OMB Control No. 2900-0747 Respondent Burden: 25 minutes

	Expiration Date: 09/30/2022
Department of Veterans Affairs	VA DATE STAMP (DO NOT WRITE IN THIS SPACE)
APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS	Received Centralized Mail Processing, Janesville, WI 10/25/2021
IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.	
1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS (Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. (See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)	
FULLY DEVELOPED CLAIM (FDC) PROGRAM     STANDARD CLAIM PROCESS	
IDES (Select this option <i>only</i> if you have been referred to the IDES Program by your Military Service Department)  BDD Program Claim (Select this option <i>only</i> if you meet the criteria for the BDD Program specified on Instruction Page 5)	
SECTION I: IDENTIFICATION AND CLAIM INFORMATION (If claim is not an original claim, only Section I, IV, and a signature	
NOTE: You may either complete the form online or by hand. If completed by hand, print the information reque	ested in ink, neatly, and legibly to expedite
processing of the form.  2. VETERAN/SERVICE MEMBER NAME (First, Middle Initial, Last)	
Homer Cornblatt	
3. VETERAN'S SOCIAL SECURITY NUMBER (SSN) 4. HAVE YOU EVER FILED A CLAIM WITH VA?	5. VA FILE NUMBER
T R A -       2 1 -       9 5 9 2         Image: Company of the properties of the	6 Y 1 5 X X 0 0
6. DATE OF BIRTH (MM-DD-YYYY) 7. VETERAN'S SERVICE NUMBER (If applicable)	8. SEX
0 1 - 1 5 - 1 9 9 6	MALE
9. BDD CLAIMS ONLY: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY (MM-DD-YYYY)  10. TELEPHONE NUMBER (Optional) (In	nclude Area Code)
5 5 5 - 5 5 -	1 2 1 2
Enter International Phone Number (If applie	cable)
11. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country) No. &	
Street 3 1 H o p k i n s P I a z a	
Apt./Unit Number City B a I t i m o r e	
State/Province M D Country U S ZIP Code/Postal Code 2 1 2 0 1	-
12. EMAIL ADDRESS (Optional)   I agree to receive electronic correspondence from VA in regards to my claim.	
H C o r n b l a t t @ e m a i l . c	o m
13. 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 14A through 14C.	
14A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)	
C TEMPORARY C PERMANENT	
14B. 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	-
14C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is <b>temporary</b> , complete both the beginning and (If your change of address is <b>permanent</b> , please enter your effective date in the beginning date only)	ending date of your temporary address)
Month Day Year Month	Day Year
BEGINNING DATE: — — ENDING DATE:	
A FORM OF TOOM	Page 8

For Training Purposes Only VETERANS SOCIAL SECURITY NO. 9 **SECTION III: HOMELESS INFORMATION** IMPORTANT: The following questions (Items 15A through 15F) 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. 15A. ARE YOU CURRENTLY HOMELESS? 15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION: LIVING IN A HOMELESS SHELTER YES (If "Yes," complete Item 15B regarding your living situation) NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent) ONO STAYING WITH ANOTHER PERSON FLEEING CURRENT RESIDENCE OTHER (Specify) 15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION: 15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS? O HOUSING WILL BE LOST IN 30 DAYS (If "Yes," complete Item 15D regarding your living situation) LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)  $\bigcirc$ NO OTHER (Specify) 15E. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you) 15F. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code) **SECTION IV: CLAIM INFORMATION** 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 IV. **EXAMPLES OF HOW THE EXAMPLES OF EXPOSURE EXAMPLES OF DISABILITY(IES) EXAMPLES OF DATES TYPE** DISABILITY(IES) RELATE TO SERVICE Example 1. HEARING LOSS NOISE HEAVY EQUIPMENT OPERATOR IN SERVICE **JULY 1968** Example 2. DIABETES AGENT ORANGE SERVICE IN VIETNAM WAR DECEMBER 1972 INJURED LEFT KNEE WHEN BRACE ON 6/11/2008 Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE RIGHT KNEE FAILED **APPROXIMATE DATE** IF DUE TO EXPOSURE, EVENT, OR **EXPLAIN HOW THE DISABILITY(IES) CURRENT DISABILITY(IES)** INJURY, PLEASE SPECIFY DISABILITY(IES) **RELATES TO THE IN-SERVICE BEGAN OR WORSENED** (e.g., Agent Orange, radiation) **EVENT/EXPOSURE/INJURY PTSD** Combat in Afghanistan nightmares, anxiety 1. 11/16/2020 2. 3. 4. 5. 6. 7. 8. 9. 10 11 12

13

14

15

VETERANS SOCIAL SECURITY NO. 9 5 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: NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B. C. CHECK THE BOX IF B. DATE OF TREATMENT A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY YOU DO NOT HAVE (MM-YYYY) DATE(S) OF TREATMENT Baltimore Vet Center Don't have date 1 0 2 0 2 Don't have date Don't have date 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 <u>www.va.gov/vaforms</u>) Required Form(s): For: VA Form 20-0995, Decision Review Request: Supplemental Claim Supplemental Claims VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674 Dependents Individual Unemployability VA Form 21-8940 and 21-4192 Post-Traumatic Stress Disorder VA Form 21-0781 or 21-0781a VA Form 26-4555 Specially Adapted Housing or Special Home Adaptation VA Form 21-4502 Auto Allowance Veteran/Spouse Aid and Attendance benefits VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779 **SECTION V: SERVICE INFORMATION** 18B. LIST THE OTHER NAME(S) YOU SERVED UNDER: 18A. DID YOU SERVE UNDER ANOTHER NAME? (If "Yes," complete NO (If "No," skip to Item 18B) Item 19A) 19A. BRANCH OF SERVICE 19B. COMPONENT ARMY ○ NAVY MARINE CORPS ACTIVE RESERVES NATIONAL GUARD AIR FORCE COAST GUARD SPACE FORCE 20A. MOST RECENT ACTIVE SERVICE DATES (MM,DD,YYYY) 20B. PLACE OF LAST OR ANTICIPATED ENTRY DATE: F 0 r t Н u а С h С 0 1 4 2 0 1 6 EXIT DATE: 1 7 2 2 0 1 0 0 Day Month Year 20C. DID YOU SERVE IN A COMBAT ZONE From: 20D. ADDITIONAL PERIODS OF SERVICE (Indicate SINCE 9-11-2001? enlistment and discharge date(s), if applicable) YES ○ NO 21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN 21C. OBLIGATION TERM OF SERVICE 21B. COMPONENT THE RESERVES OR NATIONAL GUARD? Month Day Year NATIONAL YES (If "Yes," complete Items 21B thru 21F) From: **GUARD** NO (If "No," skip to Item 22A) RESERVES To: 21E. CURRENT OR ASSIGNED PHONE 21F. ARE YOU CURRENTLY 21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT: RECEIVING INACTIVE DUTY NUMBER OF UNIT (Include Area TRAINING PAY? Code) YES O NO 22A ARE YOU CURRENTLY ACTIVATED ON FEDERAL 22B. DATE OF ACTIVATION: 22C. ANTICIPATED SEPARATION DATE: ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? Month Dav Year Month Day Year O YES (If "Yes," complete Items 22B & 22C) NO 23B. DATES OF CONFINEMENT 23A. HAVE YOU EVER BEEN A PRISONER OF WAR? From: To: YES (If "Yes," complete Item 23B) Day Month Day Year Month Year NO Month Month Day Year Year Day

