



DEPARTMENT OF VETERANS AFFAIRS

July 14, 2025

JAMES FREDERICK LIVINGSTON
1273 OLD TAMAH RD
IRMO SC 29063

In reply, refer to:
377/KJ
JAMES LIVINGSTON

IMPORTANT -- reply needed within 30 days

Dear Mr. JAMES FREDERICK LIVINGSTON:

We are working on your claim.

What Do We Still Need From You?

We need additional evidence from you. *Please put your VA file number on the first page of every document you send us.*

- You may be entitled to compensation at the 100 percent rate if you are unable to secure and follow a substantially gainful occupation because of your service-connected disabilities. If you believe you qualify, complete, sign, and return the enclosed VA Form 21-8940, *Veterans Application for Increased Compensation Based on Unemployability*.

Please also include, if possible, VA Form 21-4192, *Request for Employment Information in Connection with Claim for Disability Benefit*, completed by each of the employers identified on VA Form 21-8940.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the VA.gov website. Just visit www.VA.gov to register. Please also refer to the 'What is VA.gov?' section of this letter for more information.

You can also mail what we need to the appropriate address listed on the attached *Where to Send Your Correspondence* chart.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. **If we do not hear from you, we may make a decision on your claim after 30 days.**



What is VA.gov?

VA.gov provides electronic resources in a self-service environment to Servicemembers, Veterans, and their families. Use of these resources often helps us serve you faster! Through the VA.gov website you can:

- Submit claims for benefits and/or upload documents directly to the VA
- Request to add or change your dependents
- Update your contact and direct deposit information and view payment history
- Track the status of your claim or appeal
- Obtain verification of military service, civil service preference, or VA benefits
- And much more!

Enrolling in VA.gov is easy. Just visit www.va.gov for more information. If you submit a claim in the future, consider filing through VA.gov. Filing electronically, especially if you participate in our fully developed claim program, may result in a faster decision than if you submit your claim through the mail.

Where to Send Written Records

Please mail all written responses to the **Compensation Benefits** address listed on the attached Where to Send Your Correspondence chart.

If You Have Questions or Need Assistance

If you have any questions or need assistance with this claim, you may contact us by telephone, e-mail, or letter.

| If you | Here is what to do. |
|------------------|---|
| Telephone | Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711. |
| Use the Internet | Send electronic inquiries through the Internet at https://www.va.gov/contact-us/ . |
| Write | VA now uses a centralized mail system. For all written communications, put your full name and VA file number on the letter. Please mail all written correspondence to the appropriate address listed on the attached <i>Where to Send Your Correspondence</i> . |

In all cases, be sure to refer to VA file number 624011213.

If you are looking for general information about benefits and eligibility, you should visit our web site at <https://www.va.gov> or contact us, or explore our FAQs and other resources at



<https://www.va.gov/contact-us/>.

We sent a copy of this letter to VETERANS OF FOREIGN WARS OF THE US, who you have appointed as your representative(s). If you have questions or need assistance, you can also contact your representative.

We look forward to resolving your claim in a fair and timely manner.

Respectfully,

Regional Office Director

Enclosure(s): Where to Send Correspondence
 VA Form 21-8940
 VA Form 21-4192

cc: VETERANS OF FOREIGN WARS OF THE US
 POA National Organization



Where to Send Your Correspondence

Documents may be submitted by mail, in person at a VA regional office or electronically. However, VA recommends submitting correspondence electronically as this is the fastest method of receipt.

VA provides several tools to assist in electronic submission. To learn more about how to submit documents and claims electronically, visit www.va.gov/disability/upload-supporting-evidence. You can also go directly to access.va.gov to digitally upload any correspondence using QuickSubmit.

By visiting www.va.gov you can also check your claim status and learn about other VA benefits.

If you need assistance, you can find a local, accredited representative at <https://www.benefits.va.gov/vso/>

If you prefer to mail your correspondence, please use the related mailing address below:

| | |
|---|---|
| Compensation Benefits Department of Veterans Affairs Compensation Intake Center P.O. Box 4444 Janesville, WI 53547 Toll Free Phone: 1-800-827-1000 Toll Free Fax: (844) 531-7818 | Pension & Survivors Benefits Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, WI 53547 Toll Free Phone: 1-800-827-1000 Toll Free Fax: (844) 655-1604 |
| Board of Veterans' Appeals Department of Veterans Affairs Board of Veterans' Appeals P.O. Box 27063 Washington, DC 20038 Toll Free Fax: (844) 678-8979 | Fiduciary Department of Veterans Affairs Fiduciary Intake Center P.O. Box 5211 Janesville, WI 53547 Toll Free Phone: 1-800-827-1000 Toll Free Fax: (888) 581-6826 |

These addresses serve **all United States and foreign locations.**

Veterans Crisis Line:
Dial 988 then Press 1

You can also send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. For more information, visit www.veteranscrisisline.net

SECTION III - EMPLOYMENT STATEMENT (Continued)

18. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED
 (Include any military duty including inactive duty for training) (Note: For additional employment information use Section V, Remarks)

| NAME AND ADDRESS OF EMPLOYER (OR UNIT) | | TYPE OF WORK | HOURS PER WEEK |
|---|---|--|--|
| | | | <input type="text"/> <input type="text"/> <input type="text"/> |
| | | | |
| D. DATES OF EMPLOYMENT | | TIME LOST FROM ILLNESS | HIGHEST GROSS EARNINGS PER MONTH |
| FROM | TO | | |
| <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> | \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> |
| NAME AND ADDRESS OF EMPLOYER (OR UNIT) | | TYPE OF WORK | HOURS PER WEEK |
| | | | <input type="text"/> <input type="text"/> <input type="text"/> |
| | | | |
| DATES OF EMPLOYMENT | | TIME LOST FROM ILLNESS | HIGHEST GROSS EARNINGS PER MONTH |
| FROM | TO | | |
| <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> | \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> |
| NAME AND ADDRESS OF EMPLOYER (OR UNIT) | | TYPE OF WORK | HOURS PER WEEK |
| | | | <input type="text"/> <input type="text"/> <input type="text"/> |
| | | | |
| DATES OF EMPLOYMENT | | TIME LOST FROM ILLNESS | HIGHEST GROSS EARNINGS PER MONTH |
| FROM | TO | | |
| <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> | \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> |
| NAME AND ADDRESS OF EMPLOYER (OR UNIT) | | TYPE OF WORK | HOURS PER WEEK |
| | | | <input type="text"/> <input type="text"/> <input type="text"/> |
| | | | |
| DATES OF EMPLOYMENT | | TIME LOST FROM ILLNESS | HIGHEST GROSS EARNINGS PER MONTH |
| FROM | TO | | |
| <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> | \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> |
| NAME AND ADDRESS OF EMPLOYER (OR UNIT) | | TYPE OF WORK | HOURS PER WEEK |
| | | | <input type="text"/> <input type="text"/> <input type="text"/> |
| | | | |
| DATES OF EMPLOYMENT | | TIME LOST FROM ILLNESS | HIGHEST GROSS EARNINGS PER MONTH |
| FROM | TO | | |
| <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> | \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> |

| SECTION III - EMPLOYMENT STATEMENT (Continued) | | |
|---|---|---|
| 19. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NATIONAL GUARD, DOES YOUR SERVICE CONNECTED DISABILITY PREVENT YOU FROM PERFORMING YOUR MILITARY DUTIES? <input type="radio"/> YES <input type="radio"/> NO | | |
| 20A. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS \$, | 20B. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME \$, | |
| 21A. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY? <input type="radio"/> YES <input type="radio"/> NO <i>(If "Yes," explain in Item 26, "Remarks")</i> | 21B. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS? <input type="radio"/> YES <input type="radio"/> NO | 21C. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS? <input type="radio"/> YES <input type="radio"/> NO |
| 22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BECAME TOO DISABLED TO WORK? <input type="radio"/> YES <input type="radio"/> NO <i>(If "Yes," complete Items 22A, 22B, and 22C)</i> | | |
| 22A. | 22B. | 22C. |
| NAME AND ADDRESS OF EMPLOYER | TYPE OF WORK | DATE APPLIED (MM/DD/YYYY) |
| | | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> |
| | | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> |
| | | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> |
| SECTION IV - SCHOOLING AND OTHER TRAINING | | |
| 23. EDUCATION <i>(Check highest year completed)</i> GRADE SCHOOL <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 HIGH SCHOOL <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12 COLLEGE <input type="radio"/> Fresh <input type="radio"/> Soph <input type="radio"/> Jr <input type="radio"/> Sr | | |
| 24A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK? <input type="radio"/> YES <input type="radio"/> NO <i>(If "Yes," complete Items 24B and 24C)</i> | | |
| 24B. TYPE OF EDUCATION OR TRAINING | 24C. DATES OF TRAINING | |
| | BEGINNING (MM/DD/YYYY) | COMPLETION (MM/DD/YYYY) |
| | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> |
| 25A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK? <input type="radio"/> YES <input type="radio"/> NO <i>(If "Yes," complete Items 25B and 25C)</i> | | |
| 25B. TYPE OF EDUCATION OR TRAINING | 25C. DATES OF TRAINING | |
| | BEGINNING (MM/DD/YYYY) | COMPLETION (MM/DD/YYYY) |
| | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> - - </div> |

SECTION V - REMARKS

NOTE: This section can be used for any additional information, if needed.

26. REMARKS

SECTION VI - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the 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 except protected health information, and I waive any privilege which makes the information confidential.

CERTIFICATION OF STATEMENTS: I CERTIFY THAT as a result of my service-connected disabilities, I am unable to secure or follow *any* substantially gainful occupation and that the statements in this application are true and complete to the best of my knowledge and belief. I understand that these statements will be considered in determining my eligibility for VA benefits based on unemployability because of service-connected disability.

