Hugh D. Cox
Attorney at Law
North Carolina Bar Number 6567
Department of Veterans Accreditation Number 8925
2411 B Charles Boulevard; Post Office Box 154
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March 16, 2015

We MUST know the date of your last denial immediately.
Appeals must be filed within 30 to 120 days of denial.
Please keep a DIARY of your medical episodes even if not treated by a medical facility.

[CLIENT FULL NAME]
[ST ADDRESS]
[CITY STATE ZIP]

Dear [MR./MS. LAST]:

Thank you for serving in the military and being a veteran. I need to know the procedural status of your case. Can you let me know by completing the attached forms? I also need certain other information from you.

Thank you for contacting my law office about your VA service-connected disability claim. I will be honored to represent you if possible. If you have not yet applied for VA service-connected disability, I ask that you do so as soon as possible without entering into a contract with me to see if you win your case without an attorney or without owing an attorney fee. You may only retain an attorney after you file your Notice of Disagreement to your first denial of a new or reopened claim for compensation. If your Notice of Disagreement is denied, you can contact me and I will be glad to represent you at that time. If you win your benefits before you have to file a Notice of Disagreement, you would not owe an attorney if the system works fairly – it rarely does.

If you decide to hire me to represent you, I ask that you sign the THREE attached contracts and return them to my office as soon as possible. To make certain that we received the contracts, you should contact my office within one week of mailing or delivering these contracts to insure that we received them. One goes to the VA since they must approve my fee, another goes to you (by email or mail) and I keep one. Until I receive your signed contracts and I sign the same three contracts and give you an original, I do NOT yet represent you. Please help me make certain that I receive all three signed contracts so that I can sign these and give you an original contract. I will then send you a formal letter stating that I represent you.

Please remember that I do not represent you until I sign the contract and send you an original with my signature.

I am very concerned about the time for an appeal. Your appeal must be filed within varying deadlines. Some appeal deadlines are as short as 30 days. That means that I must have a

copy of your last denial *before* 30 days after you receive it. *Please insure that you provide me with a copy of your last denial immediately* so that I know when the deadline for the last day to appeal your case. The VA and the Courts do not accept late appeals except in rare circumstances.

I admit that I am an attorney who relies on clients to fill out my forms. I insist that you fill out the forms that I provide to you and that you return them to my office as soon as possible. Cases are won on written information from the claimant, medical records from a doctor, and legal research from a lawyer. I will also ask you to present forms (I will provide these forms) to your physicians to prove your disability. I find it is best that patient deals with the doctor rather than the attorney being involved. Then we know if the doctor really supports the claimant's disability.

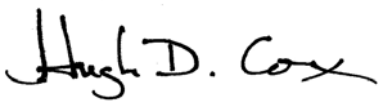
You need to treat our forms as "opportunities" rather than "burdens" If you have severe back problems and you indicate on a form that you can walk a mile with no problem, you probably will not be awarded compensation benefits or increased benefits. Please answer all forms and questions honestly and realistically to show your full physical and mental limitations.

Much of my work involves reading lengthy and complicated medical reports and evaluating evidence to be compiled into a brief or document about your case. I spend much of each day writing briefs or research. I tell my staff NOT to interrupt me with telephone calls. If you need to communicate with me, you must do so through my staff. I will answer your emails to hughcox@hughcox.com with short responses. I often require several days to return phone calls. For me, the choice is to work on cases or talk on the telephone, and I choose working on client cases. I hope you understand.

Please be prepared for a long process of appeal. Currently, the VA service-connected process of determining disability takes years. This extraordinary length of time places a great hardship on disabled people who must survive financially on the resources of family and friends. Lawyers are prohibited by the Rule of Professional Conduct from providing money to clients. Please prepare yourself for this long ordeal.

I look forward to helping you with your case. Please feel free to communicate with me through my staff or by email.

Sincerely,



Hugh D. Cox

UPDATED October 28, 2013
Appeals must be filed within as little as 30 days of denial.
We MUST know the date of your last denial immediately.

Status: [PUBLIC OR PRIVATE ASSISTANCE]

We also need to know if you received unemployment compensation, workers compensation, short or long term disability benefits, insurance plan disability benefits, Social Security benefits, DMV Handicapped sticker, or Federal Employee Retirement System (FERS) benefits after your disability onset date.

Sample email text to be used in email message:

Dear [MR./MS. LAST],
I am honored that you contacted me. I want to represent you in your claim for VA service-connected disability benefits.
My first concern is that we must appeal your case within 30 days of the last denial being mailed to you. Can you provide me with that date? We want to appeal on time.
If you have no claim at the present time and you wish to apply, we can provide you with that application.
You might want to check to see if your short or long term disability insurance plan requires repayment.
Attached to this email is my “kit” that I send potentials clients containing a cover letter with contract, questionnaires, and forms. Until you return my contract and I sign it, I do not represent you.
One thing I always look for in cases like yours is pain clinic treatment – often with psychological care. Chronic pain always causes mental health issues. Medical records win these cases.
Thank you for contacting me.
Many thanks,
Hugh Cox

VETERAN BENEFITS LEGAL REPRESENTATION AND FEE AGREEMENT

This contract and agreement of three pages for Veteran benefits legal services is entered into between the undersigned client, **[CLIENT FULL NAME] ,** hereinafter referred as "Client," and **Hugh D. Cox**, Attorney at Law, 2411 B Charles Boulevard, P. O. Box 154, Greenville, North Carolina 27835-0154, hereinafter referred to as "Attorney." Client and Attorney agree as follows:

