OMB Control No. 2900-0886 Respondent Burden: 15 minutes Expiration Date: 05/31/2027

VA U.S. Department of Veterans Affairs	VA DATE STAMP (DO NOT WRITE IN THIS SPACE)			
DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM				
<b>IMPORTANT</b> : Please read the Privacy Act and Respondent Burden information on page 3 before completing the form. Use this form to submit a claim if you disagree with a decision you received. For more information you can contact us online through Ask VA: <a href="https://ask.va.gov/">https://ask.va.gov/</a> or call us toll-free at 1-800-698-2411 (TTY:711). If you prefer you may complete and submit the form online <a href="https://ask.va.gov/">by using the addresses and weblinks listed in the Instructions, Page 1 or 2.</a>				
BENEFIT TYPE (PLEASE CHECK ONLY ONE BOX)     Note: If you would like to file for multiple benefit types, you must complete a separate VA Form 20-0995 for each benefit type.				
	FIDUCIARY			
EDUCATION LOAN GUARANTY	LIFE INSURANCE			
VETERAN READINESS AND EMPLOYMENT NATIONAL CEMETERY ADMINISTRATION				
VETERANS HEALTH ADMINISTRATION ( <b>NOTE</b> : If checked, specify in the space provided below, which benefit type you are claiming for VHA. (e.g., Travel/Mileage Reimbursement, Medical Treatment Reimbursement, Health Care Eligibility, Clothing Allowance, etc.)				
SECTION I: VETERAN'S IDENTIFICATION INFORMATION				
NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable checkbox to help expedite processing of the form.				
2. VETERAN'S NAME (First, Middle Initial, Last)				
WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW				
3. SOCIAL SECURITY NUMBER 4. VA FILE NUMBER (If applicable) 5. DATE OF BIRTI	H (MM/DD/YYYY)			
1 2 3 - 4 5 - 6 7 8 9 9 8 7 6 5 4 3 2 1 1 2 - 3	1 - 1 9 6 9			
6. SERVICE NUMBER (If applicable) 7. VA INSURANCE POLICY NUMBER (If applicable)				
8 7 6 5 4 3 2 1 0 9 8 7 6 5 4 3 2 1 1 2 3 4	5 6 7 8 9			
8. MAILING ADDRESS (Number, street or rural route, P.O. Box, City, State, ZIP Code and Country)  No. &				
Street	<u> МИММИМИМИМ МИМИМИМИМ</u>			
Apt./Unit Number City WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW				
State/Province N Y Country W W ZIP Code/Postal Code WWWWW -				
9. TELEPHONE NUMBER (Optional) (Include Area Code) 10. E-MAIL ADDRESS (Optional)	r veteran email			
Enter International Phone Number (If applicable)				
SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION (Complete this section ONLY IF the claimant is NOT the veteran)				
11. CLAIMANT'S NAME (First, Middle Initial, Last) (If <b>other</b> than veteran)				
мимимимимимимимимимимимимимимимимимими	WWWWWWWWWWWWW			
12. SOCIAL SECURITY NUMBER 13. VA FILE NUMBER (If applicable)				
14. DATE OF BIRTH (MM/DD/YYYY)  15. VA INSURANCE POLICY NUMBER (If applicable)				
16. RELATIONSHIP TO VETERAN (Check one)  ☐ SPOUSE ☐ CHILD ☐ FIDUCIARY ☐ PARENT ☒ OTHER (Specify) ыпытытыгылыгылыгылыгылыгыныгы байын байы				
SPOUSE CHILD FIDUCIARY PARENT NOTHER (Specify) WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW				
No. &	<u> </u>			
Street WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW				
State/Descriptor	www.www.wwwwwww			
19. TELEDHONE NUMBER (Optional) (Include Area Code)				
19. E-MAIL ADDRESS (Optional)  WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW				
Enter International Phone Number (If applicable)	МИМИМИМИМИМИМИМИМИМИМИМИМИМИМ			

