OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 09/30/2022

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Received Centralized Mail Processing, Janesville, WI Date Received 09/10/2021

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 ***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: IDENTIFICATION AND CLAIM INFORMATION
(If claim is not an original claim, only Section I, IV, 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 to expedite processing of the form.

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*

Hester | Hamilton

3. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*: TRA – 04 – 8085

4. HAVE YOU EVER FILED A CLAIM WITH VA? (●) YES ( ) NO *(If "Yes," provide your file number in Item 5)*

5. VA FILE NUMBER: 6Y28XX00

6. DATE OF BIRTH *(MM-DD-YYYY)*: 01 – 07 – 1952

7. VETERAN'S SERVICE NUMBER *(If applicable)*:

8. SEX ( ) MALE (●) FEMALE

9. BDD CLAIMS ***ONLY:*** **PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** ***(MM-DD-YYYY)***: – –

10. TELEPHONE NUMBER *(Optional) (Include Area Code)*: 555 – 555 – 1212

Enter International Phone Number *(If applicable)*:

11. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street: 31 Hopkins Plaza

Apt./Unit Number: | City: Baltimore

State/Province: MD | Country: US | ZIP Code/Postal Code: 21201 –

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

( ) 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)*

( ) TEMPORARY ( ) 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 **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:**			

VETERANS SOCIAL SECURITY NO. T R A – 0 4 – 8 0 8 5

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?

- ○ YES *(If "Yes," complete Item 15B regarding your living situation)*
- ○ NO

15B. 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)

15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

- ○ YES *(If "Yes," complete Item 15D regarding your living situation)*
- ○ NO

15D. 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)

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 DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE 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

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	low back condition	increase		
2.	PTSD	increase		
3.	Individual Unemployability due to low back condition and PTSD			
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

VETERANS SOCIAL SECURITY NO. T R A – 0 4 – 8 0 8 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.

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
	–	○ Don't have date
	–	○ 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 www.va.gov/vaforms)

For:	***Required Form(s):***
Supplemental Claims	VA Form 20-0995, *Decision Review Request: Supplemental Claim*
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
Post-Traumatic Stress Disorder	VA Form 21-0781 or 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
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 V: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
○ YES *(If "Yes," complete Item 18B)* ◉ NO *(If "No," skip to Item 19A)*

18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:

19A. BRANCH OF SERVICE
○ ARMY ○ NAVY ○ MARINE CORPS
◉ AIR FORCE ○ COAST GUARD ○ SPACE FORCE

19B. COMPONENT
◉ ACTIVE ○ RESERVES ○ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES *(MM,DD,YYYY)*

	Month	Day	Year
ENTRY DATE:	06	11	1970
EXIT DATE:	03	31	1990

20B. PLACE OF LAST OR ANTICIPATED
Travis Air Force
California

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
○ YES ◉ NO

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate enlistment and discharge date(s), if applicable)*

	Month	Day	Year
From:			
To:			

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
○ YES *(If "Yes," complete Items 21B thru 21F)*
◉ NO *(If "No," skip to Item 22A)*

21B. COMPONENT
○ NATIONAL GUARD
○ RESERVES

21C. OBLIGATION TERM OF SERVICE

	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?
○ YES ○ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
○ YES *(If "Yes," complete Items 22B & 22C)*
◉ NO

22B. DATE OF ACTIVATION: Month – Day – Year

22C. ANTICIPATED SEPARATION DATE: Month – Day – Year

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
○ YES *(If "Yes," complete Item 23B)*
◉ NO

23B. DATES OF CONFINEMENT

From: Month – Day – Year	To: Month – Day – Year

VETERANS SOCIAL SECURITY NO. T R A – 0 4 – 8 0 8 5

SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?

- ○ YES *(If "Yes," complete Items 24C and 24D)*
- ◉ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?

