Veteran Integration Program

For Agency Use Only:

Approved date:
_____
Staff Approval:
_____
_____
HOSWWA received
Date: _____
Time: _____
By: _____
*Input#*_____

Housing Opportunities of Southwest Washington does not discriminate on the basis of race, color, national origin, religion, sex, physical or mental disability, or familial status.

1. HEAD OF HOUSEHOLD (please print): _____

2. PHONE: _____

3. MAILING ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____

4. HOUSEHOLD COMPOSITION: (List ALL family members who will reside with Head of Household).

Name (First, Middle Initial, Last)	Relationship	Birth date	City, State, County of Birth	Sex	Social Security #
	Self				

5. FAMILY STATUS: *Your response to this question is VOLUNTARY*. Per HUD Regulations, elderly, disabled and displaced families with up to two members will be given a preference over all "other single" applicants regardless of Local preference status. "Other Singles" denotes a one-person household in which the individual member is not elderly, disabled or displaced by government action. Please answer the following questions by circling the correct response:

1. Is the Head of Household or Spouse 62 years of age or older? ☐ Yes ☐ No

2. Is the Head of Household or Spouse Disabled or Handicapped? ☐ Yes ☐ No

6. INCOME: (List all sources of income for all family members who will reside with head of household while assisted i.e. full or part time employment, welfare (TANF or General Assistance), social security, SSI, disability, pensions, unemployment, babysitting, alimony, child support, loans, scholarships, grants, etc.) Attach additional sheet if necessary.

Income Source	Total Monthly

7. ASSETS: Please list all bank accounts (checking, savings, IRA's, Keough Accounts, Certificates of Deposit), stocks, bonds, real estate (land, residence, or rental property) or Real Estate Contracts:

Type of Asset	Name of Bank	Account #	Value

- Do you own real estate? ☐ Yes ☐ no
- Do you own, or are you purchasing a mobile home, manufactured home or any other form of Real Estate? ☐ Yes ☐ no

If yes, please list _____

Emergency Notification:

Name _____ Relationship _____

Address _____ Phone #_____

Military Service:

Branch _____ MOS/Job _____ Type of Discharge _____

Length of Service _____yrs. _____mos. From _____/_____/_____ To: _____/_____/_____

Service Era (circle): ☐ WWII 12/41-12/46 ☐ Pre-Korean 1/47 - 6/50 ☐ Korean 7/50 – 1/55

☐ Post-Korean 2/55 – 7/64 ☐ Vietnam 8/64 – 4/75 ☐ Post-Vietnam 5/75 – 7/90 ☐ Persian Gulf 8/90 - Present

Race (circle): ☐ Asian ☐ Asian/White ☐ Black ☐ Black/White ☐ White/Hispanic

☐ Hispanic ☐ American Indian/Alaskan Native ☐ Indian/Alaskan & White

☐ Multiple Races ☐ Hawaiian/Pacific

Homelessness:

Have you ever been homeless? ☐ Yes ☐ No # of Times _____

Length of Homelessness (circle): ☐ 1- 30 days ☐ 31-180 days ☐ 6 mo-1yr

☐ 1 yr- 2yrs ☐ more than 2 yrs Not Homeless

Legal:

Ever been arrested? ☐ Yes ☐ No # of Times _____ Convicted? ☐ Yes ☐ No

# of Misdemeanors _____ Charges _____

# of Felonies _____ Charges _____

Currently on Probation/Parole? ☐ Yes ☐ No Where? _____

Community Custody Officer Name & Address _____

Outstanding fines and/or fees? ☐ Yes ☐ No Amount Owed $ _____

Do you have outstanding Warrants? ☐ Yes ☐ No Describe _____

_____

Will background check results verify your answers? ☐ Yes ☐ No

Restraining Orders? ☐ Yes ☐ No State _____ From whom? _____

Child Support? ☐ Yes ☐ No Monthly Payment $ _____ Back Amount Owed $ _____

Drivers License? ☐ Yes ☐ No State _____ License # _____

Vehicle in your possession? ☐ Yes ☐ No Type_____ Insurance? Yes No

Employment:

Most recent job _____

Employed from: _____/_____/_____ to: _____/_____/_____

Mental Health:

Have you been diagnosed with a mental illness? Yes No (If yes, please explain below)

_____

Currently being treated for _____
By_____

Type of treatment (circle): Individual Counseling Group Therapy Medications

If not currently being treated, would you like to participate in any counseling or therapy? ____
_____

Physical Health:

Do you have any Physical Medical Conditions that could impair you from working or complying with program requirements? ☐ Yes ☐ No (If yes, please explain below)
_____

When was the last time that you checked into a hospital? _____

What was the nature of the visit? _____

Chemical Dependency:

Are you now or have you ever been addicted to any drug or alcohol? ☐ Yes ☐ No
(If yes, please explain) _____

Drug(s) of Choice: _____ How Long _____

Times in treatment _____ Longest Sobriety _____ Sobriety Date _____/_____/_____

PETS:

How many:_____ Type of pet(s):_____

Is this pet a service/companion animal? ☐ Yes ☐ No

Questions:

Why do you want to enter the Veteran Integration Program? _____

_____

_____

If you could only accomplish one thing while on this program, what would that be and why?

