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OMB Control No. 2900-0862 Respondent Burden: 15 minutes Expiration Date: 4/30/2024

Department of Veterans Affairs														DO) NO	VA	ĎΑ	TE S	TAN	MP S SP		
DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM																						
INSTRUCTIONS: PLEASE READ THE PRIVACY ACT NOT NOT PAGE 2 BEFORE COMPLETING THIS FORM.	ITOI	ICE A	ND R	ESF	PONDE	NT BU	JRDE	N INI	FOR	MAT	'IO	N										
PART I -	CL	.AIM	ANT'	'S II	DENTI	FYIN	IG IN	FOR	RMA	TIO	N											
NOTE: You can either complete the form online or by hand. form.	If co	omple	ted by	/ har	nd, print	the in	ıforma	tion r	eque	sted	in i	nk, i	neatl	y, ar	nd le	gibl	ly to	exp	edite	pro	essi	ng the
1. VETERAN'S NAME (First, Middle Initial, Last)																						
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2. VETERAN'S SOCIAL SECURITY NUMBER	3. \	VA FII	_E NU	IMBE	ER (If ap)	plicabl	'e)					VET lonth		N'S		E O ay	F B	RTH	(MA	1/DD Ye		Y)
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5. VETERAN'S SERVICE NUMBER (If applicable)	6.	INSU	RANC	EΡ	OLICY N	IUMBI	ER (If	applica	able)													
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7. CLAIMANT'S NAME (First, Middle Initial, Last) (If other than vete	eran))																				
8. CLAIMANT TYPE:																						
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Apt./Unit Number City																						
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10. TELEPHONE NUMBER (Include Area Code)					11. E	E-MAII	L ADD	RESS	(Opi	ional	<u>-</u> -											
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12. BENEFIT TYPE: PLEASE CHECK ONLY ONE (If you would	d like	to file				types, j	you mi						ques	t fori	n for	eac	h be	nefit	type.)			
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PART II	l - IS	SSU	E(S)	FO	R SUP	PLE	MEN	ITAL	CL	AIN	I											
13. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU notice(s) for a list of adjudicated issues. For each issue, please identify each additional sheet.				lecisi	ion. (You	may at	tach a	ddition	al sh													
Check this box if any issue listed below is being withdrawn from the leg				ess.	× OPT	-IN fr	om S0	OC/SS	ОС					l								
13A. SPECIF	FIC I	SSUE	(S)																	SISIO	N NC	OTICE
right shoulder															00 00/8					04-3	30-2	2020
lower back															90 00/8					02-2	24-2	2021
torn rotator cuff														1	98	9 -	- 0	3 –	07			
, ,																				04-3	30-2	2020
hearing loss															93 oc/s					05-3	30-2	2016
sciatica															00					01 (2010
bowel obstruction															99					∩T−(12-2	2012
														SC	DC/S	SSC	C I	Date	∋:	08-1	3-2	2019
right eye														1	92	0 -	- 0	4 –	02			

PART III - NEW AND RELEVANT EVIDENCE

14. To complete your application, you must submit new and relevant evidence to VA or tell us about new and relevant evidence that VA can assist you in gathering in support of your supplemental claim. If you have records in your possession, please attach the records to this form. Please list your name and file number on each page. If you would like VA to obtain **non-federal records**, please review your decision notification letter for the appropriate authorization forms to complete and submit those forms to VA with this request form.

15. DO YOU WANT VA TO GET FEDERAL RECORDS?

LIST BELOW ANY **VA MEDICAL CENTER(S) (VAMC), VA TREATMENT FACILITIES, OR FEDERAL DEPARTMENTS OR AGENCIES** THAT HAVE NEW AND RELEVANT EVIDENCE THAT YOU ARE AUTHORIZING VA TO OBTAIN IN SUPPORT OF YOUR SUPPLEMENTAL CLAIM: You may attach additional sheets of paper, if necessary. Please list your name and file number on each additional sheet.

15A. NAME AND LOCATION	15B. DATE(S) OF RECORDS
X-Ray VAMC	2020-04-10 2020-01-02 to 2020-02-01 2020-02-20 to 2020-02-22 2019-02-02 to 2020-02-03
Blood Lab VA Facility	2020-02-20 to 2020-02-22 2020-02-02 to 2020-02-07
Doctor's Notes VAMC	2020-04-10

PART IV - 5103 NOTICE ACKNOWLEDGMENT (This section applies to Compensation benefit claims only)

NOTE: If your decision was issued within the past year, this section can be skipped.

16. I CERTIFY THAT I have received or reviewed the notice of evidence necessary to substantiate a claim for Veterans Disability Compensation and related Compensation benefits as provided at www.va.gov/disability/how-to-file-claim/evidence-needed.

X YES

NO (If "NO" is checked, VA will send the 5103 notice to you via mail.)

PART V - CERTIFICATION AND SIGNATURE

NOTE: This section is MANDATORY and completion is required to process your claim, any omission may delay claim processing time.

VA AUTHORIZED REPRESENTATIVES ONLY: I certify that the claimant has authorized the undersigned representative to file this supplemental 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.

17A. SIGNATURE OF VETERAN OR CLAIMANT OR VA AUTHORIZED REPRESENTATIVE (Sign in ink)

17B. DATE SIGNED

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02/03/2021

17C. NAME OF VA AUTHORIZED REPRESENTATIVE (Please Print)

Jäñe ø Doé

ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

18. 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.

18A. SIGNATURE OF ALTERNATE SIGNER (Sign in ink)

18B. DATE SIGNED

18C. NAME OF ALTERNATE SIGNER (Please Print)

PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

VA FORM 20-0995, APR 2021 Page 4

Veteran Email:

Additional Issues

A. Specific Issue(s)	B. Date of Decision	C. SOC/SSOC Date					
left index finger	2018-08-17	03-20-2021					
spinal compression	2013-09-11	08-24-2020					

Additional Evidence Names and Locations

A. Name and Location	B. Date(s) of Records
CT scan VA Medical Facility	2020-07-19, 2018-03-06 to 2019-02- 12
Lab work VAMC	2018-03-06, 2018-01-15
Veteran indicated they will send evidence documents to VA.	