- ○ **YES** *(If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)*
- ○ NO

24C. BRANCH OF SERVICE

- ○ ARMY
- ○ AIR FORCE
- ○ NAVY
- ○ MARINE CORPS
- ○ COAST GUARD
- ○ SPACE FORCE

24D. MONTHLY AMOUNT

$, .00

25. RETIRED STATUS

- ○ RETIRED
- ○ PERMANENT DISABILITY RETIRED LIST
- ○ TEMPORARY DISABILITY 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.**

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

- ○ ARMY
- ○ NAVY
- ○ MARINE CORPS
- ○ AIR FORCE
- ○ COAST GUARD
- ○ SPACE FORCE

27D. AMOUNT RECEIVED *(Provide pre-tax amount)*

$, .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

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 VIII)*

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

Account No.: 4 6 9 8 7 9 4 6 8

- ◉ CHECKING
- ○ SAVINGS

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

U S A A

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

3 1 4 0 7 4 2 6 9

VETERANS SOCIAL SECURITY NO. T R A – 0 4 – 8 0 8 5

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 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 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**)	33B. DATE SIGNED *(MM-DD-YYYY)*
Hester Hamilton	0 9 – 1 0 – 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 using an "X")*	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. 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 CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, 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 an individual; **AND**, that the claimant is under the age of 18; **OR**, is 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**, 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 my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**)	36B. DATE SIGNED *(MM-DD-YYYY)*
	– –

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE
(NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.
NOTE: A POA's signature ***will not*** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

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.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for 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 Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Received Centralized Mail Processing,
Janesville, WI
Date Received 09/10/2021

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative.* When completed you can mail ***or*** fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

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

Hester Hamilton

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

TRA – 04 – 8085

3. VA FILE NUMBER *(If applicable)*

6Y28XX00

4. VETERAN'S DATE OF BIRTH

Month 01 – Day 07 – Year 1952

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

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street: 31 Hopkins Plaza

Apt./Unit Number:

City: Baltimore

State/Province: MD

Country: US

ZIP Code/Postal Code: 21201 –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING 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 –

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

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

American Legion

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

Brady T. Owen

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

NSO

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

btowen.al@email.com

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

09/08/2021

VETERAN'S SOCIAL SECURITY NUMBER T R A – 0 4 – 8 0 8 5

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

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

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
Hester Hamilton	09/08/2021
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*
Brady T. Owen	09/08/2021

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

RECOGNIZED SERVICE ORGANIZATIONS

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

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

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

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

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

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

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

FOR ALL **COMPENSATION** CLAIMS MAIL OR FAX THIS FORM TO THE FOLLOWING ADDRESS:

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444
Or fax your form to:
Toll Free: (844) 531- 7818
Local: 248-524-4260

FOR **VETERANS PENSION** AND **SURVIVOR BENEFIT** CLAIMS MAIL OR FAX THIS FORM TO THE APPROPRIATE ADDRESS SHOWN BELOW:

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Milwaukee Pension Center
P.O. Box 5192
Janesville, WI 53547-5192
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: St. Paul Pension Center
P.O. Box 5365
Janesville, WI 53547-5365
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD SAFEGUARD IT | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME *(Last, First, Middle)*	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO.
Hamilton, Hester	Air Force	TRA 04 8085

4.a. GRADE, RATE OR RANK	4.b. PAY GRADE	5. DATE OF BIRTH *(YYYYMMDD)*	6. RESERVE OBLIG. TERM. DATE (Year / Month / Day)
Master Sergeant	E-7	19520107	

7.a. PLACE OF ENTRY INTO ACTIVE DUTY	7.b. HOME OF RECORD AT TIME OF ENTRY *(City and State, or complete address if known)*
Baltimore, MD	31 Hopkins Plaza, Baltimore, MD 21201 (US)

8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	8.b. STATION WHERE SEPARATED
Western Air Defense Sector (WADS) McChord AFB, WA	McChord AFB, WA

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
N/A	[ ] NONE AMOUNT: $

11. PRIMARY SPECIALTY *(List number, title and years and months in specialty. List additional speciality numbers and titles involving periods of one or more years.)*
461X0 - Munitions Maintenance (19 years)

12. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. Date Entered AD This Period	70	06	11
b. Separation Date This Period	90	03	31
c. Net Active Service This Period	19	10	22
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	00	00
f. Foreign Service	00	00	00
g. Sea Service	00	00	00
h. Effective Date of Pay Grade	89	01	20