1. Legal Services to be Provided: Client retains Attorney to represent Client before the Department of Veterans Affairs Regional Office and/or Board of Veterans' Appeals (BVA) and/or United States Court of Appeals for Veterans Claims (CAVC) for award or increase of award of veteran benefits either by appeal, reconsideration or by renewed claim based on new and material evidence on the issues stated or inferred in that decision of denial or partial award. This statement of benefits includes client's claim for compensation for secondary, inferred, or implied claims for compensation that are pending at any stage before the Department of Veterans Affairs. Client seeks to secure all benefits reasonable stated or inferred in any Department of Veterans Affairs decision that the Client is entitled to receive as of the date of most recent DVA claim. Client understands that pursuit of client's claim may involve motions or remands before the Department of Veterans Affairs (including Regional Office) and/or Board of Veterans' Appeals and/or United States Court of Appeals for Veterans Claims. Attorney is also entitled to a contingency fee as stated below for any claim for benefits by the Veteran giving notice of appeal to a denial of a Board of Veterans' Appeals denial decision which post-dates November 18, 1988 or the date of enactment of the Veteran's Judicial Review Act and/or as provided by Veterans Benefits, Health Care, and Information Technology Act of 2006 where the veteran filed a Notice of Disagreement on or after June 20, 2007.

2. Contingency Fee Agreement:

(a) There shall be no attorney fees except those expenses set forth in paragraphs herein owed by Client to Attorney if there is no recovery of veteran benefits for Client by Attorney unless such Equal Access to Justice Act (EAJA) attorney fees are approved.

(b) Client agrees to pay Attorney (1) a fee contingent upon the outcome of the claims of Client described in paragraph entitled, "Legal Services to be Provided". This contingency fee shall be TWENTY PERCENT (20%) of the gross amount of any past due DVA or VA benefits recovered for veterans and dependents/children whether by judgment, settlement or administrative action, and (2) if there is an award of attorney fees under the Equal Access to Justice Act (EAJA), Attorney shall be entitled to the greater of (1) or (2) in this paragraph above. Client agrees and acknowledges that Attorney fees sought shall be at a rate established by 28 U.S.C. 2412 and the current consumer price index if an EAJA award is pursued. EAJA attorney fees sought and recovered shall be applied to Client's contingency fee owed to Attorney for the same work and the same issue.

3. Client Directs DVA Withholding of Attorney fees or Agrees to pay Attorney Fees into Attorney Trust Account: Client directs that the DVA withhold 20% of past due benefits payable to veteran for attorney fees. Client acknowledges that Client is personally responsible for payment of 20% of past due benefits into Attorney's trust account in the event the Secretary of the Department of Veterans Affairs (DVA) or any of his agencies or agents pays such attorney fees directly to Client. In such event of VA payment of attorney fees to Client, Client shall pay this amount of 20% of past due benefits into Attorney Trust Account within 5 days of receipt of any check containing attorney fees or upon notice of such VA mistake. Upon approval of attorney fees, Attorney will account to Client for Attorney Trust Account transactions. Should Attorney have to litigate to collect attorney fees, Client agrees that all legal State and federal remedies available to Attorney may be utilized. Client agrees to notify Attorney of any payment of new benefits for which Client was represented by Attorney within 5 days by providing a copy of such new benefits check.

4. Expenses Related to Representation: In addition to fees and retainers discussed above, Client agrees, regardless of recovery or no recovery, that Client is responsible for and will pay for all out-of-pocket expenses incurred by Attorney in connection with this agreement. Client agrees that these out of-pocket expenses may include, but are not limited to, medical records, military records, court costs, photocopying at $.20 per copy, postage, messenger and delivery services, retaining of medical and vocational experts and other reasonable expenses deemed necessary by Attorney related to Client's claim.

5. Billing for out-of-pocket Expenses: Client agrees to pay within thirty (30) days for all out-of-pocket expenses prior to Attorney advancing such money upon telephone or written notification of Client by Attorney. Client agrees to go to each of client's medical facilities to request medical records at the request of Attorney prior to Attorney requesting such medical records directly from medical facility. When impractical to give advanced notification of out-of-pocket expenses to Client, Attorney will bill Client for payment of out-of-pocket expenses. Client agrees to promptly pay for such out-of-pocket expenses within thirty (30) days of receipt of the bill

from Attorney. Attorney agrees to give advanced notification to client of all anticipated expenses in excess of $50.00 prior to Attorney advancing such sums.

6. Client's Information to Attorney and Cooperation with Attorney: Client agrees to sign any and all necessary forms in order for Attorney to obtain medical, official file and procedural information on this case. Client agrees to locate and contact witnesses and provide documents requested by Attorney. Client agrees to cooperate with Attorney by meeting with him or by telephone call when requested and to attend required hearings or examinations when scheduled. Client further agrees to keep Attorney advised of current address and telephone number as well as necessary information on someone else who can always contact client. Client agrees that Attorney may designate other persons for outside professional services, outside research assistants, and outside experts for portions of Client's case if, in the judgment of Attorney, that such services are in the best interest of Client and Attorney and that such services are not within the expertise and control of Attorney. Client and Attorney agree that the designation of any such professional services may require that Client be billed for additional out-of-pocket expenses under Paragraph 5. Attorney agrees to notify Client in advance of any expense exceeding fifty dollars ($50.00).

7. Client's Discharge of Attorney: Client may discharge Attorney upon written notice to Attorney except that if the Client discharges the Attorney without securing substitute counsel after the Attorney has entered an appearance in court, the court may require Attorney to continue to represent the Client until substitute counsel enters an appearance and Attorney's appearance in the proceeding is terminated by the court. If Client discharges Attorney without good and adequate cause after the Attorney has fully performed, substantially performed, or contributed in any way to the results finally obtained by the Client, the Client shall be liable for payment of the Attorney's fees and expenses per a quantum meruit amount of attorney fees based upon the time invested by Attorney in this matter at a rate per hour equal to that allowed by the Equal Access to Justice Act or upon other reasonable standard decided by the CAVC, BVA, or DVA based upon applicable law if said amount of quantum meruit attorney fees exceed any fees paid as set forth in paragraph 2 above. Withdrawal by Client shall allow Attorney to elect the greater attorney fees under quantum meruit or under paragraph 2 above as approved by the Court of Appeals for Veterans Claims or Department of Veterans Affairs.