For Training Purposes Only VETERANS SOCIAL SECURITY NO. R Α 2 9 5 9 SECTION VI: 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? (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending YES (If "Yes," complete Items 24C and 24D) YES MEB/PEB and also complete Items 24C and 24D) NO O NO 24C. BRANCH OF SERVICE 24D. MONTHLY AMOUNT 25. RETIRED STATUS O PERMANENT DISABILITY RETIRED LIST ARMY  $\bigcirc$ MARINE CORPS ○ RETIRED .00 \$ AIR FORCE COAST GUARD TEMPORARY DISABILITY RETIRED LIST NAVY SPACE FORCE 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. C 26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay. 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? (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) ARMY ○ NAVY MARINE CORPS \$ 00 ○ AIR FORCE ○ COAST GUARD ○ SPACE FORCE 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

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

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, <u>and</u> attach either a voided personal check <u>or</u> a deposit slip. If you **do not** have a bank account, please visit <a href="https://www.benefits.va.gov/benefits/banking.asp">https://www.benefits.va.gov/benefits/banking.asp</a>. 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.

C 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUT	TION OR CERTIFIED PAYMENT AGENT (If you check this box skip to Section VIII)
30. ACCOUNT NUMBER (Check only <b>one</b> box below and provide the account number)	
Account No.:	CHECKING SAVINGS
31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit)	32. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)
A I r e a d y p r o v i d e	

VA FORM 21-526EZ, SEP 2019 Page 11

VETERANS SOCIAL SECURITY NO. 5 2 1

### SECTION VIII: 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 disclosable.

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 inc facility such as a VA medical center; <b>OR</b> , I have no information or evidence to give VA t 8, indicating I want my claim processed under the standard claim process because I plan t	to support my claim; <b>OR</b> , I have checked the box in Item 1, on page													
33A. VETERAN/SERVICE MEMBER SIGNATURE (REQUIRED)	33B. DATE SIGNED (MM-DD-YYYY)													
Homer T Cornblatt	1 0 - 1 4 - 2 0 2 1													
SECTION IX: WITNESSES TO	SIGNATURE													
34A. SIGNATURE OF WITNESS (Sign in ink) (Note: Only sign if veteran signed in Item 33A us an "X")	ing 34B. PRINTED NAME AND ADDRESS OF WITNESS													
354 SIGNATURE OF WITNESS (Sign in ink) (Note: Only sign if voteran signed in Item 334 us	sing 35B. PRINTED NAME AND ADDRESS OF WITNESS													
SIGNATURE OF WITNESS (Sign in ink) (Note: Only sign if veteran signed in Item 33A using an "X")  35B. PRINTED NAME AND ADDRESS OF WITNESS														
SECTION X: ALTERNATE SIGNER CERTIF (NOTE: REQUIRED ONLY IF ITEN														
I certify that by signing on behalf of the claimant, that I am a court-appointed representatic claimant under a durable power of attorney; <b>OR</b> , a person who is responsible for the care relative; <b>OR</b> , a manager or principal officer acting on behalf of an institution which is resunder the age of 18; <b>OR</b> , is mentally incompetent to provide substantially accurate informade on the form are true and complete; <b>OR</b> , is physically unable to sign this form.  I understand that I may be asked to confirm the truthfulness of the answers to the best of may request further documentation or evidence to verify or confirm my authorization to s Examples of evidence which VA may request include: Social Security Number (SSN) or court with competent jurisdiction showing your authority to act for the claimant with a justification appointment of fiduciary; durable power of attorney showing the name and signal health care power of attorney, affidavit or notarized statement from an institution or person responsibility of care provided; or any other documentation showing such authorization.  36A. ALTERNATE SIGNER SIGNATURE ( <b>REQUIRED</b> )	of the claimant, to include but not limited to a spouse or other sponsible for the care of an individual; <b>AND</b> , that the claimant is nation needed to complete the form, or to certify that the statements my knowledge under penalty of perjury. I also understand that VA sign or complete an application on behalf of the claimant if necessary. Taxpayer Identification Number (TIN); a certificate or order from a dge's signature and a date/time stamp; copy of documentation ature of the claimant and your authority as attorney in fact or agent; on responsible for the care of the claimant indicating the capacity or													
SECTION XI: POWER OF ATTORNE' (NOTE: POA'S CANNOT SIGN FOR AN C														
I certify that the claimant has authorized the undersigned representative to file this claim of the information provided in this document. I certify that the claimant has authorized the u and completion of the information contained in this document to the best of claimant's knote. NOTE: A POA's signature will not be accepted unless at the time of submission of this claimant's Representative, or VA Form 21-22a, Appointment of Individual of record with VA.	indersigned representative to state that the claimant certifies the truth owledge.  laim a valid VA Form 21-22, Appointment of Veterans Service													
37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	37B. DATE SIGNED (MM-DD-YYYY)													
PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S. VA may disclose the information that you provide, including Social Security numbers, outside VA if the disc the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation information is considered relevant and necessary to determine maximum benefits under the law. Information other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional owed to the United States. Ititigation in which the United States is a party or has an interest, the administration	S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). closure is authorized under the Privacy Act, including the routine uses identified in an and Employment Records - VA, published in the Federal Register. The requested a submitted is subject to verification through computer matching programs with al communications, epidemiological or research studies, the collection of money													

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 compensation. 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.

