATION *(Continued)*

14. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ***ONE*** SECURITY QUESTION BOX IN 14A AND PROVIDE THE ANSWER IN 14B.

A. SECURITY QUESTION	B. ANSWER
☐ The city and state your mother was born in	
☐ The name of the high school you attended	
☐ Your first pet's name	
☐ Your favorite teacher's name	
☐ Your father's middle name	

SECTION IV - DECLARATION OF INTENT

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

15A. SIGNATURE *(Do NOT print)*	15B. DATE SIGNED

PRIVACY ACT INFORMATION: 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. 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.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. 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.

Veterans Angels Inc.

"Our tribute to those who have gone before, and our service to those who carry on"

501(c)(3)
Tax-Exempt
Public Charity in Nevada

EIN Number
27-0204290

Dear Claimant;

If you would like Linda R. Stone, an Accredited Claims Agent with the Department of Veterans Affairs, to be your advocate during the processing period, please do the following:

1. **Mail all the completed VA claim forms for review to Veterans Angels, Inc.**
2. **Complete the Disclosure Page** (Contact person may sign.)
3. **Complete the VA Form 21-22a** (Claimant's signature is needed on Page 1 and 2)
4. **Complete the Contact Information Page**
5. **Complete the Confidential Information Page** (Contact person may sign)
6. **MAKE COPIES OF EVERY PAGE SENT TO VETERANS ANGELS, INC. AND KEEP IN YOUR FILE.**

Mail the following: **All VA forms and Support Documents - (use Supporting Documents Checklist)**
Disclosure Page
21-22a
Confidential Information Page
Contact Information Page

Mail to: **Veterans Angels, Inc.**
10170 W. Tropicana Ave
 # 156-440
Las Vegas, NV 89147

Upon receiving the completed claim, I will contact you to review. We will submit the completed claim to the Department of Veterans Affairs.

I will receive copies of VA correspondence sent to you, but please stay in contact with me during processing.

I look forward to being of assistance.

Respectfully,

Linda R. Stone
Accredited Claims Agent with the Department of Veterans Affairs

Veterans Angels Inc.

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DISCLOSURE PAGE

I_____, on _____(date) state that I have requested information from Veterans Angels, Inc., regarding the Non-Service connected pension benefit or the Surviving Spouse Death pension (the "benefit") through the Department of Veterans Affairs (DVA). By signing below, I indicate that I wish to proceed with the application process.

I also acknowledge that the individual assisting me is not an employee of the DVA and I have not paid this individual for any services provided.

I give permission to the staff associated with Linda Stone, Accredited Claims Agent with the DVA, to assist in the application process.

I, further acknowledge that I am aware that application for "the benefit" may have an impact on any future application for Medicaid.

I also acknowledge, that the individual(s) assisting me, nor any affiliations, can guarantee "the benefit" will be awarded.

I am aware there are income and asset qualifications and there may be tax consequences. I understand that I may consult with my personal attorney, accountant, or other professionals.

By signing below, I agree to hold harmless and release from all liability the individual(s) assisting me, as well as, any of their affiliations.

I agree to remain in contact with Veterans Angels, Inc., during this process, regarding any correspondence, phone calls, or requests for additional information from the Department of Veterans Affairs.

_____ _____
Claimant's Name Date

_____ _____
Contact Person's Name Date

MAIL ONLY
10170 W. TROPICANA AVE., # 156-440 • LAS VEGAS, NV 89147-8465 • TOLL FREE **888-319-1117** • FAX 702-450-2259
EMAIL: SUPPORT@VETANGELS.ORG • WWW.VETANGELS.ORG

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

Department of Veterans Affairs

1. VA FILE NO(S) *(Include prefix)*

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have a service organization assist you with your claim, you may use VA Form 21-22, "Appointment of Veterans Service Organization As Claimant's Representative."

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, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. 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 individuals appointed by claimants to act on their behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902, 5903, and 5904) and for those individuals to accept appointment. We will also use the information to verify consent for disclosure of VA records to the appointed representative (38 U.S.C. 5701(b) and 7332) Title 38, United States Code, allows us to ask for this information. We estimate that claimants and individuals appointed for purposes of representation will each 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. A Valid OMB control number 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.

2. NAME OF CLAIMANT *(Veteran, guardian, beneficiary, dependent, or next of kin)*	3. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*
4. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	5. SERVICE NUMBERS

6. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify* _____)

7A. NAME OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE

Linda Ruth Stone

7B. INDIVIDUAL IS *(check appropriate box)*

☐ ATTORNEY ☒ AGENT ☐ INDIVIDUAL PROVIDING REPRESENTATION UNDER SECTION 14.630
*(*See required statement below. Signatures are required in Items 7C and 7D)*

☐ SERVICE ORGANIZATION REPRESENTATIVE (*Specify organization below*)

_____

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

(Skip to Item 8, if the box for "Individual Providing Representation Under Section 14.630" was not checked in Item 7B)

The appointment of the individual named in Item 7A (the representative) authorizes the individual to represent the claimant named in Item 2 for a particular claim pursuant to the provisions of 38 CFR 14.630. By our signatures below, we, the representative and the claimant, attest that no compensation will be charged or paid for the individual named in Item 7A.