8. The Attorney's Withdrawal From Agreement and Right Not to Pursue Appeal: Attorney does not anticipate any problems that would require withdrawal from this Agreement, and the Attorney intends to pursue Client's matter to the best of his ability. If, however, circumstances arise such as Client's claim not being allowed under the Veterans Judicial Review Act (VJRA) which would disallow attorney fees or reasons that necessitate withdrawal in accordance with the Code of Professional Responsibility, the Attorney will (a) notify the Client in writing of the withdrawal from this Agreement, and (b) take reasonable steps to avoid foreseeable prejudice to the rights of the Client. Client agrees that Attorney shall not be required to pursue a further appeal after the first level of decision of this case if, in the opinion of Attorney, such appeal is not in the best interest of Attorney or Client. Withdrawal by Attorney at Attorney's sole election shall entitle Client to have his fees under paragraph 2 above returned to Client, but withdrawal by attorney because of actions by Client (such as misinformation or non-cooperation) shall not entitle Client to return of fees described in paragraph 2 above.

9. Settlement Offers: The Attorney will advise the Client of all settlement offers and no dismissal or settlement of any claim or claims will be made without the consent of the Client. VA Settlements are exceedingly rare.

10. DVA is Not Authorized to Contact Client Directly: Under no circumstances shall the DVA be authorized to contact the Client directly with respect to any matter related to the Clients' VA claim for compensation. Client directs that any correspondence to the Client shall also be addressed to and received by the Attorney.

11. Complete Integration, Binding Upon All Parties: This Agreement of three pages contains the entire agreement between the Client and the Attorney regarding this matter and the payment of fees and expenses. This Agreement shall not be modified except by written agreement signed by the Client and the Attorney. This Agreement shall be binding upon the Client and the Attorney and their respective heirs, executors, legal representatives, and successors.

12. No Promises or Guarantees About Outcome: The Client has read and understands this contract and agrees that the Attorney has made no promises or guarantees regarding the outcome of this matter.

13. **Revocation of Prior Powers of Attorney:** Client intends that this contract shall revoke all prior Powers of Attorney for representation which may have been filed with the Department of Veterans Affairs by any other attorney or veteran's service organization or other veteran representative. A new representation form will be signed by Client and Attorney

14. **Interpretation of Agreement:** The Client and the Attorney understand that the U.S. Court of Appeals for Veterans Claims or Board of Veterans' Appeals is vested with the authority to determine the reasonableness of this fee Agreement. Further, the Client and the Attorney agree that in the event that there is a disagreement about the meaning of any term of this Agreement, the Veterans Judicial Review Act shall govern the interpretation of this Agreement. The Client further agrees that, if there is recourse to the judicial process to resolve a dispute about this Agreement, he will submit to the jurisdiction of the appropriate courts and will permit the dispute to be adjudicated by said courts.

15. **Commencement of Representation:** Actual work on behalf of Client by Attorney under this Agreement will not commence until the Attorney receives a copy of this Agreement signed by the Client. The effective date of this Agreement to represent shall be the date on which the Attorney signs this Agreement. Attorney and Client agree that this Contract will be filed with the DVA, BVA and CAVC as appropriate. An original contract will be forwarded to Client by Attorney.

16. **Mutual Agreement:** We agree that the above agreement and contract of THREE pages represents our complete mutual agreement.

_____ _____

[CLIENT FULL NAME]
Service Number or SSN: [SSN]
Street Address: [ST ADDRESS]
City, State, ZIP: [CITY STATE ZIP]
Telephone: [TEL #]
Email: [EMAIL]

Date

_____ _____

Hugh D. Cox
Attorney at Law
North Carolina Bar Number 6567
VA Accreditation Number 8925
2411 B Charles Boulevard
Post Office Box 154
Greenville, North Carolina 27858

Date

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This contract and agreement of three pages for Veteran benefits legal services is entered into between the undersigned client, **[CLIENT FULL NAME] ,** hereinafter referred as "Client," and **Hugh D. Cox**, Attorney at Law, 2411 B Charles Boulevard, P. O. Box 154, Greenville, North Carolina 27835-0154, hereinafter referred to as "Attorney." Client and Attorney agree as follows:

1. Legal Services to be Provided: Client retains Attorney to represent Client before the Department of Veterans Affairs Regional Office and/or Board of Veterans' Appeals (BVA) and/or United States Court of Appeals for Veterans Claims (CAVC) for award or increase of award of veteran benefits either by appeal, reconsideration or by renewed claim based on new and material evidence on the issues stated or inferred in that decision of denial or partial award. This statement of benefits includes client's claim for compensation for secondary, inferred, or implied claims for compensation that are pending at any stage before the Department of Veterans Affairs. Client seeks to secure all benefits reasonable stated or inferred in any Department of Veterans Affairs decision that the Client is entitled to receive as of the date of most recent DVA claim. Client understands that pursuit of client's claim may involve motions or remands before the Department of Veterans Affairs (including Regional Office) and/or Board of Veterans' Appeals and/or United States Court of Appeals for Veterans Claims. Attorney is also entitled to a contingency fee as stated below for any claim for benefits by the Veteran giving notice of appeal to a denial of a Board of Veterans' Appeals denial decision which post-dates November 18, 1988 or the date of enactment of the Veteran's Judicial Review Act and/or as provided by Veterans Benefits, Health Care, and Information Technology Act of 2006 where the veteran filed a Notice of Disagreement on or after June 20, 2007.

2. Contingency Fee Agreement:

(a) There shall be no attorney fees except those expenses set forth in paragraphs herein owed by Client to Attorney if there is no recovery of veteran benefits for Client by Attorney unless such Equal Access to Justice Act (EAJA) attorney fees are approved.