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.

OMB Approved No. 2900-0043 Respondent Burden: 30 minutes Expiration Date: 09/30/2021

# 8

### **Department of Veterans Affairs**

# APPLICATION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

**INSTRUCTIONS**: Make sure you sign and date this form in Items 26A and 26B. **Note**: Unless the claimant is the veteran's surviving spouse or a designated "alternate signer", the veteran *must* sign in Item 26A. When you have completed this form, you can mail or fax it to the address or the fax number shown at the bottom of Page 2. If you prefer you may complete and submit the form online at <a href="https://www.va.gov">www.va.gov</a>.

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

Received Centralized Mail Processing, Janesville, WI 10/25/2021

If you prefer yo	u r	nay o	con	nple	te an	ia su	omnt	me i	orn	ı onı	ime	at <u>w s</u>	<u>ww.</u>	va.go	<u>)v</u> .																	
	(	Note	: C	omp	letio																		ay de	elay	pro	ces	sin	g)				
NOTE: You may con	тр	ete the	e for	m on	line o	by ho	and. If	сотр	leted	by ho	and, p	rint th	e info	rmati	on re	queste	ed in	ink, r	eatly	v and	l legi	bly i	o help	э ехр	edite	e proc	cess	ing o	f the	form.		
1. VETERAN'S N	ΑN	IE (Fi	rst, I	Midd	le Ini	tial, L	.ast)																									
H o m	е	r								1	Т	С	0	r	n	b		ı	а	t	t											
2. VETERAN'S S	OC	IAL SI	ECU	JRITY	′ NUN	1BER		•	<u> </u>	3. V	4 FILE	NUN	1BER					-		4.	VET	ER/	N'S I	DATI	E OF	BIR.	TH	'	•		•	
																			_		Mon	th			Day				Ye	ar		
T R A	_	2	1	╗-	- [9	) 5	5 9	2	11	Т	R	Α	2	1	9	5	9	2			0	1	_	1	5	;	-[	1	9	9	6	1
5. CLAIMANT'S N	۱A۱	ME ( <i>If</i>	othe	r tha	n veter	ran) (l	First, M	1iddl	e Inii	tial, L	ast)																					
										] ٦									T					Τ	T	T			Τ		T	
6. CLAIMANT'S	30	CIAL S	SEC	URIT	Y NU	MBEF		•	Ī		TFR	N'S S	SERV	ICF N	IUMB	FR (I	f ant	licabl	e)	8	TELE	РН	ONE	NI IN	IRFE	? (Inc	ludo	Area	Cod	0)		
			_	_		1	_	1	٦		T	T		102	T		, upp	I							IDLI	(Inc.	шие	леи	Cou	ε)		
	_	L			<u>- L</u>				<u>]                                    </u>											(5	55)5	55.	1212	<u> </u>								
9. E-MAIL ADDR	ES	S (Opt	iona	l)																												
_																																
	You prefer you may complete and submit the form online at \( \text{ WWW. Yag. QOV.} \)																															
Street 3 1			Н	0	р	k	i	n	s		Р	1	а	z	а																	
Apt./Unit Number								City		В	а	ı	t	i	m	0	r	е														
State/Province	Ī	м	_		Caur																											
	- 1	141	ן ש		Cour	ntry	U	S		Z	IP Co	de/Po	stal (	Code		2	1	2	0	1	7 -	- [										
	L	141	<u></u>		Cour	ntry			ON I												] - ISE	- [										
11A. SPOUSE'S				t, Mic			SE		ON I												SE	-[										
	NA	ME (I		t, Mic			SE		ON I		IFOF	RMA	TIO	N NE	ED	ED 1	ΓΟ	ADD	SP	OU		- [ 		T				I		T	T	
S u s	NA a	ME (I	First				SE	CTI	11C.	II: IN	E USE'S	C S SOC	TIOI o	r SECU	EDI n RITY	ED 1	FO A	ADD	SP	t	t	- [	TE C	DF M.	ARR	LIAGE						
S u s	NA a	ME (I	First		ldle I	nitial,	SE	СТІ	11C.	SPO	E USE'S	C S SOC not ha	TIOI o	r SECU	EDI n RITY	ED 1	FO A	ADD	SP	t	<b>t</b>			DF M.			]			Yea		
S u s  11B. SPOUSE'S  Month	NA a DA	ME (I	First	RTH	ddle Ii	nitial,	SE Last)	СТІ	11C. your . IX, Ita	SPO spouse em 25	E USE'S e does , Remo	C S SOC not ha	o CIAL Sive an	r SECU SSN,	EDI n RITY	b NUM	TO I	ADD I a	SP N) (I)	t	t 11D	lont	h	] DF М.	Da	ay	]_			_		9
S u s  11B. SPOUSE'S  Month  0 6 —	You prefer you may complete and submit the form online at \( \) \\ \( \) \(\																															
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF  State, or City and O	NA a DA 1	n TE Oloay  7  RRIAG	F BI	RTH	idle Ii	nitial, Year	SE Last)	CTIO	11C. your . IX, Ita  T	SPO SPO spouse em 25	E USE'S e does , Rema	C S SOC not haurks)	o CIAL Sive an	r SECU SSN, o	n RITY explair	b NUM why	IBEF in So	ADD R (SS ection	SP N) (I)	t	t 11D M	lont	h 2	-[	Da	ау <b>9</b>	] -			0		9
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF  State, or City and O	NA a DA 1	n TE Oloay  7  RRIAG	F BI	RTH	idle Ii	nitial, Year	SE Last)	CTIO	11C. your . IX, Ita  T 1F. H	SPO SPO SPOUSS SPOUSS EM 25	USE'S e does , Rema	C S SOC not haurks)  L C S SOC S CER	o CIAL Sive an	r SECU SSN, a	n RITY explai	b NUM why	IBEFF in So	ADD R (SS ection  6	SP  SP  5	t	t 11D M	lont	h 2	-[	Da	ау <b>9</b>	] -			0		9
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF  State, or City and O	SECTION I: VETERANCLAIMANTS IDENTIFICATION INFORMATION (Note: Completion of this section is REQUIRED to process your request; any omission may delay processing of the form.  VETERANS NAME (First, Middle Initial, Last)  T C O r N D I a t t VETERANS NAME (First, Middle Initial, Last)  T R A - 2 I - 9 5 9 2  T R A 2 I 9 5 9 2  T R A 2 I 9 5 9 2  T R A 2 I 9 5 9 2  T R A 2 I 9 5 9 2  Veterand Social Security Number  3. VA FILE NUMBER  7. VETERANS SOCIAL SECURITY NUMBER  6. CLAIMANT'S NAME (If other than veteran (First, Middle Initial, Last)  8. CLAIMANT'S NAME (If other than veteran (First, Middle Initial, Last)  9. E-MAIL ADDRESS (Optional)  HCOrnblatt @email.com  10. COMPLETE MALING ADDRESS OF VETERANCLAIMANT (Number and Street or Rural Route, P. O. Box, City, State, ZIP Code and Country)  10. & 3 1 H O P k I N S P I A Z A D D I D D DOUSE  11A. SPOUSE'S NAME (First, Middle Initial, Last)  SECTION II: INFORMATION NEEDED TO ADD SPOUSE  11A. SPOUSE'S DATE OF BIRTH  Month Day Year  11B. SPOUSE'S DATE OF BIRTH  Month Day Year  11C. SPOUSE'S SOCIAL SECURITY NUMBER (If applicable)  11B. SPOUSE'S NAME (First, Middle Initial, Last)  SECTION II: INFORMATION NEEDED TO ADD SPOUSE  11A. SPOUSE'S NAME (First, Middle Initial, Last)  SECTION II: INFORMATION NEEDED TO ADD SPOUSE  11A. SPOUSE'S DATE OF BIRTH  Month Day Year  11B. SPOUSE'S OAT OF MARRIAGE (Top and State, Country and Iff. How Werer You MARRIED? (Check one)  Sole, or City and Country)  11B. PLACE OF MARRIAGE (Top and State, Country and Iff. How Werer You Married? (Firek, Minister, Priess, Robbil, etc.) or CIVII. CERIMONY (i.e. Justice of the Ponce)  Sole, or City and Country)  12B. SPOUSE'S VA FILE NUMBER (If applicable)  12C. SPOUSE'S SERVICE NUMBER (If applicable)  12C. SPOUSE'S SERVICE NUMBER (If applicable)  12C. SPOUSE'S SERVICE NUMBER (If applicable)																															