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED *(All periods of service)*
Air Force Achievement Medal 4OLC
Air Force Commendation Medal 3OLC
Air Force Good Conduct Medal
National Defense Service Medal

14. MILITARY EDUCATION *(Course title, number of weeks, and months and years completed)*
Munitions Maintenance (52 weeks)

15.a. MEMBER CONTRIBUTED TO POST VIETNAM ERA VETERAN'S EDUCATION ASSISTANCE PROGRAM	YES	NO	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT	YES	NO	16. DAYS ACCRUED LEAVE PAID
	X			X		

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION [ ] YES [ ] NO

18. REMARKS
RVN 19720310 - 19730309

09/10/2021 RECEIVED Centralized Mail Processing, Janesville, WI

I HEREBY CERITFY THAT THIS IS A TRUE AND EXACT COPY OF THE ORIGINAL DOCUMENT.
Certified by Marcy Morris this 08 day of September, 2021.

19.a. MAILING ADDRESS AFTER SEPERATION *(Include Zip Code)*	19.b. NEAREST RELATIVE *(Name and Address - include Zip Code)*
31 Hopkins Plaza Baltimore, MD 21201 (US)	Brenda Hamilton 2560 E. Newlands Dr, Fernley, NV 89408 (US)

20. MEMBER REQUESTS COPY 6 BE SENT TO _____ DIR. OF VET AFFAIRS [ ] YES [ ] NO

22. OFFICIAL AUTHORIZED TO SIGN *(Type name, grade, title and signature)* Capt. Samuel D. Hawkins ADMINO
Samuel D. Hawkins

21. SIGNATURE OF MEMBER BEING SEPARATED
Hester Hamilton

DD FORM 214, NOV 88 S/N 0102-LF-006-5500 *Previous editions are obsolete.* **MEMBER - 1**

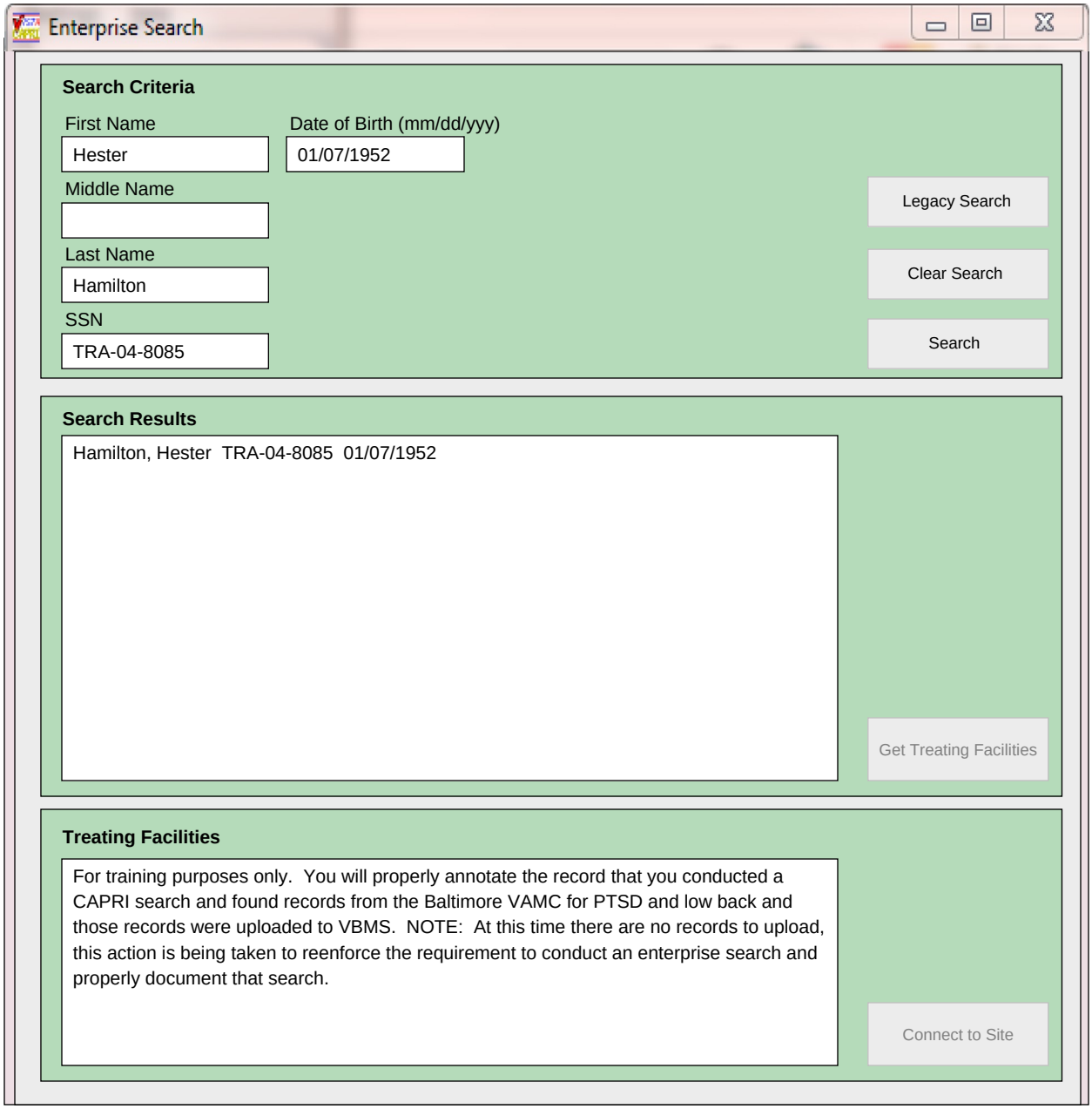
SPECIAL ADDITIONAL INFORMATION *(For use by authorized agencies only)*