(b) Client agrees to pay Attorney (1) a fee contingent upon the outcome of the claims of Client described in paragraph entitled, "Legal Services to be Provided". This contingency fee shall be TWENTY PERCENT (20%) of the gross amount of any past due DVA or VA benefits recovered for veterans and dependents/children whether by judgment, settlement or administrative action, and (2) if there is an award of attorney fees under the Equal Access to Justice Act (EAJA), Attorney shall be entitled to the greater of (1) or (2) in this paragraph above. Client agrees and acknowledges that Attorney fees sought shall be at a rate established by 28 U.S.C. 2412 and the current consumer price index if an EAJA award is pursued. EAJA attorney fees sought and recovered shall be applied to Client's contingency fee owed to Attorney for the same work and the same issue.

3. Client Directs DVA Withholding of Attorney fees or Agrees to pay Attorney Fees into Attorney Trust Account: Client directs that the DVA withhold 20% of past due benefits payable to veteran for attorney fees. Client acknowledges that Client is personally responsible for payment of 20% of past due benefits into Attorney's trust account in the event the Secretary of the Department of Veterans Affairs (DVA) or any of his agencies or agents pays such attorney fees directly to Client. In such event of VA payment of attorney fees to Client, Client shall pay this amount of 20% of past due benefits into Attorney Trust Account within 5 days of receipt of any check containing attorney fees or upon notice of such VA mistake. Upon approval of attorney fees, Attorney will account to Client for Attorney Trust Account transactions. Should Attorney have to litigate to collect attorney fees, Client agrees that all legal State and federal remedies available to Attorney may be utilized. Client agrees to notify Attorney of any payment of new benefits for which Client was represented by Attorney within 5 days by providing a copy of such new benefits check.

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_____ _____

[CLIENT FULL NAME]
Service Number or SSN: [SSN]
Street Address: [ST ADDRESS]
City, State, ZIP: [CITY STATE ZIP]
Telephone: [TEL #]
Email: [EMAIL]

Date

_____ _____

Hugh D. Cox
Attorney at Law
North Carolina Bar Number 6567
VA Accreditation Number 8925
2411 B Charles Boulevard
Post Office Box 154
Greenville, North Carolina 27858

Date

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from Attorney. Attorney agrees to give advanced notification to client of all anticipated expenses in excess of $50.00 prior to Attorney advancing such sums.

6. Client's Information to Attorney and Cooperation with Attorney: Client agrees to sign any and all necessary forms in order for Attorney to obtain medical, official file and procedural information on this case. Client agrees to locate and contact witnesses and provide documents requested by Attorney. Client agrees to cooperate with Attorney by meeting with him or by telephone call when requested and to attend required hearings or examinations when scheduled. Client further agrees to keep Attorney advised of current address and telephone number as well as necessary information on someone else who can always contact client. Client agrees that Attorney may designate other persons for outside professional services, outside research assistants, and outside experts for portions of Client's case if, in the judgment of Attorney, that such services are in the best interest of Client and Attorney and that such services are not within the expertise and control of Attorney. Client and Attorney agree that the designation of any such professional services may require that Client be billed for additional out-of-pocket expenses under Paragraph 5. Attorney agrees to notify Client in advance of any expense exceeding fifty dollars ($50.00).

7. Client's Discharge of Attorney: Client may discharge Attorney upon written notice to Attorney except that if the Client discharges the Attorney without securing substitute counsel after the Attorney has entered an appearance in court, the court may require Attorney to continue to represent the Client until substitute counsel enters an appearance and Attorney's appearance in the proceeding is terminated by the court. If Client discharges Attorney without good and adequate cause after the Attorney has fully performed, substantially performed, or contributed in any way to the results finally obtained by the Client, the Client shall be liable for payment of the Attorney's fees and expenses per a quantum meruit amount of attorney fees based upon the time invested by Attorney in this matter at a rate per hour equal to that allowed by the Equal Access to Justice Act or upon other reasonable standard decided by the CAVC, BVA, or DVA based upon applicable law if said amount of quantum meruit attorney fees exceed any fees paid as set forth in paragraph 2 above. Withdrawal by Client shall allow Attorney to elect the greater attorney fees under quantum meruit or under paragraph 2 above as approved by the Court of Appeals for Veterans Claims or Department of Veterans Affairs.

8. The Attorney's Withdrawal From Agreement and Right Not to Pursue Appeal: Attorney does not anticipate any problems that would require withdrawal from this Agreement, and the Attorney intends to pursue Client's matter to the best of his ability. If, however, circumstances arise such as Client's claim not being allowed under the Veterans Judicial Review Act (VJRA) which would disallow attorney fees or reasons that necessitate withdrawal in accordance with the Code of Professional Responsibility, the Attorney will (a) notify the Client in writing of the withdrawal from this Agreement, and (b) take reasonable steps to avoid foreseeable prejudice to the rights of the Client. Client agrees that Attorney shall not be required to pursue a further appeal after the first level of decision of this case if, in the opinion of Attorney, such appeal is not in the best interest of Attorney or Client. Withdrawal by Attorney at Attorney's sole election shall entitle Client to have his fees under paragraph 2 above returned to Client, but withdrawal by attorney because of actions by Client (such as misinformation or non-cooperation) shall not entitle Client to return of fees described in paragraph 2 above.

9. Settlement Offers: The Attorney will advise the Client of all settlement offers and no dismissal or settlement of any claim or claims will be made without the consent of the Client. VA Settlements are exceedingly rare.

10. DVA is Not Authorized to Contact Client Directly: Under no circumstances shall the DVA be authorized to contact the Client directly with respect to any matter related to the Clients' VA claim for compensation. Client directs that any correspondence to the Client shall also be addressed to and received by the Attorney.

11. Complete Integration, Binding Upon All Parties: This Agreement of three pages contains the entire agreement between the Client and the Attorney regarding this matter and the payment of fees and expenses. This Agreement shall not be modified except by written agreement signed by the Client and the Attorney. This Agreement shall be binding upon the Client and the Attorney and their respective heirs, executors, legal representatives, and successors.