7C. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 7A

7D. SIGNATURE OF CLAIMANT NAMED IN ITEM 2

8. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE *(No. and street or rural route, city or P.O., State, and ZIP code)*

10170 W. Tropicana Ave. # 156-440, Las Vegas, NV 89147

9. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 7A 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 individual named in Item 7A 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 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

10. LIMITATION OF CONSENT. My consent in Item 9 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

No Limitations

11. AUTHORIZATION FOR REPRESENTATIVE TO ACT ON CLAIMANT'S BEHALF TO CHANGE CLAIMANT'S ADDRESS

Unless I check the box below, I do not authorize the individual named in Item 7A to act on my behalf to change my address in my VA records.

☐ I authorize the individual named in Item 7A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual with out 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

CONDITIONS OF APPOINTMENT

I, the claimant named in Item 2, hereby appoint the individual named in Item 7A as my representative to prepare,present, and prosecute my claims for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 4. If the individual named in Item 7A is an accredited agent or attorney, the scope of representation provided before VA may be limited by the agent or attorney as indicated below in Item 15. If the individual indicated in Item 7A is providing representation under 14.630, such representation is limited to a particular claim only. I authorize VA to release any and all of my records (other than as provided in Items 9 and 10) to that individual appointed as my representative, and if the individual in Item 7A is an accredited agent or attorney, this authorization includes the following individually named administrative employees of my representative:

Signed and accepted subject to the foregoing conditions.

12. SIGNATURE OF CLAIMANT	13. DATE OF SIGNATURE	14. CLAIMANT'S RELATIONSHIP TO VETERAN *(If other than the veteran)*

15. LIMITATIONS ON REPRESENTATION - AGENTS OR ATTORNEYS ONLY *(Unless limited by an agent or attorney, this power of attorney revokes all previously existing powers of attorney)*

16. SIGNATURE OF REPRESENTATIVE	17. DATE OF SIGNATURE

FEES: Section 5904, Title 38, United States Code, contains provisions regarding fees that may be charged, allowed, or paid for services of agents or attorneys in connection with a proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Department.

Confidential Information

The following information needs to be completed as accurately as possible. All information is held confidential by Veterans Angels, Inc.

Countable Monthly Income

	Claimant
Social Security (Gross before deductions)	
Pensions (Civil Service, Railroad Retirement)	
Pensions (Military)	
Pensions (Corporate)	
Long Term Care Insurance	
401 K's, 457	
403 B's, IRA (withdrawals)	
SSI/Public Assistance	
Other Income	
Other Income	

Countable Assets

All Checking Accounts	
All Savings Accounts	
CD's, Money Market	
Real Estate (other than Residence)	
IRA's, 401 K's, etc…	
Annuities(non-qualified)	
Stock, Bonds, Mutual Funds	
Life Insurance Cash Value	

Countable Monthly Expenses for Health or Medical (Paid by You)

Medicare Part B	
Supplemental Health Ins. Premiums	
Long Term Care Premiums	
Medicare (Part D)	
Assisted Living or Group Home Cost	
Home Caregiver Cost	
Incontinence products, Oxygen, Insulin	
Equipment Rental	

I/we declare, under the state laws where I reside, that the foregoing information regarding Income, Assets, and Expenses are accurate to the best of my knowledge.

_____ _____

Signature of Claimant or Responsible Party **Date**

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Public Charity in Nevada

EIN Number
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CONTACT INFORMATION PAGE

Contact Name:_____

Address:_____

_____

_____

Phone Numbers:
(Home)_____(Cell)_____

(Work)_____Email:_____

Relationship to Claimant:_____

Name of Claimant:_____

Claimant's Date of Birth:_____
State where Claimant Resides:_____

****

Claim was mailed to:

_____

Date Claim was Mailed :_____

3-17

MAIL ONLY
10170 W. TROPICANA AVE., # 156-440 • LAS VEGAS, NV 89147-8465 • TOLL FREE **888-319-1117** • FAX 702-450-2259
EMAIL: SUPPORT@VETANGELS.ORG • WWW.VETANGELS.ORG

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Public Charity in Nevada

EIN Number
27-0204290

Your generous, tax-deductible donations enable us to continue our mission of helping thousands of senior Veterans and their families.

We do not charge fees for our services and receive NO government funding.
Our average donation is $100.
Recurring donations of any amount are greatly appreciated.

Donations may be made by check or credit card to:
Veterans Angels, Inc.
10170 W. Tropicana Ave., # 156-440
Las Vegas, NV 89147-8465
OR
Make a donation online at www.vetangels.org

Please select the level of donation you wish to make and Thank You!

_____ US $50.00 **_____ US $150.00**

_____ US $100.00 **_____ US $250.00**

_____ Other Contribution Amount

US $_____ I wish to make a monthly recurring donation to Honor:

Honoree's Name:_____

****

Please complete, if paying by credit card:
Cardholder's Name_____

Credit Card Number_____

Card Type_____Expiration Date_____

Billing Address_____

City_____State_____Zip Code_____

Email Address_____Phone #_____

Donor Information (if different from Credit Card Information)

First Name_____Last Name_____

Address_____

City_____State_____Zip_____

Company (optional)_____

3-17

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