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE *(Include upgrades)*	
Retirement	Honorable	
25. SEPARATION AUTHORITY	**26. SEPARATION CODE**	**27. REENTRY CODE**
MILPERSMAN 3620150	MBK	RE-4

28. NARRATIVE REASON FOR SEPARATION
Expiration of enlistment

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4
31	HH Initials

DD FORM 214, NOV 88 S/N 0102-LF-006-5500 *Previous editions are obsolete.* **MEMBER - 4**


Enterprise Search
Search Criteria
First Name
Hester
Date of Birth (mm/dd/yyy)
01/07/1952
Middle Name
Last Name
Hamilton
SSN
TRA-04-8085
Legacy Search
Clear Search
Search
Search Results
Hamilton, Hester TRA-04-8085 01/07/1952
Get Treating Facilities
Treating Facilities
For training purposes only. You will properly annotate the record that you conducted a CAPRI search and found records from the Baltimore VAMC for PTSD and low back and those records were uploaded to VBMS. NOTE: At this time there are no records to upload, this action is being taken to reenforce the requirement to conduct an enterprise search and properly document that search.
Connect to Site

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

07/09/2021 RECEIVED Centralized Mail Processing, Janesville, WI

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

NOTE: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

NOTE: You can ***either*** complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*

2. CLAIMANT'S SOCIAL SECURITY NUMBER: TRA — 04 — 8085

3. VA FILE NUMBER *(If applicable)*:

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY): Month 01 — Day 07 — Year 1952

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***: Hester Hamilton

6. VETERAN'S SOCIAL SECURITY NUMBER: TRA — 04 — 8085

7. VETERAN'S SEX: ☐ MALE ☒ FEMALE

8. VETERAN'S SERVICE NUMBER (if applicable): 6Y28XX00

9. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street: 31 Hopkins Plaza

Apt./Unit Number:

City: Baltimore

State/Province: MD

Country: US

ZIP Code/Postal Code: 21201 —

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? ☒ YES ☐ NO

11. TELEPHONE NUMBER *(Include Area Code)*: (555)555-1212

12. EMAIL ADDRESS *(If applicable)*:

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: ***(Choose all that apply)***

☒ COMPENSATION ☐ PENSION

NOTE: Only check the box below if you are a surviving dependent of the veteran.