12. No Promises or Guarantees About Outcome: The Client has read and understands this contract and agrees that the Attorney has made no promises or guarantees regarding the outcome of this matter.

13. **Revocation of Prior Powers of Attorney:** Client intends that this contract shall revoke all prior Powers of Attorney for representation which may have been filed with the Department of Veterans Affairs by any other attorney or veteran's service organization or other veteran representative. A new representation form will be signed by Client and Attorney

14. **Interpretation of Agreement:** The Client and the Attorney understand that the U.S. Court of Appeals for Veterans Claims or Board of Veterans' Appeals is vested with the authority to determine the reasonableness of this fee Agreement. Further, the Client and the Attorney agree that in the event that there is a disagreement about the meaning of any term of this Agreement, the Veterans Judicial Review Act shall govern the interpretation of this Agreement. The Client further agrees that, if there is recourse to the judicial process to resolve a dispute about this Agreement, he will submit to the jurisdiction of the appropriate courts and will permit the dispute to be adjudicated by said courts.

15. **Commencement of Representation:** Actual work on behalf of Client by Attorney under this Agreement will not commence until the Attorney receives a copy of this Agreement signed by the Client. The effective date of this Agreement to represent shall be the date on which the Attorney signs this Agreement. Attorney and Client agree that this Contract will be filed with the DVA, BVA and CAVC as appropriate. An original contract will be forwarded to Client by Attorney.

16. **Mutual Agreement:** We agree that the above agreement and contract of THREE pages represents our complete mutual agreement.

_____ _____

[CLIENT FULL NAME] **Date**
Service Number or SSN: [SSN]
Street Address: [ST ADDRESS]
City, State, ZIP: [CITY STATE ZIP]
Telephone: [TEL #]
Email: [EMAIL]

_____ _____

Hugh D. Cox **Date**
Attorney at Law
North Carolina Bar Number 6567
VA Accreditation Number 8925
2411 B Charles Boulevard
Post Office Box 154
Greenville, North Carolina 27858

VA SERVICE-CONNECTED TELEPHONE INFORMATION FOR ATTORNEY: filename v_Telephone_Fillout_sheet_basic_info

NAME:	DATE:
SSN:	EMAIL
ADDRESS:	COUNTY:
PHONES: (HOME):	(CELL):
DO YOU STILL WORK?	DATE LAST WORKED?
SUMMARY OF CIVILIAN WORK HISTORY -- CLIENT'S USUAL OCCUPATIONS?	
HOW MANY CIVILIAN JOBS HAVE YOU HAD? EXPLAIN. DIFFICULTIES KEEPING JOBS? ☐YES ☐NO WHY?	
FAMILY: spouse name:	married since: Dependents
AGE/DOB?	EDUCATION?
DO YOU RECEIVE SOCIAL SECURITY DISABILITY? ☐YES ☐NO	
DO YOU RECEIVE ANY OTHER BENEFITS? ☐WORK COMP ☐DISABILITY PAYMENTS OF ANY TYPE ☐RETIREMENT ☐PUBLIC ASSISTANCE ☐UNEMPLOYMENT COMP	
LOCAL VA REGIONAL OFFICE: ☐WSRO	☐Other _____
DATE OF FIRST S/C APPLICATION?	

ACTIVE DUTY HISTORY: Retired from active duty ☐YES ☐NO

Service branch	Enlisted date	Separated date	Discharge type	Rank OLD SVC NO.

MOS:	Units	post assignments
Served in War Zone ☐YES ☐NO	Served during war time☐YES	☐NO

RESERVE/GUARD HISTORY: Retired from reserves/guard ☐YES ☐NO

Service branch	Enlisted date	Separated date	Discharge type	rank

SERVICE CONNECTED **RATINGS** NOW?

diagnosis	rating	date awarded	va physicians	private physicians	remarks

SERVICE CONNECTED **DENIALS** NOW PENDING?

diagnosis	application	date denied	va physician	private physician	diagnosed in service

WHAT DO YOU WANT TO ACHIEVE FROM THE VA?

REMARKS?

VA SERVICE-CONNECTED CASE INITIAL FORM TO BE COMPLETED BY POTENTIAL CLIENT:
(Fill out completely. Consider this form as an opportunity and not a burden)

WHEN WAS THE DATE YOU ACTUALLY BECAME DISABLED -- CLAIMED ONSET DATE:
Ave you been awarded MEDICAID either now or in the past? ☐YES ☐NO (If YES, get copy of Award.)
FULL NAME: [CLIENT FULL NAME] email [EMAIL]
STREET ADDRESS:
CITY STATE ZIP:
TELEPHONE (h) (o)
TELEPHONE NUMBER OF SOMEONE WHO CAN ALWAYS CONTACT YOU:
WHO IS THIS PERSON WHO CAN ALWAYS CONTACT YOU:
SOCIAL SECURITY NUMBER: DATE OF BIRTH: AGE
LAST DAY YOU ACTUALLY WORKED:
WERE YOU ACTUALLY DISABLED BEFORE YOUR LAST WORK DATE, BUT CONTINUED TO WORK: ☐YES ☐NO
WHAT VA SERVICE-CONNECTED BENEFITS DID YOU APPY FOR: ☐DISABILITY ☐SSI ☐SURVIVOR/WIDOW(ER)
HAVE YOU APPLIED BEFORE FOR VA SERVICE-CONNECTED DISABILITY AND BEEN DENIED, ABANDONED YOUR APPEAL, THEN TRIED AGAIN WITH A NEW CLAIM: ☐YES ☐NO
IS THIS AN SSI CASE ONLY? ☐YES ☐NO
SPOUSE FULL NAME YOUR CHILDREN'S AGES:
SPOUSE JOB TITLE/EMPLOYER:
DO YOU EARN ANY MONEY NOW: ☐YES ☐NO DO YOU RECEIVE ANY PUBLIC ASSISTANCE: ☐YES ☐NO

