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)

# 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 <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a>.

the appropriate intake center address shown on Page 4. VA forms are available at <u>www.va.gov/vaforms</u> .				
SECTION I: VETERAN'S INFORMA	ATION			
NOTE: You can either complete the form online or by hand. If completed by hand, print the information requ	uested in ink, neatly, and legibly to expedite processing of the form.			
1. VETERAN'S NAME (First, Middle Initial, Last)				
2. VETERAN'S SOCIAL SECURITY NUMBER (SSN) 3. VA FILE NUMBER	4. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)			
	Month Day Year			
5. VETERAN'S SERVICE NUMBER (If applicable)  6. INSURANCE NUMBER(S) (If applicable)	e) (Include letter prefix)			
7. VETERAN'S TELEPHONE NUMBER (Include Area Code) 8. VETERAN'S EMAIL ADDRESS (Option	nal)			
SECTION II: CLAIMANT'S INFORMATION (If o	ther than veteran)			
9. CLAIMANT'S NAME (First, Middle Initial, Last)				
10. CLAIMANT'S MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and C	Country)			
No. & Street				
Apt./Unit Number City				
State/Province Country ZIP Code/Postal Code —				
11. CLAIMANT'S TELEPHONE NUMBER (Include Area Code) 12. CLAIMANT'S EMAIL ADDRESS (Optional) 13. RELATIONSHIP TO VETERAN				
Th. CLAIMANTS TELEPHONE NOWBER (Include Area Code)				
SECTION III: SERVICE ORGANIZATION INFORMATION				
14. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on Page 3 before selecting organization)				
15A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE	15B. JOB TITLE OF PERSON NAMED IN ITEM 15A			
ORGANIZATION NAMED IN ITEM 14 (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)				
16. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 14	17. DATE OF THIS APPOINTMENT (MM/DD/YYYY)			
	1			

VETERAN'S SOCIAL SECURITY NUMBER	-	-			
SECTION	ON IV: AU	THORIZ	ATION INF	ORMATION	
box below I authorize VA to disclose to the service org	18. 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.				rds that may be in my file relating to
I <b>authorize</b> the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 14 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 14, either by explicit revocation or the appointment of another representative.					
19. LIMITATION OF CONSENT- I authorize disclosure o	f records rela	ated to tre	eatment for a	Il conditions listed in	Item 18 except:
DRUG ABUSE	INFECT	ION WITI	H THE HUM	AN IMMUNODEFICI	ENCY VIRUS (HIV)
ALCOHOLISM OR ALCOHOL ABUSE	SICKLE	CELL AN	IEMIA		
20. AUTHORIZATION TO CHANGE CLAIMANT'S ADD act on my behalf to change my address in my VA record		checking t	he box below	v, I authorize the org	anization named in Item 14 to
I <b>authorize</b> any official representative of the organization named in Item 14 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 15A is not my appointed fiduciary.					
I, the claimant named in Items 1 or 9, hereby appoint the service organization named in Item 14 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 18 and 19), 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 20.608. 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					
21A. SIGNATURE OF VETERAN OR CLAIMANT (Do Not Print)			21B. DATE SIGNED		
22A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 15A (Do Not Print)			22B. DATE SIGNED		
<b>NOTE</b> : 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.					
	DATE SENT		ACKNOW (Date)	/LEDGED	REVOKED (Reason and date)
VA USE					

**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.

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G FILE

INSURANCE FILE

### 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 North Dakota Tennessee Minnesota 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 Rhode Island West Virginia New Jersey Florida New Mexico South Carolina Wisconsin Maryland Georgia Massachusetts New York South Dakota Wyoming Guam North Carolina Michigan

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 <a href="https://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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### 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

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			

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