☐ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online through eBenefits at **www.ebenefits.va.gov**. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE: *Hester Hamilton*

14B. DATE SIGNED *(MM,DD,YYYY)*: 07/09/2021

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*
(**NOTE**: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

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 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 only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Regional Office

Hester Hamilton

VA File Number
TRA-04-8085

Rating Decision
04/28/2020

INTRODUCTION

The records reflect that you are a Veteran of the Vietnam Era. You served in the Air Force from June 11, 1970, to March 31, 1990. You filed an original claim that was received on March 09, 2020. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for posttraumatic stress disorder (PTSD) is granted with a 30 percent evaluation effective March 09, 2020.

2. Service connection for lumbosacral strain is granted with a 20 percent evaluation effective March 09, 2020.

EVIDENCE

- DD Form 214, Certificate of Release or Discharge from Active Duty received March 17, 2020, for the period June 11, 1970, to March 31, 1990.
- Service Treatment Records received March 17, 2020, for the period June 11, 1970, to March 31, 1990.

- VA Form 21-526EZ, Application for Disability Compensation and Related Compensation Benefits, received March 09, 2020.
- Private Treatment Records, multiple entries, Cardiology of Sparks received March 09, 2020, dated February 08, 2020.
- Disability Benefits Questionnaire, Baltimore VAMC, conducted April 08, 2020.

REASONS FOR DECISION

1. Service connection for posttraumatic stress disorder (PTSD).

Service connection for posttraumatic stress disorder (PTSD) has been established as directly related to military service.

An evaluation of 30 percent is assigned from March 09, 2020.

We have assigned a 30 percent evaluation for your posttraumatic stress disorder (PTSD) based on:
• Disturbances of motivation and mood
• Mild memory loss
• Anxiety
• Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal)
• Chronic sleep impairment

The overall evidentiary record shows that the severity of your disability most closely approximates the criteria for a 30 percent disability evaluation.

A higher evaluation of 50 percent is not warranted for posttraumatic stress disorder unless the evidence shows occupational and social impairment with reduced reliability and productivity due to such symptoms as:
• flattened affect
• circumstantial, circumlocutory, or stereotyped speech
• panic attacks more than once a week
• difficulty in understanding complex commands
• impairment of short- and long-term memory (e.g., retention of only highly learned material,
forgetting to complete tasks)
• impaired judgment
• impaired abstract thinking
• disturbances of motivation and mood
• difficulty in establishing and maintaining effective work and social relationships.

2. Service connection for lumbosacral strain.

Service connection for lumbosacral strain has been established as directly related to military service.

An evaluation of 20 percent is assigned from March 09, 2020.

We have assigned a 20 percent evaluation for your lumbosacral strain based on:
• Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees

Additional symptom(s) include:
• Combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees
• Painful motion upon examination

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and applied under 38 CFR §4.59.

A higher evaluation of 40 percent is not warranted for lumbosacral strain unless the evidence
shows:
• Favorable ankylosis of the entire thoracolumbar spine; or,
• Forward flexion of the thoracolumbar spine 30 degrees or less.

REFERENCES

Title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits. For additional information regarding applicable laws and regulations, please consult your local library, or visit us at our web site, www.va.gov.

Rating Decision	***Department of Veterans Affairs Veterans Benefits Administration***		Page 1 of 1 04/28/2020	
NAME OF VETERAN	VA FILE NUMBER	SOCIAL SECURITY NR	POA	COPY TO
Hester Hamilton	TRA-04-8085	TRA-04-8085		

ACTIVE DUTY			
EOD	**RAD**	**BRANCH**	**CHARACTER OF DISCHARGE**
06/11/1970	03/31/1990	Air Force	Honorable

LEGACY CODES			
ADD'L SVC CODE	**COMBAT CODE**	**SPECIAL PROV CODE**	**FUTURE EXAM DATE**
	1		None

JURISDICATION: Non-Original Disability Claim Received 03/09/2020

ASSOCIATED CLAIM(s): 110; Original Claim; 03/09/2020

SUBJECT TO COMPENSATION (1.SC)