EDUCATION: ☐COMPLETED TH GRADE IN SCHOOL ☐HIGH SCHOOL ☐MORE THAN HIGH SCHOOL
YOUR VOCATIONAL EDUCATION (IF YOU LEARNED A TRADE, OCCUPATION OR SKILL): ☐YES ☐NO

DO YOU HAVE A LEARNING DISABILITY: ☐YES ☐NO
DID YOU SERVE IN THE MILITARY: ☐YES ☐NO WHAT SERVICE: WHAT YEARS:
HIGHEST RANK: HONORABLE DISCHARGE: ☐YES ☐NO
DID YOU SERVE IN COMBAT: ☐YES ☐NO

Does the VA, Workers Comp Agency or any Insurance consider you disabled? If YES, who?
Do you receive any VA compensation?
CAUSES OF YOUR DISABILITY (IN ORDER OF MOST DISABLING TO LEAST DISABLING)
1
2
3
4
5
6
7
8
WHO DO YOU LIVE WITH?
WHO TAKES CARE OF YOU?
ABILITY TO TRAVEL: ☐I DRIVE ☐I HAVE A DRIVER'S LICENSE ☐I OWN A VEHICLE
MILES DRIVEN PER WEEK: TIMES DRIVING PER WEEK:
☐RIGHT HANDED ☐LEFT HANDED HEIGHT/WEIGHT
PHYSICIANS WHO TREATED YOUR DISABILITY:

NAME	ADDRESS	SPECIALITY	STILL SEEING	DATES SEEN	RESTRICTIONS
1					
2					
3					
4					
4					
5					
6					
7					
8					

What physicians support your claim for disability?
WERE YOU IN A HOSPITAL IN LAST 5 YEARS:

NAME	ADDRESS	TREATMENT	DATES

[PUBLIC OR PRIVATE ASSISTANCE] - Did you receive unemployment compensation, workers compensation, short or long term disability benefits, insurance plan disability benefits, VA benefits, or Federal Employee Retirement System (FERS) benefits after your disability onset date?

PATIENT/CLAIMANT'S WORK BACKGROUND

NAME OF PATIENT/CLAIMANT: **SOCIAL SECURITY NUMBER:**

[CLIENT FULL NAME] **[SSN]**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

To be completed by the claimant - Please prepare facts carefully before entering any information. Wrong information can be embarrassing. Start at the top with your most recent job first, followed by next most recent job (and so on), and list all jobs performed within the past 15 years. Weight lifted information is to be considered a ***single*** object weight and not weights added:

Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job

SIGNATURE	DATE

PRESCRIPTION MEDICATIONS LIST

NAME OF PATIENT/CLAIMANT: SOCIAL SECURITY NO:

[CLIENT FULL NAME] **[SSN]**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

Please list all PRESCRIPTION Medications you are CURRENTLY taking plus the information asked. Please be accurate and give full information requested to include dosage:

Name of Medication and Dosage	Date first Prescribed	Daily Amount Taken	Reason for Medication	Physician Name	Adverse Effects such as stomach upset, dizzy, etc.

*Please list below any **NON-PRESCRIPTION** medications you are taking, how often you take them, and the reason for taking them*

(If additional space is needed, use another form)

SIGNATURE	DATE
	

VA SERVICE-CONNECTED TELEPHONE CONTACTS INFORMATION:
Filenamev_TELEPHONE_EMAIL_KIT_2014_10_06

NAME: **[CLIENT FULL NAME]** DATE: [TODAY'S DATE]
SSN: **[SSN]** EMAIL: **[EMAIL]**
ADDRESS: **[ST ADDRESS] . [CITY STATE ZIP]** COUNTY: **[COUNTY]**

PHONES: (HOME): **[TEL #]** (CELL):

LOCAL VA REGIONAL OFFICE: **251 N. Main Street, Winston-Salem, NC 27155**

PRIOR APPLICATIONS – OR IS FIRST APPLICATION STILL ACTIVE? **[PRIOR APPLICATIONS]**

DATE LAST DENIED: **[DATE LAST DENIAL] [DATE LAST DENIAL]**

DATE LAST WORKED: **[DATE LAST WORKED]**

AGE/DOB: **[AGE/DATE OF BIRTH]** EDUCATION: **[HIGHEST EDUCATION]**

DATE DISABILITY STARTED: **[DATE DISABILITY STARTED]**

SUMMARY OF WORK HISTORY -- CLIENT'S USUAL OCCUPATION: [OCCUPATIONS IN PAST 15 YEARS]

Military: **[MILITARY BRANCH]**
Dates of Service: [DATES OF MILITARY ACTIVE DUTY]

DIAGNOSES CAUSING DISABILITY:
[DISABILITY DIAGNOSES THAT ARE SERVICE-CONNECTED]

PHYSICIANS: [PHYSICIANS]

PHYSICIAN SUPPORTS SS DISABILITY?: PHYSICIAN SUPPORTS DISABILITY?]

REMARKS

[PUBLIC OR PRIVATE ASSISTANCE] Did you receive unemployment compensation, workers compensation, short or long term disability benefits, insurance plan disability benefits, VA benefits, or Federal Employee Retirement System (FERS) benefits after your disability onset date?
( )NEEDS KIT sent to claimant above and needs s_disability forms KIT for potential clients_2006_03_05.doc once contract Is signed.

