Intake Form

\*Required Fields

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| **Contact Information** |
| **\*Full Name:** |
| **\*Phone:** |
| **\*Address:** |
| **E-mail:** |
| **Military Information** |
| **\*Branch of Service:** |
| **\*Military Occupational Specialty (MOS)** |
| **\*Date of Entry:** |
| **\*Date of Separation:** |
| **\*Were You Deployed to a Combat Zone?** |
| **\*Do You Have a Copy of Your DD-214?** |
| **\*Type of Discharge:** |
| **\*Reason for Discharge:** |
| **\*Do You Have Any of Your Military Records?** |

**General Information**

**What Type of Assistance Do You Seek?**

(Please check one and complete the applicable section.)

* Service-Connection Disability Claim/Appeal
* Discharge Upgrade.
* Record Correction (GA only)
* Dependency and Indemnity Compensation (DIC)
* Will, Power of Attorney (POA), Healthcare Directive

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| **Service-Connection Disability Claim/Appeal**  **(if applicable)** | | |
| Total VA Disability Rating (if applicable): | | |
| List the Disabilities with rating percentages awarded by VA (if applicable): | | |
| Where is your claim currently? (Please check one.)   * No claim has been filed * Notice of Disagreement (NOD) Filed * Appeal before Board of Veterans Appeals (BVA) | | |
| When was the original claim filed? | | |
| If claim was denied, when did you receive the Rating Decision?   * What was the reason(s) for the denial? | | |
| If you filed a NOD, what date was it filed? (NODs must be filed within one year of the date of the Rating Decision)? | | |
| Do you have a current diagnosed disability for each of your claimed disabilities? If yes, is it from the VA or a private physician? | | |
| Do you have copies of your medical records regarding the condition? | | |
| What happened in service to make this a service-connection disability? | | |
| Did you go to sick call or the hospital for this claimed disability?  If hospitalized, please provide the date and location of hospitalization. | | |
| Do you have a medical opinion linking the current diagnosis to what happened in service? If not, can you get one from your doctor(s)? | | |
| If you are making a PTSD claim, do you have a PTSD diagnosis from a psychiatrist or psychologist? If yes, please provided information (date) on when you were diagnosed.   * What happened in service to cause or aggravate your PTSD? * If your PTSD is not combat related, do you have any corroborating evidence of the in-service stressor incident (i.e., buddy statements)? * Do you have a medical opinion from a psychiatrist/psychologist linking your PTSD to service? | | |
| **Discharge Upgrade (if applicable)** | | |
| \*Have You Previously Applied for an Upgrade? If so, please provide information on when you applied, the reason(s) why it was denied, and whether you appealed the decision. | | |
| Why do you want a discharge upgrade? | | |
| Was your discharge a court martial? | | |
| Did you take the discharge in lieu of court martial? | | |
| Describe what you have done since separation (i.e., work, school, community service, etc.). | | |
| **\*Mental Health Information** | | |
|  | Have you been diagnosed with any of the following conditions? | Do you have symptoms of any of the following conditions? |
| PTSD |  |  |
| Traumatic Brain Injury (TBI) |  |  |
| Any Other Mental Health Conditions |  |  |
| **Records Correction (GA Only) (if applicable)** | | |
| What charge(s) do you want restricted? | | |
| What happened to the charges (i.e., conviction, dismissed, dropped, etc.)? Please note that if you were convicted of a charge, we are unavailable to assist you. | | |
| What county did the arrest/charge take place? Please provide date of the arrest and identify the arresting agency. | | |
| **Dependency and Indemnity Compensation (DIC)**  **(Surviving spouses/dependent children only)**  (if applicable) | | |
| When did the veteran die? | | |
| How did the veteran die? What is listed as the cause of death on the death certificate? | | |
| Did the veteran have any service-connected disabilities? If yes, what was the rating? | | |
| Are you listed as the surviving spouse on the death certificate? (For surviving spouses only) | | |
| Have you remarried? (For surviving spouses only) | | |
| Are you living with someone of the opposite sex, who is not a family member? | | |

Additional Information

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| Any other comments? |
| How did you hear about the clinic? |