9411	POSTTRAUMATIC STRESS DISORDER (PTSD) [PTSD - Combat] Service Connected, Vietnam Era, Incurred Static Disability 30% from03/09/2020
5237	LUMBOSACRAL STRAIN Service Connected, Vietname Era, Incurred Static Disability 20% from 03/09/2020

COMBINED EVALUATION FOR COMPENSATION:

40% from 03/09/2020

eSign: certified by VBADENJOHNSD, DRO
Training Consultant

Reviewer

Department of Veteran Affairs
Request for Information

General Information

Address Code: 13 File No.: TRA-04-8085 Insurance No.:
VA Requesting Office: Baltimore, MD RO Requestor ID: BR549
Submit Date: 03/14/2020
PIES ID: 56565656

Veteran Name: Hester Hamilton SSN: TRA-04-8085 Date of Birth: 01/07/1952
Place of Birth: Harrodsburg, KY Date of Death:

Claim Date: 03/09/2020 Receipt Date: 03/14/2020
Branch Completion Date: 03/19/2020 Branch Completed By: TR826
Overall Status: SU Overall Completion Date: 03/19/2020

Period of Service Date for Branch:

Name	SSN	EOD	RAD	COD	Duty Status	RT Date	RT Date	Pay Grade
Hamilton, Hester	TRA-04-8085	06/11/1970	03/31/1990	Honorable	SAT			E-7

Request/Response Information

Request Paperless claim processing (PLCP)- furnish complete Medical/Dental records <STRs>
O50 and entire personnel file.

Response <<All available records mailed>>

VA Form 3101 Printable Form

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 03/28/1990

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. IDENTIFICATION NUMBER	3. GRADE AND COMPONENT OR POSITION
Hamilton, Hester	TRA-04-8085	E-7

4. HOME ADDRESS (*Number, street or RFD, city or town, state and ZIP Code*)	5. EMERGENCY CONTACT (*Name and address of contact*)
31 Hopkins Plaza Baltimore, MD 21201 (US)	Brenda Hamilton 2560 E. Newlands Dr Fernley, NV 89408 (US)

6. DATE OF BIRTH	7. AGE	8. SEX	9. RELATIONSHIP OF CONTACT
01/07/1952	38	☒ FEMALE ☐ MALE	Sister

10. PLACE OF BIRTH	11. RACE
Harrodsburg, KY	☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER

12a. AGENCY	12b. ORGANIZATION UNIT	13. TOTAL YEARS GOVERNMENT SERVICE	
		a. MILITARY	b. CIVILIAN
Air Force	Air Force	20	

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS	15. RATING OR SPECIALTY OF EXAMINER
McChord AFB, WA	MD - General Practitioner
	16. PURPOSE OF EXAMINATION: Separation exam

17. CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNORMAL	NORMAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNORMAL
X	A. HEAD, FACE, NECK AND SCALP		X	O. PROSTATE (Over 40 or clinically indicated)	
X	B. EARS - GENERAL (INTERNAL CANALS) *(Auditory acuity under items 39 and 40)*		X	P. TESTICULAR	
			X	Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)*	
X	C. DRUMS (*Perforation*)		X	R. ENDOCRINE SYSTEM	
X	D. NOSE		X	S. G-U SYSTEM	
X	E. SINUSES		X	T. UPPER EXTREMITIES *(Except feet) (Strength, range of motion)*	
X	F. MOUTH AND THROAT		X	U. FEET	
X	G. EYES - GENERAL (*Visual acuity and refraction under items 28, 29, and 36*)		X	V. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
X	H. OPHTHALMOSCOPIC		X	W. SPINE, OTHER MUSCULOSKELETAL	
X	I. PUPILS *(Equality and reaction)*		X	X. IDENTIFYING BODY MARKS, SCARS,TATTOOS	
X	J. OCULAR MOTILITY *(Associated parallel movements nystagmus)*		X	Y. SKIN, LYMPHATICS	
X	K. LUNGS AND CHEST		X	Z. NEUROLOGIC *(Equilibrium tests under item 41)*	
X	L. HEART *(Thrust, size, rhythm, sounds)*		X	AA. PSYCHIATRIC *(Specify any personality deviation)*	
X	M. VASCULAR SYSTEM *(Varicosities, etc.)*			BB. BREASTS	
X	N. ABDOMEN AND VISCERA *(Include hemia)*			CC. PELVIC *(Females only)*	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)*