I UNDERSTAND THAT IF I AM GRANTED SERVICE-CONNECTED TOTAL DISABILITY BENEFITS BASED ON MY UNEMPLOYABILITY, I MUST IMMEDIATELY INFORM VA IF I RETURN TO WORK. I ALSO UNDERSTAND THAT TOTAL DISABILITY BENEFITS PAID TO ME AFTER I BEGIN WORK MAY BE CONSIDERED AN OVERPAYMENT REQUIRING REPAYMENT TO VA.

27. SIGNATURE OF CLAIMANT *(Required)*

28. DATE SIGNED (MM/DD/YYYY)

| | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

WITNESSES NEEDED IF "X" MARK IS MADE (Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known and the signature and address of such witnesses must be shown in Items 29A & 29B and 30A & 30B.

29A. SIGNATURE OF WITNESS *(Sign in ink)*

29B. ADDRESS OF WITNESS

[illegible]

30A. SIGNATURE OF WITNESS (*Sign in ink*)

30B. ADDRESS OF WITNESS

[illegible]

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.

SECTION VII - WHERE TO SEND CORRESPONDENCE

MAIL TO:

**Department of Veterans Affairs
Evidence Intake Center
PO Box 4444
Janesville, WI 53547-4444**

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 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 Veteran Readiness and Employment Records - VA, published in the Federal Register. Your response is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5101(c)(1). VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 maximum benefits provided under the law. 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 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 45 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

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

**REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH CLAIM FOR
DISABILITY BENEFITS**

1. NAME AND ADDRESS OF EMPLOYER OF VETERAN (Complete)

RETURN
TO

2. ADDRESS (Complete)

INSTRUCTIONS: The veteran named in Item 3 has filed a claim for veterans disability benefits and has stated that he/she was recently employed by you. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Sections II, III and IV and return to this office at the address below. Please be sure to sign and date this form in Items 23A and 23B. For free help in completing this form, call VA toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547-4444

SECTION I - 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 circle to help expedite processing of the form.

3. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last)

4. SOCIAL SECURITY NUMBER

5. VA FILE NUMBER (If applicable)

6. DATE OF BIRTH

Month Day Year

SECTION II - EMPLOYMENT INFORMATION (To be completed by employer)

7. BEGINNING DATE OF EMPLOYMENT

Month Day Year

8. ENDING DATE OF EMPLOYMENT

Month Day Year

9. TYPE OF WORK PERFORMED

10. AMOUNT EARNED DURING 12 MONTHS PRECEDING LAST DATE OF
EMPLOYMENT (BEFORE DEDUCTIONS)

\$, .

11. TIME LOST DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT
(DUE TO DISABILITY)

12A. NUMBER OF HOURS WORKED (Daily)

12B. NUMBER OF HOURS WORKED (Weekly)

13. CONCESSIONS (if any) MADE TO EMPLOYEE BY REASON OF AGE OR DISABILITY

14A. IF VETERAN IS NOT WORKING, STATE THE REASON FOR TERMINATION OF EMPLOYMENT:
(IF RETIRED ON DISABILITY, PLEASE SPECIFY)

14B. DATE LAST WORKED

Month Day Year

15A. DATE OF LAST PAYMENT

Month Day Year

15B. GROSS AMOUNT
OF LAST PAYMENT

\$

16A. WAS LUMP SUM
PAYMENT MADE?

☐ YES ☐ NO

GROSS AMOUNT PAID

\$

16B. DATE PAID

Month Day Year

SECTION III - RESERVE OR NATIONAL GUARD DUTY STATUS

(Only complete if claimant is currently serving in the Reserve or National Guard)

17A. WHAT IS THE VETERAN'S CURRENT DUTY STATUS?

17B. DOES THE VETERAN HAVE ANY DISABILITIES THAT PREVENT THEM FROM PERFORMING THEIR MILITARY DUTIES?

☐ YES ☐ NO

SECTION IV - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS *(To be completed by employer)*

18. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS?

☐ YES ☐ NO *(If "Yes," complete Items 19 through 21C)*

19. TYPE OF BENEFIT

20. GROSS MONTHLY AMOUNT OF BENEFIT

\$, .

21A. DATE BENEFIT BEGAN

Month Day Year

21B. DATE FIRST PAYMENT ISSUED

Month Day Year

21C. DATE BENEFIT WILL STOP *(If known)*

Month Day Year

22. REMARKS

I CERTIFY THAT the statements made in this form are true and complete to the best of my knowledge and belief.23A. SIGNATURE OF EMPLOYER OR SUPERVISOR *(Required)*23B. DATE SIGNED *(MM/DD/YYYY)***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 fraudulent acceptance of any payment to which you are not entitled.**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 Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. The requested information is considered relevant and necessary to determine maximum benefits under the law. 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:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0065, and it expires 08/31/2027. Public reporting burden for this collection of information is estimated to average 15 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov Please refer to OMB Control No. 2900-0065 in any correspondence. Do not send your completed VA Form 21-4192 to this email address.