FOR VETERAN TO RETURN TO HUGH D. COX

MEDICAL CARE QUESTIONNAIRE

TO BE COMPLETED BY CLIENT

AFTER *EVERY* VISIT TO PHYSICIAN, OR HEALTH, VOCATIONAL OR MEDICAL FACILITY

(RETURN TO HUGH D. COX, ATTORNEY AT LAW)

NAME OF CLIENT:[CLIENT FULL NAME] SOCIAL SECURITY NO:[SSN]

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

DATE(S) OF MEDICAL TREATMENT:
NAME OF PHYSICIAN SEEN (OR OTHER HEALTH PROFESSIONAL):
PHYSICIAN SPECIALITY:
NAME OF MEDICAL FACILITY:
ADDRESS:
WHO REFERRED YOU TO THIS MEDICAL CARE?:
HOW LONG DID YOU SEE THE PHYSICIAN OR OTHER PRIVIDER (DO NOT COUNT WAITING TIME)?: MINUTES: HOURS:
WHAT DID YOU TELL THE PHYSICIAN OR HEALTH CARE PROVIDER ABOUT YOUR HEALTH?:
WHAT DID THE PHYSICIAN OR HEALTH CARE PROVIDER TELL YOU ABOUT YOUR HEALTH?:
WHAT TREATMENT OR TESTING WAS PROVIDED?
WHAT MEDICATIONS WERE PRESCRIBED OR RENEWED?: WERE YOUR MEDICATIONS CHANGED OR INCREASED? ☐YES ☐NO
WHAT PHYSICAL OR OTHER RESTRICTIONS OF YOUR ACTIVITIES WERE RECOMMENDED?:
ARE YOU SCHEDULED TO RETURN FOR ADDITIONAL CARE OR FOLLOWUP?: ☐YES ☐NO IF "YES", WHEN?: WHY?:
WERE YOU RATED? ☐YES ☐NO IF "YES", WHAT PART OF BODY WAS RATED?: RATING GIVEN:
PLEASE GIVE ANY OTHER INFORMATION YOU CONSIDER IMPORTANT ABOUT YOUR VISIT:

Submission of Documents to Department Of Veterans Affairs Centralized Mail Processing (CMP)

☐ **Evidence Intake Center**
PO Box 4444 or Box 5235
Newnan, Georgia
30271-0020
FAX 1-844-531-7818
or 1-248-524-4260

☐ **Evidence Intake Center**
PO Box 4444
Janesville, WI
53547-4444
FAX 1-844-822-5246
or 1-608-373-6690

Veteran:
C-File or SSN:
Street Address:
City, State, Zip:

Date:

From:	**Name and Relationship to Veteran**
	Title
	Address
	City, State, Zip
Tel:	**Fax**
	Email:

Type of Document Submitted:

☐Evidence on Behalf of Veteran/Dependent Named above:
☐Appeal on Behalf of Veteran/Dependent Named above
☐Inquiry on Status of Case
☐Waiver
☐Freedom of Information Act
☐Privacy Act
☐Dependency
☑Other (See below):
Request for Veteran's Entire C-File of ALL pages in (1) paper form or (2) on digital media CD/DVD containing Adobe Acrobat PDF Format.

Number of Pages Submitted (NOT including this cover sheet):	**TWO**

☑ ☒ ☑

REQUEST FOR VETERAN'S ENTIRE C-FILE

OMB Control No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The 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 required to obtain or retain benefits. 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. The 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 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: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

PRIVACY ACT WAIVER AND REQUEST FOR ENTIRE "C" FILE AND SQC INFORMATION

By my signature below, I authorize the following person: _____
ADDRESS: _____
to have access to all of my VA records.

This **includes** access to any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV) , or sickle cell anemia, that may be or are contained or maintained in my VA Claimant records.

Redisclosure of the information or records relating to the conditions named in the second paragraph above by my attorney other than to VA or the Court of Veterans Appeals is not authorized without my further written consent. This authorization pertaining to the information or records listed in the second paragraph above, will remain in effect until records listed in the second paragraph above, will remain in effect until the earlier of the following two events: **(1)** I specifically revoke this authorization by the filing of a written revocation which will be effective except to the extent that action has been taken in reliance upon the authorization, or, **(2)** disclosure of the aforementioned information or records is no longer necessary for benefits determination purposes.

My consent for the disclosure of information relating to the condition of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, that may be or are contained or maintained in VA Claimant records pertaining to. me, is limited as follows: **NOT LIMITED**

In order to waive my rights under the Privacy Act, 5 U.S.C. 552a(b), and under any other federal or state law or regulation which controls access to my records, I give my prior written consent to the National Personnel Records Center (Military Personnel records), St. Louis, Missouri; to the Department Of Veterans Affairs; to the Department of Health and Human Services; Social Security Administration; or any other public or private Custodian of (including, but not limited to, hospitals, Clinics, and current and former treating physicians), or agency that possesses or controls my military, veteran, medical, mental, Sickle Cell Anemia, infection with Human Immunodeficiency Virus (HIV), drug or alcohol treatment, Discharge Review or Correction Board records and files, to disclose fully and promptly to the person named above, his agents, or to any other person designated by this person, any and all records contained in my file which I or any other person designated may request. This authorization does not constitute a Power of Attorney or Retainer or any other form of agreement which would require someone represent me.

I also request documentation of any **SQC review** of my DVA files by any subdivision of the DVA showing the form of review problems identified, and/or any corrective or other action taken by the Regional Office or the Central Office of the DVA.

I also make this request under the Freedom of Information Act.

I want all pages of my C-FILE either sent to the person named above or to me personally either as (1) paper files or as (2) Adobe Acrobat PDF format on digital media such as a CD or DVD. If any request for my C-File was previously granted, I want all updated pages since that previous request was sent to include all pages dated after the latest date of any previous C-File page.

If represented, I state that my Attorney or Representative is _____
ADDRESS: _____

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

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.

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

Standard Form 180 (Rev. 5/12) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 01/31/201.5

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/*

(To ensure the best possible service, lease thoroughly review the accompanying instructions before Pilling out this form. Pease print clearly or type.)