18. DENTAL *(Place appropriate symbols, show in examples, above or below number of upper and lower teeth.)*

0 (1 2 3 / 32 31 30) 0 — Restorable Teeth

/ (1 2 3 / 32 31 30) / — Non-restorable Teeth

X (1 2 3 / 32 31 30) X — Missing Teeth

X X X (1 2 3 / 32 31 30) X X X — Replaced by Dentures

(X) (1 2 3 / 32 31 30) (X) — Fixed Partial Dentures

RIGHT																	LEFT
	X															X	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X															X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES: Dentally Qualified, Class III, Exam Type III

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD *(Place, date, film number and result)*
(2) URINE ALBUMIN: neg	(4) MICROSCOPIC: 1-4 WBC	
(3) URINE SUGAR: neg		#1026-69, within normal limits

C. SYPHILIS SEROLOGY *(Specify test used and results)*	D. EKG	E. BLOOD TYPE AND HR FACTOR	F. OTHER TESTS
VDRL Non-reactive	NA	A+	none

NAME	IDENTIFICATION	NO. OF SHEETS ATTACHED
Hester Hamilton	TRA-04-8085	

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
5' 9"	167	Brown	Green	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.6

26. BLOOD PRESSURE *(Arm at heart level)*

A. SITTING	SYS. 120 / DIAS. 80	B. RECUM-BENT	SYS. / DIAS.	C. STANDING (5 MINS.)	SYS. / DIAS.

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER

28. DISTANT VISION			29.REFRACTION			30. NEAR VISION	
RIGHT 20/	20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
35. FIELD OF VISION		36. NIGHT VISION *(Test used and result)*	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT LEFT

39. HEARING					40. AUDIOMETER									41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT W/V	15	/15SV	15	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT W/V	15	/15SV		/15	RIGHT		0	0	0	0				
					LEFT		0	0	0	0				

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

None.

.

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

None.

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*

A ☒ IS QUALIFIED FOR

B ☐ IS NOT QUALIFIED FOR separation from service

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Meredith Gray, MD	Dr. Meredith Gray
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
51 TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

STANDARD FORM 88 (REV. 10-94)

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 06/12/1970

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. IDENTIFICATION NUMBER	3. GRADE AND COMPONENT OR POSITION
Hamilton, Hester	TRA-04-8085	civilain

4. HOME ADDRESS (*Number, street or RFD, city or town, state and ZIP Code*)	5. EMERGENCY CONTACT (*Name and address of contact*)
31 Hopkins Plaza Baltimore, MD 21201 (US)	Brenda Hamilton 2560 E. Newlands Dr Fernley, NV 89408 (US)

6. DATE OF BIRTH	7. AGE	8. SEX	9. RELATIONSHIP OF CONTACT
01/07/1952	18	☒ FEMALE ☐ MALE	Sister

10. PLACE OF BIRTH	11. RACE
Harrodsburg, KY	☒ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER

12a. AGENCY	12b. ORGANIZATION UNIT	13. TOTAL YEARS GOVERNMENT SERVICE	
		a. MILITARY	b. CIVILIAN

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS	15. RATING OR SPECIALTY OF EXAMINER
Baltimore MEPS, Maryland	MD - General Practitioner
	16. PURPOSE OF EXAMINATION: entrance