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME	SECTION I: VETERANC LAIMANT'S IDENTIFICATION INFORMATION (Note: Completion of this section is REQUIRED to process your request; any omission may delay processing)  OTE: You may complete the firm outline or by hand. If completed by hand, print the information requested in ink, nearly and legibly to help expedite processing of the form.  1. VETERANS NAME (First, Middle Initial, Last)  T																															
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME	A DA Cou	TE OD Ay  7  RRIAG	F BI	RTH  - 1 City o	9 9 SETER	Year 8	SE Last)  3 munty are	CTIO	11C. yyour IX, Ita  T  1F. H	SPO SPOUSSEEM 25, R HOW RELIG	USE'S USE'S USE'S A WER GIOUS MON	C C S S SOCO not ha urks)  E YOU E YOU LAW xplain,	o cial save an	r r SECUUSSSN, 4	n RITYY	b NUM Num why	BEFF in So	ADD  (SS (SS)  (SS)  (SS)  (SS)	SP  SP  5	t	t 11D M	lont VIL	h <b>2</b> CERE	<b>—</b> [	Da <b>1</b>	<b>9</b> i.e. Ju		of th	e Pe	nce)	0	
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME	A DA Cou	TE OD Ay  7  RRIAG	F BI	RTH  - 1 City o	9 9 SETER	Year 8	SE Last)  3 munty are	CTIO	11C. yyour IX, Ita  T  1F. H	SPO SPOUSSEEM 25, R HOW RELIG	USE'S USE'S USE'S A WER GIOUS MON	C C S S SOCO not ha urks)  E YOU E YOU LAW xplain,	o cial save an	r r SECUUSSSN, 4	n RITYY	b NUM Num why	BEFF in So	ADD  (SS (SS)  (SS)  (SS)  (SS)	SP  SP  5	t	t 11D M	lont VIL	h <b>2</b> CERE	<b>—</b> [	Da <b>1</b>	<b>9</b> i.e. Ju		of th	e Pe	nce)	0	
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME  12A. IS YOUR SE  YES (If "Y  NO  NOTE: If you are a	A DA COUNTES, VE	ME (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	F BI	RTH  1 CCity of A V  Items  VA is	9 9 sund Sta	Year  8 8 NAN?	SE Last)  3 3 CC)	CTIO	11C. your : T	SPO SPOUSSE R R HOW OTHER SPO	E USE'S e does , Remo	C C C Not have the control of the co	B B J MAREMO	r r ssss, a ssss ssss ssss ssss ssss ssss ssss ssss	n RITYY COLOR OF THE PROPERTY	b NUM Num why 5 Check Inister,	BBEF in S. 9  9  one one of the bolical of the boli	ADD  R (SS (SS))  6  PROX	SP  SP  SP  SP  SP  SP  SP  SP  SP  SP	t t	t 11D M 12C	VIL	CERE	EE'S	Da  1  SSER	9 VICE	= NU	JMBE	ER (I)	ace)	<b>o</b>	
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME  12A. IS YOUR SE  YES (If "Y  NO  NOTE: If you are a  13A. DO YOU LI	A DA COUNTES, VE	ME (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	F BI	RTH  - 1  City of Items  VA is ER?	9 9 9 ETER 12B a	mitial, Year  8 8 AN? AN?	SE Last)  3 unity ar	CTIO	111C. 11C. 11X, Ita  T 11F. H  12B	SPO SPOUSE RHOW OTHER SPO	E USE'S e does , Remo	C C C Not have the control of the co	B B J MAREMO	r r ssss, a ssss ssss ssss ssss ssss ssss ssss ssss	n RITYY COLOR OF THE PROPERTY	b NUM Num why 5 Check Inister,	BBEF in S. 9  9  one one of the bolical of the boli	ADD  R (SS (SS))  6  PROX	SP  SP  SP  SP  SP  SP  SP  SP  SP  SP	t t	t 11D M 12C	VIL	CERE	EE'S	Da  1  SSER	9 VICE	= NU	JMBE	ER (I)	ace)	<b>o</b>	
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME  12A. IS YOUR SF  YES (If "Y  NO  NOTE: If you are a  13A. DO YOU LI  YES  13C. CURRENT N	(Note: Completion of this section is REQUIRED to process your request; any omission may delay processing)  NOTE: You may complete the form entine or by hand. If completed by hand, print the information requested in ioh, nearly and legibly to help expedite processing of the form.  1. VETERANS NAME (First, Middle Initial, Last)    H																															
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME  12A. IS YOUR SE  YES (If "Y  NO  NOTE: If you are a  13A. DO YOU LI'  YES  13C. CURRENT M	A DA COU	JSE A  TOGE N  N  N  N  N  N  N  N  N  N  N  N  N	GE (	RTH  To City of the City of th	9 9 und Sta	Year  8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	SE  Last)  3  munty and articles I Items I	CTIO	11C.  yyour T  1F. H  12B	SPO SPOUSE RHOW OTHIN SPO	USE'S A A WER GIOUS MON ER (E	E YOU E YOU AND A STANDARD TO THE YOU AND A	O O CIAL :	RRIEE DNY (ii	n RITYY	b NUM n why  5 Check mister,	BBEF in So	ADD  R (SS ection  6  )  PROX  este steet	SP  SP  Sp  Sp  Sp  Sp  Sp  Sp  Sp  Sp	t f	t 11D M 1	WIL iical	CERE	EE'S	Da  1  SSER	9 VICE	= NU	JMBE	ER (I)	ace)	<b>o</b>	
S u s  11B. SPOUSE'S  Month  0 6 —  11E. PLACE OF State, or City and O Baltimore, ME  12A. IS YOUR SF  YES (If "Y  NO  NOTE: If you are a  13A. DO YOU LI  YES  13C. CURRENT No. & 3 1	A DA COU	JSE A  TOGE N  N  N  N  N  N  N  N  N  N  N  N  N	F BI  GE (  LSCO  LSCO  LSCO  ADD  ADD	RTH  - 1  CCity of the service of th	9 9 9 S OF	mitial, Year  8 8 AN? ANP Ang add	SE Last)  3 unity and CC) USE (N	CTIO	11C. 11C. 11C. 11C. 11C. 11C. 11C. 11C.	SPO SPOUSE RHOW OTHIN SPO	E USE'S e does , Remo	E YOU E YOU AND A STANDARD TO THE YOU AND A	8 8 JUMA REMODN FILE	RRIE DNY (ii no loi OR S	n RITYYEXPlai	b NUM n why  5 Check mister,	BBEF in So	ADD  R (SS ection  6  )  PROX  este steet	SP  SP  Sp  Sp  Sp  Sp  Sp  Sp  Sp  Sp	t f	t 11D M 1	WIL iical	CERE	EE'S	Da  1  SSER	9 VICE	= NU	JMBE	ER (I)	ace)	<b>o</b>	