20-0995

VA FORM MAY 2024

SECTION III: HOMELESS INFORMATION				
<b>IMPORTANT</b> : The following questions (Items 20A through 20D) should <b>ONLY</b> 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.				
20A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?	20B. WHICH OF THESE STATEMEN SITUATION? (Select all that app	ITS BEST DESCRIBES YOUR LIVING		
YES (If "Yes," complete Items 20B through 20D regarding your living situation)	I LIVE OR SLEEP IN A PLACE	THAT IS NOT MEANT FOR REGULAR bandoned building, bus station, train station,		
	I LIVE IN A SHELTER (e.g., a l stays)	notel or motel that is meant for temporary		
	I AM STAYING WITH A FRIEN UNABLE TO OWN A HOME R	D OR FAMILY MEMBER, BECAUSE I AM		
		L HAVE TO LEAVE A FACILITY, LIKE A		
	IN THE NEXT 30 DAYS, I WILI  Note: This selection includes a space that you own, rent, or liv	L LOSE MY HOME ny house, apartment, trailer, or other living e in without paying rent, any hotels or orary stays, or a living space that you share		
	NONE OF THESE SITUATION	IS APPLY TO ME		
	you feel comfortable sharing more at	nave other housing risks not listed here. If bout your situation, you can check `other' r you can check `other' and not include any only to prioritize your request.		
	OTHER (Specify)			
20C. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)	20D. POINT OF CONTACT TELEPH	ONE NUMBER (Include Area Code)		
		-		
	Enter International Phone Number (If applicable)			
SECTION IV: ISSUE(S) FOR SU	JPPLEMENTAL CLAIM			
21. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU WOULD LIKE VA TO REVIEW AS PART OF YOUR <b>SUPPLEMENTAL CLAIM</b> ( <b>Note</b> : Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's decision.)  If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in Item 21A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.				
21A. SPECIFIC ISSUE(S)		21B. DATE OF VA DECISION NOTICE		
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имимимимимимимимимимимимимимимимимимим		0 1 - 0 6 - 1 9 0 0 SOC/SSOC Date: 02-24-2021		
$\overline{\mathbf{w}}$		0 3 - 0 7 - 1 9 8 9 SOC/SSOC Date: 04-30-2020		
ИМИМИМИМИМИМИМИМИМИМИМИМИМИМИМИМИМИМИМ		1 0 - 2 0 - 1 9 3 0 SOC/SSOC Date: 05-30-2016		
IWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW		0 1 - 1 9 - 2 0 0 7 SOC/SSOC Date: 01-02-2012		
IMWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	МММММММММММММММММ	1 2 - 2 9 - 1 9 9 9 SOC/SSOC Date: 08-13-2019		
имимимимимимимимимимимимимимимимимимим	МММММММММММММММММ	0 4 - 0 2 - 1 9 2 0 SOC/SSOC Date: 11-19-2019		
им	TATTATTATTATTATTATTATTATTATTATTATTATTAT	l		
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Page 5 VA FORM 20-0995, MAY 2024