17. CLINICAL EVALUATION

NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL	NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL
X	A. HEAD, FACE, NECK AND SCALP		X	O. PROSTATE (Over 40 or clinically indicated)	
X	B. EARS - GENERAL (INTERNAL CANALS) *(Auditory acuity under items 39 and 40)*		X	P. TESTICULAR	
			X	Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)*	
X	C. DRUMS (*Perforation*)		X	R. ENDOCRINE SYSTEM	
X	D. NOSE		X	S. G-U SYSTEM	
X	E. SINUSES		X	T. UPPER EXTREMITIES *(Except feet) (Strength, range of motion)*	
X	F. MOUTH AND THROAT		X	U. FEET	
X	G. EYES - GENERAL (*Visual acuity and refraction under items 28, 29, and 36*)		X	V. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
X	H. OPHTHALMOSCOPIC		X	W. SPINE, OTHER MUSCULOSKELETAL	
X	I. PUPILS *(Equality and reaction)*		X	X. IDENTIFYING BODY MARKS, SCARS,TATTOOS	
X	J. OCULAR MOTILITY *(Associated parallel movements nystagmus)*		X	Y. SKIN, LYMPHATICS	
X	K. LUNGS AND CHEST		X	Z. NEUROLOGIC *(Equilibrium tests under item 41)*	
X	L. HEART *(Thrust, size, rhythm, sounds)*		X	AA. PSYCHIATRIC *(Specify any personality deviation)*	
X	M. VASCULAR SYSTEM *(Varicosities, etc.)*			BB. BREASTS	
X	N. ABDOMEN AND VISCERA *(Include hemia)*			CC. PELVIC *(Females only)*	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)*

18. DENTAL *(Place appropriate symbols, show in examples, above or below number of upper and lower teeth.)*

0 (1 2 3) 32 31 30 0 — Restorable Teeth
/ (1 2 3) 32 31 30 / — Non-restorable Teeth
X (1 2 3) 32 31 30 X — Missing Teeth
X X X (1 2 3) 32 31 30 X X X — Replaced by Dentures
(X) (1 2 3) 32 31 30 (X) — Fixed Partial Dentures

RIGHT																	LEFT
	X															X	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X															X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD *(Place, date, film number and result)*
(2) URINE ALBUMIN	(4) MICROSCOPIC	
(3) URINE SUGAR		

C. SYPHILIS SEROLOGY *(Specify test used and results)*	D. EKG	E. BLOOD TYPE AND HR FACTOR	F. OTHER TESTS

NSN 7540-00-634-6038
88-126
Designed using Perform Pro, WHS/DIOR, Jan 97

STANDARD FORM 88 (Rev. 10-94) (EG)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

NAME	IDENTIFICATION	NO. OF SHEETS ATTACHED
Hester Hamilton	TRA-04-8085	

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
5' 9"	167	Brown	Green	☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	

26. BLOOD PRESSURE *(Arm at heart level)*

A. SITTING SYS.	A. SITTING DIAS.	B. RECUM-BENT SYS.	B. RECUM-BENT DIAS.	C. STANDING (5 MINS.) SYS.	C. STANDING (5 MINS.) DIAS.

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER

28. DISTANT VISION		29.REFRACTION			30. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
35. FIELD OF VISION		36. NIGHT VISION *(Test used and result)*	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT W/V	/15SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT W/V	/15SV	/15	RIGHT									
			LEFT									

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*

A ☒ IS QUALIFIED FOR

B ☐ IS NOT QUALIFIED FOR _____

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Vincent Brag, M.D.	Vincent Brag. M.D.
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
51 TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

STANDARD FORM 88 (REV. 10-94)

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12/28/1970	NO KNOWN ALLERGIES
	Sore throat, chills ack ~ back of legs T-101
	Pustule on (L) side of throat to see MO. Node anterior of neck
	throat minimal injections, 5 pustules/exaclate
	lungs clear, hat RSR, no (ng)
	comp URI
	X: NPC PnG CTM benalyn
12/31/1970	f/u Chills, fever, aching body
	T-100 Continue on previous meds.
	Return to see MO in A.M. if necessary
10/27/1971	sore throat URI
	time in 0800
	CRx, ZnCL2, ADC
	T-98.6

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY/ID NUMBER	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*

Hamilton, Hester
TRA-04-8085
Female
01/07/1952

REGISTER NUMBER	WARD NUMBER

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 11/2010)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

PREVIOUS EDITION IS NOT USABLE

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*