VETERAN'S SOCIAL SECURITY NO.

Т	R	Α	_	2	1	_	9	5	9	2

NOTE: You <i>must</i> prov	ride complete information	on about <i>your prior marria</i>	ges and your curren	t spouse's prior marr	iages.						
	VETE	ERAN/CLAIMANT'S PREVIOU (If no prior marriages, this sec		TION							
14A. DATE A OF MAR		14B. TO WHOM MARRIED (First, Middle Initial,	14C. REASON FOR TERMINATION		PLACE MARRIAGE NATED						
MM/DD/YYYY	CITY & STATE, COUNTY & STATE, or CITY & COUNTRY	Last Name)	(Death, Divorce, Annulment)	MM/DD/YYYY	CITY & STATE COUNTY & STATE, or CITY & COUNTRY						
	CUF	RRENT SPOUSE'S PREVIOUS (If no prior marriages, this sec		ION							
15A. DATE A OF MAR		15B. TO WHOM MARRIED	15C. REASON FOR TERMINATION		PLACE MARRIAGE INATED						
MM/DD/YYYY	CITY & STATE COUNTY & STATE, or CITY & COUNTRY	(First, Middle Initial, Last Name)	(Death, Divorce, Annulment)	MM/DD/YYYY	CITY & STATE COUNTY & STATE, or CITY & COUNTRY						
(If		ON III: INFORMATION NEE our children, fill out adder			on)						
16A. NAME OF <b>FIRST</b> CH	ILD TO ADD (First, Middle In	nitial, Last)	-								
B a r t		S C o r	n b I a t	t							
16B. SOCIAL SECURITY I	NUMBER	16C. DATE OF BIRTH		16D. PLACE OF BIRTH (P and State, or City and C							
l		MonthDay	Year	Baltimore, MD	•						
T R A — 9	4 - 9 7 9 8		<b>-</b> 2 0 1 0								
16E. IF THE CHILD DOES	S NOT LIVE WITH THE CLAIN	MANT, PROVIDE NAME OF PERS	ON THE CHILD RESIDES	WITH							
16F. IF THE CHILD DOES	NOT LIVE WITH THE CLAIM	IANT, PROVIDE COMPLETE PHY	SICAL ADDRESS WHERE	CHILD RESIDES							
		,									
16G. CHILD STATUS (Che	ck all that apply)										
⊠ BIOLOGICAL		SCHOOL (If checked, fill out VA For	, <u> </u>		OF SELF-SUPPORT						
CHILD PREVIOUSLY  16H. HOW AND WHEN M.		the date marriage ended and how the	marriage ended in Item 16H)	STEPCHILD (If chec	ked, complete Item 16I)						
DATE	(MM/DD/YYYY)	ANNULLED DECLA	RED VOID OTHER	(Explain)							
		STEPCHILD THE BIOLOGICAL C		• •							
YES (If "Yes," provide	the date the child entered vetera										
☐ NO											