SECTION V: NEW AND RELEVANT EVIDENCE				
IMPORTANT: 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, attach the records to this form. List your name and file number on each page. If you would like VA to obtain non-Federal records, review your decision notification letter or read the instructions for this section on Page 3 that lists the appropriate forms to complete and submit those forms to VA with this request form. Note: Unless your supplemental claim is based on a change in law, you'll need to submit supporting evidence that's new and relevant for your application to be complete. You can also identify evidence you'd like us to gather for you.				
22A. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that	t apply)			
PRIVATE HEALTH CARE PROVIDER (including non-Federal records)				
☐ VA VET CENTER				
COMMUNITY CARE (Paid for by VA)				
VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPA	ATIENT CLINICS (CBOC)			
DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)				
OTHER (Specify):				
Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your <b>private provider</b> , (excluding community care (paid for by VA)) or VA Vet Center health records, VA requires your consent by completing VA Forms 21-4142, Authorization to Disclose Information to VA, and 21-4142a, General Release for Medical Provider Information to VA. VA forms are available at <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a> .				
Note: If treatment began from 2005 to present,	you do not need to provide in Item 22C th	e date(s) of treatment.		
22B. NAME AND LOCATION OF THE TREATMENT FACILITY	22C. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY)	22D. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT		
мимимимимимимимимимимимимимимимимимими	04-2020 01-2020 to 02-2020 02-2020 to 02-2020 02-2019 to 02-2020	Don't have date		
иммимимимимимимимимимимимимимимимимими	02-2020 to 02-2020 02-2020 to 02-2020	Don't have date		
WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	04-2020	Don't have date		
<u>ММММММММММММММММММММММММММММММММММММ</u>				
SECTION VI: 5103 (This section applies to Compensati Note: If we issued your decis	sion within the past year, skip to Se	ction VII		
SECTION VI: 5103 (This section applies to Compensati	on, Pension, DIC, and Accrued ben sion within the past year, skip to Se	ction VII		
SECTION VI: 5103 (This section applies to Compensati Note: If we issued your decis	on, Pension, DIC, and Accrued ben sion within the past year, skip to Se IM, VISIT ONE OF THESE PAGES ON www.va.	ction VII gov.		
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SECTION VI: 5103 (This section applies to Compensation Note: If we issued your decise 23. FOR SPECIFIC EVIDENCE YOU NEED TO PROVIDE WITH YOUR CLA • Evidence to support a claim for Veterans Disability Compensation and re	on, Pension, DIC, and Accrued bension within the past year, skip to Se IM, VISIT ONE OF THESE PAGES ON <a href="https://www.va.gov/resources/evidence-to-support">www.va.gov/resources/evidence-to-support</a>	gov. v/disability/how-to-file-claim/evidence-needed/.		
SECTION VI: 5103 (This section applies to Compensation Note: If we issued your decise 23. FOR SPECIFIC EVIDENCE YOU NEED TO PROVIDE WITH YOUR CLA  • Evidence to support a claim for Veterans Disability Compensation and received to support a claim for VA pension, DIC, or accrued benefits: https://doi.or.	on, Pension, DIC, and Accrued bension within the past year, skip to Se IM, VISIT ONE OF THESE PAGES ON <a href="https://www.va.go">www.va.go</a> elated Compensation benefits: <a href="https://www.va.gov/resources/evidence-to-support">https://www.va.gov/resources/evidence-to-support</a> ELATES TO MY CLAIM.	gov. v/disability/how-to-file-claim/evidence-needed/.		
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VA FORM 20-0995, MAY 2024 Page 6

SECTION VIII: CERTIFICATION AND SIGNATURE				
I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.				
25A.VETERAN/CLAIMANT'S SIGNATURE See attached page for signature of veteran claimant o	25B. DATE SIGNED (MM/DD/YYYY)			
	0 2 - 0 3 - 2 0 2 1			
SECTION IX: WITNESSES TO SIGNATURE  (Note: Only use this section if the veteran/claimant used an "X" in Item 25A)				
26A. SIGNATURE OF THE FIRST WITNESS	26B. PRINTED NAME AND ADDRESS OF FIRST WITNESS			
	Name:			
	Address:			
27A. SIGNATURE OF THE SECOND WITNESS	27B. PRINTED NAME AND ADDRESS OF SECOND WITNESS			
	Name:			
	Address:			
SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGN	ATURE (Note: Required only if Item 25A is blank.)			
NOTE 1: An alternate signer signature will not be accepted unless a valid VA Form				
request.				
NOTE 2: For insurance appeals, either VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, VA Form 21-22A, Appointment of Individual as Claimant's Representative, OR VA Form 21P-555, Certificate of Legal Capacity to Receive and Disburse Benefits and Fee Authorization, needs to be of record to allow an alternate signer to sign on behalf of the claimant.				
I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; <b>OR</b> , an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; <b>OR</b> , a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; <b>OR</b> , a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; <b>AND</b> , that the claimant is under the age of 18; <b>OR</b> , 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; <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 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.				
28A. ALTERNATE SIGNER'S SIGNATURE	28B. DATE SIGNED (MM/DD/YYYY)			
SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE				
(Note: This section does not apply to insurance claims)  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, or VA Form 21-22a, indicating the appropriate POA is of record with VA.				
29A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE	29B. DATE SIGNED (MM/DD/YYYY)			
29C. ACCREDITATION NUMBER	29D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known)			
PENALTY: The law provides severe penalties which include fine or impriso	nment, or both, for the willful submission of any statement or			

VA FORM 20-0995, MAY 2024 Page 7

evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

## **Veteran Email:**

## **Additional Evidence Names and Locations**

A. Name and Location	B. Date(s) of Records
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	07-2020, 03-2018 to 02-2019
WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	03-2018, 01-2018
Veteran indicated they will send evidence documents to VA.	

## Signature of veteran, claimant, or representative:

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