_____

_____

A criminal background check may be performed on each adult expected to participate in any rent assistance program. Federal Regulations prevent Longview Housing Authority from providing rent assistance to any person that are subject to a lifetime sex offender registration requirement are prohibited from receiving rent assistance or who have been evicted in a court of law with in the last 3 years while on a Federally funded housing assistance. I have read and understand I may be subject to a criminal background check prior to receiving any rent assistance with the Longview Housing Authority. _____ (please initial)

I CERTIFY AND AFFIRM, UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON, THAT THE FORGOING STATEMENTS AND INFORMATION ARE TRUE AND CORRECT.

??

Applicant Signature Date

Addendum (A) to Application for Tenancy

LETTER OF AUTHORIZATION

Revised 9/2017

To Whom It May Concern:

In compliance with the Fair Credit Reporting Act, State and Federal laws, this is to inform you and your household members that an investigation involving the statements made on this application for tenancy are being initiated by ORCA Information, Inc., PO Box 277, Anacortes, Washington 98221, 360-588-1633. I certify that to the best of my knowledge all statements are "true and complete". I further authorize ORCA Information, Inc. to obtain Credit Reports, Employment References (including verifying salary), Court Records and Character References, Mode of Living, and Rental References as needed to verify all information put forth on this application and otherwise available regarding all applicants identified on this application.

Furthermore I warrant the accuracy of all information contained on this rental application, including that relating to the other intended occupants of the subject property. I understand and agree that if subsequently a determination is made that I provided false or inaccurate information on the rental application it is a breach of the terms of any rental agreement signed based on that information and Owner and/or his/her agent may take legal action to terminate said Agreement.

In addition, I confirm receipt of the **Tenant Selection Policy** (per WA State Fair Tenant Screening Act, 2012) from this landlord/property management BEFORE submitting this completed rental application and that I read, and understand my rights as described therein.

I also understand Orca Information's role is to provide background information to landlord/property manager. Orca Information does not make the decision to lease/rent or take any adverse action. Decision to lease/rent remains with the property manager/landlord.

_____
Applicant's Name (please print)

_____
Applicant's Signature

_____
Date of Authorization

_____
Manager's/Assistant Manager's Signature

List All Juvenile Age Occupants 12yrs-17yrs:

Full Legal Name	Nickname(s)	Date of Birth
Full Legal Name	Nickname(s)	Date of Birth
Full Legal Name	Nickname(s)	Date of Birth

CREDIT REPORT AUTHORIZATION

THE FOLLOWING MUST BE COMPLETED IN FULL

ADDRESS INFORMATION				
Applicant's Last Name	First	M.I.	Social Security Number	Date of Birth
Present Address	City		State	Zip Code
Day Phone ( )		Fax ( )		
Night Phone ( )		Email:		

In compliance with the Fair Credit Reporting Act, we are informing you that information as to your **CREDIT REPORT** will be retrieved. I certify that the facts set forth in this application are true and complete. I agree that a complete investigation of all information on this application will not constitute invasion of privacy. I authorize **ORCA INFORMATION, INC., PO Box 277, Anacortes, WA 98221, 360-588-1633** to obtain a **CREDIT REPORT,** as necessary for application of tenancy.

_____ _____

Signature of Applicant Date

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

Portland VA Health Care System
3710 SW U.S. Veterans Hospital Rd., Portland, OR 97239
(503) 220-8262

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Veteran Integration Program
1207 Commerce Ave Longview, WA 98632

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☑ OTHER *(Please specify)* to coordinate placement/retention in housing

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ OTHER *(Describe)*: Two-way verbal/written communications-includes Veteran's ID information for purposes related to Veterans' needs and assistance

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☑ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☑ UNDER THE FOLLOWING CONDITION(S): one year from date of signature

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Estimated Burden Avg. 30 min.
Expiration Date 12/31/2020

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC,OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	

7. VA CLAIM NUMBER	8A. DATE OF BIRTH *(mm/dd/yyyy)*	8B. PLACE OF BIRTH *(City and State)*	9. RELIGION

10A. PERMANENT ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. RESIDENTIAL ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

14A. NEXT OF KIN NAME	14B. NEXT OF KIN ADDRESS	14C. NEXT OF KIN RELATIONSHIP

14D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH *(Note: This does not constitute a will or transfer of title)*

16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT	17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE	1C. FUTURE DISCHARGE DATE	1D. LAST DISCHARGE DATE

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS
Continued

VETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO 6B. EFFECTIVE DATE *(mm/dd/yyyy)*

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	
1D. DATE OF MARRIAGE *(mm/dd/yyyy)*		2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*	

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	1B. DATE OF RETIREMENT	
1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN
(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____ **DATE** _____