VETERAN'S SOCIAL SECURITY NO. TRADE TO THE REPORT OF THE T

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN) <i>(Continued)</i> (If claiming more than four children, fill out addendum (Page 12) and submit with application)		
17A. NAME OF <b>SECOND</b> CHILD TO ADD (First, Middle Initial, Last)		
17A. NAWL OF SECOND CHIED TO ADD (Pursi, Madde Handi, Last)		
17B. SOCIAL SECURITY NUMBER 17C DATE OF BIRTH 17D PLACE OF BIRTH (Provide	Gir I Gran	<u> </u>
17B. SOCIAL SECURITY NUMBER  17C. DATE OF BIRTH  17D. PLACE OF BIRTH (Provide and State, or City and Country)  Month Day Year		County
17E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH		
17F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES		
17G. CHILD STATUS (Check all that apply)		
BIOLOGICAL 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674) ADOPTED CHILD INCAPABLE OF S	SELF-SUPPO	RT
CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 17H)  STEPCHILD (If checked, co	omplete Item 1	7I)
17H. HOW AND WHEN MARRIAGE ENDED		
DATE:(MM/DD/YYYY)		
17I. IF YOU CHECKED "STEPCHILD" IN ITEM 17G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?		
YES (If "Yes," provide the date the child entered veteran's household): (MM/DD/YYYY)		
NO 18A. NAME OF <b>THIRD</b> CHILD TO ADD (First, Middle Initial, Last)		
TOA. NAIME OF THIRD OF HED TO ADD (First, Middle Huttu, East)		
18B. SOCIAL SECURITY NUMBER  18C. DATE OF BIRTH  18D. PLACE OF BIRTH (Providence of the content		e, County
Month Day Year	. 77	
18E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH		
18F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES		
18G. CHILD STATUS (Check all that apply)		
BIOLOGICAL 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674) ADOPTED CHILD INCAPABLE C	OF SELF-SUF	PPORT
CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 18H)  STEPCHILD (If checked)	ed, complete It	em 18 <b>I</b> )
18H. HOW AND WHEN MARRIAGE ENDED		
DATE: (MM/DD/YYYY) ANNULLED DECLARED VOID OTHER (Explain)		
18I. IF YOU CHECKED "STEPCHILD" IN ITEM 18G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?		
YES (If "Yes," provide the date the child entered veteran's household): (MM/DD/YYYY)		
NO		
19A. NAME OF <b>FOURTH</b> CHILD TO ADD ( <i>First, Middle Initial, Last</i> )		
19B. SOCIAL SECURITY NUMBER 19C. DATE OF BIRTH 19D. PLACE OF BIRTH (Provide		e, County
Month Day Year and State, or City and Cour	ntry)	
19E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH		
40F IF CHILD DOES NOT LIVE WITH THE CLAMMANT PROVIDE COMPLETE DIVISION ADDRESS WHERE CHILD DESIDES		
19F. IF CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES		
19G. CHILD STATUS (Check all that apply)		
BIOLOGICAL 18-23 YEARS OLD AND IN SCHOOL (If checked, fill out VA Form 21-674) ADOPTED CHILD INCAPABLE OF	F SELF-SUPF	PORT
CHILD PREVIOUSLY MARRIED (If checked, provide the date marriage ended and how the marriage ended in Item 19H)  STEPCHILD (If checked	l, complete Iten	n 19I)
19H. HOW AND WHEN MARRIAGE ENDED		
DATE: (MM/DD/YYYY)		
19I. IF YOU CHECKED "STEPCHILD" IN ITEM 19G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?		
YES (If "Yes," provide the date the child entered veteran's household): (MM/DD/YYYY)		
NO		

VETERAN'S SOCIAL SECURITY NO.

т	Р	_	_	2	4	<b> </b>	۵	5	۵	2
	1			_			9	J	9	

	SECTION IV: VETERAN REP	PORTING DIVORCE FRO child(ren), also complete		
NOTE: If marriage ended as ar	n annulment or declared void, use Sec			
20A. NAME OF FORMER SPOU	USE (First, Middle Initial, Last)			
			<u>                                     </u>	
20B. PLACE OF DIVORCE (Pro	ovide city and state, county and state, or city and	country)	20C. DATE OF DIVORCE  Month Day	Year
	SECTION V: VETERAN/CL	AIMANT REPORTING ON	N STEPCHILD(REN)	
21A. DID YOU HAVE A STEPCH	- IILD(REN) THAT WAS THE BIOLOGICAL (	OR ADOPTED CHILD(REN) OF	THE FORMER SPOUSE LISTED IN ITEM 20	JA?
YES (If "YES," list the name(s	s) of the stepchild(ren) here):			
NO (If "NO," skip to Section	VI)			
21B. ARE YOU STILL SUPPORT	TING YOUR STEPCHILD(REN) LISTED IN	ITEM 21A?		
YES (If "YES," complete Item.	is 21C through 21G)			
NO (If "NO," skip to Section	. VI)			
21C. NAME OF STEPCHILD YOU ARE SUPPORTING	21D. IF STEPCHILD DOES NOT LIV WITH YOU, PROVIDE THE NAME O PERSON WITH WHOM STEPCHILD RESIDES		TH YOU, LEFT VETERAN'S	21G. FINANCIAL SUPPORT PROVIDED
				More than half Half Less than half
				More than half
				Half
				Less than half
				More than half
				Half
				Less than half
				More than half
				Half
				Less than half
and DEDENIDENT TYPE (SI	SECTION VI: VETERAN/CLA	IMANT REPORTING DEATH	H OF A DEPENDENT	
22A. DEPENDENT TYPE (Check	ik all that apply) INOR CHILD (UNDER 18 YEARS OLD	STEPCHILD ADOPTE	ED DEPENDENT PARENT	
CHILD INCAPABLE OF S	SELF-SUPPORT 18-23 YEARS OLD	AND IN SCHOOL		
	OF DEPENDENT(S)	22C. DATE OF DEATH	22D. PLACE OF DEA	
(First, Mid	ldle Initial, Last)	(MM/DD/YYYY)	(City & State, County & State, or C	City & Country)
	SECTION VII: VETERAN/C	LAIMANT REPORTING MAR	RRIAGE OF CHILD	
23A. NAME OF CHILD (First, Mid	ddle Initial, Last)			
23B. DATE OF MARRIAGE				
Month Day	Year			

