OMB Approved No. 2900-0061
Respondent Burden: 1 hour
Expiration Date: 3/31/2018

Department of Veterans Affairs

REQUEST FOR AND RECEIPT OF SUPPLIES

(Chapter 31 - Vocational Rehabilitation)

PRIVACYACTINFORMATION:Nobenefitsmaybepaidunlessacompletedapplicationformhasbeenreceived(38C.F.R.21.212and21.224).Theinformation requestedonthisformisnecessarytodeterminyourentitlementtothebenefitforwhichyouhaveapplied. Theresponsesyousubmitareconsideredconfidential,(38 U.S.C.5701),formerly3301.TheymaybedisclosedoutsidetheDepartmentofVeteransAffairs(VA)onlyifthedisclosureisauthorizedundertherivacyAct, includingtheroutineusesidentifiedintheVAsystemofrecords,58VA21/22/28Compensation,Pension,EducationandVocationalRehabilitationRecords-VA, published in the Federal Register.The requested information is considered relevant and necessary to determine maximum benefits under the law.Information submittedis subject to verification through computer matching programs with other agencies.

RESPONDENTBURDEN:VAmaynotconductorsponsor,andrespondentisnotrequiredtorespondtothiscollectionofinformationunlessitdisplaysavalidOMB ControlNumber.Publicreportingburdenforthiscollectionofinformationisestimatedtoaverageonehourperresponse,includingthetimeforreviewinginstructions,searchingexistingdatasources,gatheringandmaintainingthedataneeded,andcompletingandreviewingthecollectionofinformation.Ifyouhavecommentsregarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

SECTION A: TO BE SUBMITTED TO THE DEPARTMENT OF VETERANS AFFAIRS

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	REHABILITATION GOAL	VA FILE NUMBER
Mr. Roy White	Computer Systems Technical	Last 4 digits: 9090 / 00

ADDRESS TO WHICH SUPPLIES MAY BE DELIVERED TO VETERAN *(Number and Street or Rural Route, City or P.O., State and Zip Code)*

5530 Amb Caffery Pkwy Apt 7102

INSTRUCTIONS

REHABILITATION PROVIDER

A. The Department of Veterans Affairs (VA) may furnish supplies to the veteran named above, who is entering into or is already taking part in a VA rehabilitation, independent living, or employment assistance program, if all of the following conditions are met:

1. The facility/employer requires all persons being trained for or employed in the same occupational or independent living goal to personally possess the same books, tools, and other supplies; and
2. The veteran does not already possess the required items; and
3. The VA case manager has determined the supplies may be provided in accordance with limitations and restrictions found in 38 U.S.C. and applicable federal regulations.

B. VA will not furnish tools or other supplies which commonly are on hand for use of all trainees or employees or which the veteran already owns.

REHABILITATION PROVIDER (Continued)

C. If items are required under the conditions stated in A, and are not being requested merely because the veteran desires them, request these supplies by completing the section immediately following these instructions.You may continue to list required items on another VA For 28-1905m.Additional pages may be used if necessary.

D. In Section B, please sign and complete the Request and Certification of Establishment section.

VETERAN

A.In Section B, the veteran's signature acknowledges that he or she does not already possess the required items.

B.The veteran must complete Section C of this form and return it to the VA case manager to report receipt of items.

SECTION B: REQUEST AND CERTIFICATION OF FACILITY OR ESTABLISHMENT

TYPE OF PROGRAM

☐ On-Job Training ☒ Educational or Vocational Training ☐ Independent Living ☐ Employment ☐ Other *(Specify)*

('1)	ITEM NO. *(If applicable)*	NAME OF ARTICLE AND DESCRIPTION *(Catalog identification, size, etc.)*	QUANTITY *(Set, pair, etc.)*	ESTIMATED COST
☐		Laptop w/extended warranty (see attachment)		
☐		Printer w/extended warranty		
☐		Lo-jack		
☐		Antivirus software		
☐		Microsoft office		
☐		accessories		
☐				

SIGNATURE AND TITLE OF OFFICIAL | DATE

NAME AND ADDRESS OF FACILITY OR ESTABLISHMENT *(Number and street or rural route, city or P.O., state and Zip Code)*

SIGNATURE OF VETERAN *(Please sign in ink.)*	DATE	SIGNATURE OF CASE MANAGER *(Please sign in ink.)*	DATE
R Smith White	06/2/2020		