SECTION I – INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle) **[CLIENT FULL NAME]** 2. SOCIAL SECURITY NO. **[SSN]** **3.** DATE OF BIRTH **4.** PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT					
b. RESERVE COMPONENT					
c. NATIONAL GUARD					

6. 15 THIS PERSON DECEASED? If "YES" enter the date of death. ☐NO ☐YES

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE? ☐NO ☐YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** When was the DD Form(s) 214 issued? YEAR(S):_____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214.☐.

The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☒ **All Documents in Official Military Personnel File (OMPF)**

☐**Medical Records** (Includes Service Treatment Records, Health (outpatient) and dental records.) If hospitalized (inpatient), the facility name and date for each admission **must** be provided: _____

☐ **Other** (Specify):

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary;** however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☒ Benefits ☐ Employment ☐VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain:

SECTION III – RETURN ADDRESS AND SIGNATURE

I. REQUESTER IS: *(Signature Required in #3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) .No signature required for Archival records.*

☐Military service member or veteran identified in Section I, above
☐Next of kin of deceased veteran: _____ ***(Relationship)***
☐Legal guardian (Must submit copy of court appointment.)
☐Other (specify)_____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

2. **SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 4 on accompanying instructions.)

3. AUTHORIZATION SIGNATURE WHEN REQUIRED *(See items 2a or 3a on accompanying instructions.)* I. declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct. No signature required for Archival records.

For: HUGH D. COX, ATTORNEY AT LAW SIGN HERE **3/16/2015**

Name			Signature Required - Do not print	Date
POST OFFICE 154			**(252) 757-3977**	**(252) 757-3420**
Street		Apt.	Daytime phone	Fax Number
GREENVILLE,	**NC**	**27858**	**hughcox@hughcox.com**	
City	State	Zip Code	Email address	

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf on* the National Archives and Records Administration (NARA) web site.*

OMB Control No. 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affairs

1. VA FILE NO(S) *(Include prefix)*
[C-FILE #]

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have a service organization assist you with your claim, you may use VA Form 21-22, "Appointment of Veterans Service Organization As Claimant's Representative."

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, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. 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 individuals appointed by claimants to act on their behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902, 5903, and 5904) and for those individuals to accept appointment. We will also use the information to verify consent for disclosure of VA records to the appointed representative (38 U.S.C. 5701(b) and 7332) Title 38, United States Code, allows us to ask for this information. We estimate that claimants and individuals appointed for purposes of representation will each 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. A Valid OMB control number can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

2..NAME OF CLAIMANT (*Veteran, guardian, beneficiary, dependent, or next of kin*)	3.ADDRESS OF CLAIMANT (*No. and street or rural route, city or P.O., State and ZIP Code*)
[CLIENT FULL NAME]	**[ST ADDRESS]** **[CITY STATE ZIP]**
4. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	5. SERVICE NUMBERS **[SSN]**

6. BRANCH OF SERVICE **[MILITARY BRANCH]**
ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify*_____)

7A. NAME OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE
Hugh D. Cox, Attorney at Law

7B. INDIVIDUAL IS *(check appropriate box)*

☒ **ATTORNEY** ☐ AGENT ☐ INDIVIDUAL PROVIDING REPRESENTATION UNDER SECTION 14.630 *(*See required statement below. Signatures are required in Items 7C and 7D)*

☐ SERVICE ORGANIZATION REPRESENTATIVE (*Specify organization below*)
_____

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

(Skip to Item 8, if the box for "Individual Providing Representation Under Section 14.630" was not checked in Item 7B)

The appointment of the individual named in Item 7A (the representative) authorizes the individual to represent the claimant named in Item 2 for a particular claim pursuant to the provisions of 38 CFR 14.630. By our signatures below, we, the representative and the claimant, attest that no compensation will be charged or paid for the individual named in Item 7A.

7C. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 7A

7D. SIGNATURE OF CLAIMANT NAMED IN ITEM 2

SIGN HERE

8. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE *(No. and street or rural route, city or P.O., State, and ZIP code)*

Post Office Box 154
Greenville, NC 27835-0154

2411 B Charles Blvd
Greenville, NC 27858

9. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 7A 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.

I authorize the VA facility having custody of my VA claimant records to disclose to the individual named in Item 7A 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 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

10. LIMITATION OF CONSENT. My consent in Item 9 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

NONE

11. AUTHORIZATION FOR REPRESENTATIVE TO ACT ON CLAIMANT'S BEHALF TO CHANGE CLAIMANT'S ADDRESS

Unless I check the box below, I do not authorize the individual named in Item 7A to act on my behalf to change my address in my VA records.

I authorize the individual named in Item 7A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual 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 individual named in Item 7A, either by explicit revocation or the appointment of another representative.

CONDITIONS OF APPOINTMENT

I, the claimant named in Item 2, hereby appoint the individual named in Item 7A as my representative to prepare,present, and prosecute my claims for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 4. If the individual named in Item 7A is an accredited agent or attorney, the scope of representation provided before VA may be limited by the agent or attorney as indicated below in Item 15. If the individual indicated in Item 7A is providing representation under 14.630, such representation is limited to a particular claim only. I authorize VA to release any and all of my records (other than as provided in Items 9 and 10) to that individual appointed as my representative, and if the individual in Item 7A is an accredited agent or attorney, this authorization includes the following individually named administrative employees of my representative:

Signed and accepted subject to the foregoing conditions.

12. SIGNATURE OF CLAIMANT	13. DATE OF SIGNATURE	14. CLAIMANT'S RELATIONSHIP TO VETERAN
	3/16/2015	*(If other than the veteran)*

15. LIMITATIONS ON REPRESENTATION - AGENTS OR ATTORNEYS ONLY *(Unless limited by an agent or attorney, this power of attorney revokes all previously existing powers of attorney)*

NONE

16. SIGNATURE OF REPRESENTATIVE	17. DATE OF SIGNATURE
	3/16/2015

FEES: Section 5904, Title 38, United States Code, contains provisions regarding fees that may be charged, allowed, or paid for services of agents or attorneys in connection with a proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Department.