VETERAN'S SOCIAL SECURITY NO. T R A - 2 1 - 9 5 9 2

VETERATION CONTRACTOR OF THE SECOND CONTRACTOR		
SECTION VIII: VETERAN/CLAIMANT REPORTING A SCHOOLCHILD OVER 18	HAS STOPPED ATTENDING	S SCHOOL
24A. NAME OF SCHOOLCHILD (First, Middle Initial, Last)		
24B. DATE SCHOOLCHILD STOPPED ATTENDING SCHOOL		
Month Day Year		
SECTION IX: REMARKS		
25. REMARKS (If any)		
SECTION X: BENEFICIARY/CLAIMANT'S CERTIFICATION (Note: Completion of this section is REQUIRED to proceed		
<b>IMPORTANT</b> : The primary purpose of this form is to gather information or statements the		
signing this form you have given permission to make benefit payment changes that coul		n overpayment. If such
adverse actions are taken you will receive additional notification from VA regarding repa	yment options.	
I HEREBY CERTIFY THAT the information I have given above is true and correct to the best of my	knowledge and belief.	
26A. SIGNATURE OF BENEFICIARY/CLAIMANT OR ALTERNATE SIGNER* (Please sign in ink)		26B. DATE (MM/DD/YYYY)
	(TOR USE BI VII OI. EI)	,
Homer T Cornblatt		10/14/2021
*ALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, I certify that the claimant	is:	
under the age of 18,		

- mentally incompetent to provide substantially accurate information needed to complete the form or to certify that the statements made on the form are true and complete, or
- physically unable to sign the form

\*ALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, I certify that I am:

- · a court-appointed representative,
- an attorney in fact or agent authorized to act on behalf of the claimant under a durable power of attorney,
- a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative, or
- a manager or principal officer acting on behalf of an institution which is responsible for the care of the claimant.

**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.

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 required to obtain or retain benefits. Giving us your and your dependents' SSN account information is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed under Title 38 USC 5101 (c)(1). 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. 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.

**RESPONDENT BURDEN:** We need this information to determine marital status and eligibility for an additional allowance for dependents under 38 U.S.C. 1115. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 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 <a href="https://www.reginfo.gov/public/do/PRAMain.">www.reginfo.gov/public/do/PRAMain.</a> If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VETERAN'S SOCIAL SECURITY NO.

			_		1.01	110		ig I	urpo	363	0
Т	R	Α	_	2	1	_	9	5	9	2	

(Ple	ease	e sı	ıbmi	t thi				the co	omp		d ap	pli	cati	ion	if y	you	hav	e a	dditi	ona	l chil	dre	n to a					n. If	f mc	ore s <sub>l</sub>	oace	is
4.0		F 01	- 0111	БТС			•	lease				tion	aı (	cop	oles	S OT	tnis	pa	ge to	su	bmit	WITI	n you	ır ap	plic	atioi	n.)					
1A.	NAM	T	- CHI	דט וכ	ADL	(Firs	t, Mic	ddle In	itiai,	, Last)		л Г		lГ			Г	$\overline{}$	$\overline{}$	$\overline{}$	<del></del>	Г	$\overline{}$	П	Т	Т	$\overline{}$	$\overline{}$	$\overline{}$	$\overline{}$	Π	
			)FOU	DITY		<u> </u>	Ш_		<u> </u>		<u> </u>	Щ		Ц		<u> </u>						Ц,	15	DI A			<u> </u>	ببل	<u></u>			Щ
1B.	SOC	IAL S	SECU	RITY	NUMI	3EK					1	C. D Mor		: OF	BIF	RTH Day	,			Year			1D.					rovide Countr		and Sta	ite, Co	ounty
		Т	Π_	- [	T	٦_		П			۱г	10101	1011	1 –	٠.	T	Π.	—Г	Т	Tear		٦l							,			
 1F	F TH	IF C	HII D	DOES	TON	<u> </u>   IVE	WITE	THE	CL A	IMANT	PRO	חואכ חואכ	FΝ	<u>]</u> Амг	L OF	PFF	RSON	J THI	F CHII	D R	FSIDE	S WI	TH									
·	Τ	T	T	T	T		<del></del>	<del></del>	T	T	T	JБ		, 1 Г		· -·	T	T	T	T	T	T	<del></del>	Т	Г	1	$\overline{}$	$\overline{}$	o	$\overline{}$	Ι	$\overline{}$
						<u> </u>	<u></u>		Щ	Щ	<u> </u>	لل		Щ		<u> </u>	L	<u> </u>				<u> </u>		L			<u></u>		上			
1F.	F CF	HILD	DOE	S NO	LIVE	: WITH	1 THE	E CLAII	MAN	T, PR	OVID	E CC	OMP	LEI	ΕP	PHYS	ICAL	ADE	RESS	3 WH	ERE C	HILE	RES	IDES								
1G.	CHIL	D S1	ATU	S (Che	ck all	that ap	ply)																									
	BIO	LOG	ICAL		] 18	-23 YE	EARS	OLD A	٩ND	IN SC	НОО	L ( <i>If</i>	chec	ked,	fill c	out VA	A Forn	n 21-	674)		ADOP	TED			CHIL	D IN	CAPA	BLE	OF S	ELF-S	UPP	ORT
	CHII	DΡ	RFVI	OUSI	У МА	RRIF	) (If c	hecked,	nroi	ide the	date	marr	iaae	endi	ed as	nd ho	w the i	marr	iaoe en	ded i	n Item	1H)			STE	PCHIL	LD (If	check	ced. cc	omplete	Item	11)
<u></u> 1H. I						AGE E			prov	tue me	шие	mari	iuge	enu	cu ui	iu no	w ine i	nun	iuge en	ueu ii	n nem .	111)		Ш							110	/
											A					ם כי	21 A D	- C \	(OID		OTU	<b>-</b> D /	r	,								
DATI		1.0:				(MN		,	<u></u>		ANNU			10:	<u> </u>				VOID	<u> </u>			Explain	ι)								
11. IF								EM 1G															(F)									
		(If	"Yes,"	provi	te the	date th	e chile	d entere	≀d vet	teran's	house	ehold,	):							(M	1M/DD	YYYY	r)									
2.2	NO	r ^:	- CI !!	D T.	V V C C	/E'	4 14.	111. 7	:4: 7	T 1																						
2A.	NAM	E OF	· CHI	טוכ	ADD	(Firs	t, Mia	ddle In	ıtıaı,	Last)	_	- r		1 6		1	_	_		1		1	_	1	_	_	_		_			
									L	$oldsymbol{ol}}}}}}}}}}}}}}}}}}$		Ш		Ц																Ш.		
2B.	SOCI	AL S	SECU	RITY	NUME	3ER					2	C. D		OF	BIF	_							2D.					Provide Countr		and Sta	ite, Co	ounty
	_	_	_		_	٦		$\overline{}$	—		-	Mor	nth	1	г	Day	_	_		Year	<u> </u>	٦1		ana s	iaie, o	or City	ana C	Jounir	у)			
	L	L				ഥ	Ш	Ш			Щ			L	L					$\perp$		Ш										
2E.	FTF	IE CI	HILD	DOES	NOT	LIVE	WITH	1 THE	CLAI	MANT	PRO	JVID	E N	AME	: OF	PEF	RSON	ITHE	E CHIL	D RI	ESIDE	S WI	TH									
							1																									
2F. I	F CH	IILD	DOES	TON 8	LIVE	WITH	THE	CLAIN	MAN	T, PRO	OVID	E CC	MP	LET	EΡ	HYSI	ICAL .	ADD	RESS	WH	ERE C	HILD	RESI	DES								
2G.	CHIL	D S	ΓATU	S (Che	ck all	that a	oply)																									
			ICAL	Ē	_	•		S OLD	AND	IN SC	CHOC	DL (If	che	cked.	fill	out V	A For	m 21	-674)		] AD	OPTE	ΞD		CH	וו די וע		ADIE	: OE	SELF-S	SLIDE	OPT
																			,	, , .												
								hecked,	, prov	nde the	date	marr	rage	ena	ea ai	na no	w the i	marr	rage en	ided i	n Item .	2H)			311	ЕРСП	ILD (I	ıj cnec	:кеа, с	complet	e iten	1 21)
2H.	HOW	/ AN	D WH	EN M	AKKI	AGE E	INDE	D																								
DAT	E:					(M	M/DD	/YYYY)			ANN	ULLE	ΞD			DE	CLAF	RED	VOID		OTH	IER (	Explair	n)								
2I. IF	YO	J CH	IECK	ED "S	TEPC	HILD"	'IN IT	EM 20	3, IS	STEP	CHIL	D TH	IE B	IOL	OGI	CAL	CHIL	D OF	YOU	R SF	POUSE	?										
	YES	(If	"Yes, '	provid	le the	date th	e chile	d entere	≀d vet	eran's	house	hold,	):							(M	M/DD	YYYY	?)									
	NO																															
3A. I	MAV	E OF	CHII	D TO	ADD	(Firs	t, Mia	ldle In	itial,	Last)																						
												11																				
3B. \$	SOCI	AL S	ECU	RITY	NUME	3ER			_		3	C. D.	ATE	OF	BIR	RTH	<u> </u>	<u> </u>				┪	3D.	. PLA	CE OI	F BIR	TH (F	rovid	e City	and Ste	ate, C	ounty
			_			_						Mor	nth			Day				Year				and S	State, c	or City	and (	Countr	<i>ry)</i>			
			<b>-</b>	•		-								] –	٠Г		□-	-Г				71										
3E.	F TH	IE C	HILD	DOES	NOT	LIVE	WITH	1 THE	CLA	.IMAN	PRO	OVID	ΕN	AMI	OF	F PEI	RSON	1 TH	E CHII	LD R	ESIDE	S W	ITH									
		Τ			Т	$\top$	Т	Т		Т		7 [		] [													П	Т	Т	Т		
3F	F CF		DOF	NOT	LIVE	WITI	1 1 THF	L CLAII	<u>L</u> MAN	T. PR		E CC	OMP	I L	ΕP	HYS	ICAI	ADF	RESS	I WH	ERF (	HIIF	) RES	IDES	<u> </u>	<u> </u>	<u> </u>	<u>—</u>	<u>—</u>	<u>—</u>	<u> </u>	
J	0.								•	,						5							0									
3G	CHII	D.S	ΓΑΤΙΙ	S (Ch	ck all	that ap	nnlv)																									
			ICAL	_ , _,	_			SOLD	AND	) IN SC	CHOC	DL (I+	che	cked	. fill	out V	'A For	m 21	-674)	Г	☐ AD	ОРТ	ED		СН	ILD IN	NCAP	ABLF	OF	SELF-	SUPF	PORT
				۔	_														,						•							
							ט (If c	checked	, prov	vide the	e date	marı	iage	end	ed a	nd ho	w the	marr	rage er	ıded i	n Item	3H)		L	511	EPUH	ILD (	іј спес	:кеа, с	comple	ie Iten	n 31)
3H.	HOW	/ AN	υ WH	EN M	ARRI	AGE																										
DATI								YYYY)			ANN			_			CLAR						Explain	ı)								
3I. II								ГЕМ ЗС																								
	YES	(If	"Yes,	' provi	de the	date th	ıe chile	d entere	ed vet	teran's	house	ehold,	): _							(M	M/DD	/YYYY	Y)									
	NO																															