OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

Note: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

NOTE: You can ***either*** complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, middle initial, last)*
Clint D Barton

2. CLAIMANT'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
011-25-2006		**01-11-1977**

5. VETERAN'S NAME *(First, middle initial, last)* ***(If different from claimant)***
Clint D Barton

6. VETERAN'S SOCIAL SECURITY NUMBER	7. VETERAN'S SEX	8. VETERAN'S SERVICE NUMBER (If applicable)
011-25-2006	☑ MALE ☐ FEMALE	

9. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street **890 fifth avenue**

Apt./Unit Number

City **New York**

State/Province **NY** Country **US** ZIP Code/Postal Code **10001**

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?	11. TELEPHONE NUMBER *(Include Area Code)*	12. E-MAIL ADDRESS *(If applicable)*
☑ YES ☐ NO	**3368675309**	**Hawkeye2022@gmail.com**

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: *(Choose all that apply)*

☑ **COMPENSATION** ☐ **PENSION**

NOTE: Only check this box if you are a surviving dependent of the veteran.

☐ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online through eBenefits at www.ebenefits.va.gov. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits;*** (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE	14B. DATE SIGNED *(MM,DD,YYYY)*
Dale Phillips VFW	**06/04/2021**

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*
(**NOTE:** This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

Veterans of Foreign Wars of the United States

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 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 only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. 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 the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). 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.

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 09/30/2022

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS *(Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. (See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)*

- [x] FULLY DEVELOPED CLAIM (FDC) PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*
Clint D Barton

3. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*
011-25-2006

4. HAVE YOU EVER FILED A CLAIM WITH VA? *(If "Yes," provide your file number in Item 5)*
- [ ] YES
- [x] NO

5. VA FILE NUMBER

6. DATE OF BIRTH *(MM,DD,YYYY)*
Month Day Year
01-11-1977

7. VETERANS SERVICE NUMBER *(if applicable)*

8. SEX
- [x] MALE
- [ ] FEMALE

9. BDD CLAIMS ***ONLY*: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY *(MM,DD,YYYY)***
Month Day Year

10. TELEPHONE NUMBER(S) *(Include Area Code)*
Daytime: **3368675309**
Evening:
Cell: **()**

11. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street **890 fifth avenue**
Apt./Unit Number
City **New York**
State/Province **NY** Country **United States** ZIP Code/Postal Code **10001**

12. E-MAIL ADDRESS *(Optional)*
Hawkeye2022@gmail.com

- [ ] 13. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX *(Includes Work Study/Internship)? (If you are not a VA employee skip to Section II, if applicable)*

SECTION II: CHANGE OF ADDRESS

NOTE: If you are temporarily or permanently changing your address, complete Items 14A through 14C.

14A. TYPE OF ADDRESS CHANGE *(Complete if applicable) (Check only one box)*
- [ ] TEMPORARY
- [ ] PERMANENT

14B. NEW ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street
Apt./Unit Number
City
State/Province
Country
ZIP Code/Postal Code

14C. EFFECTIVE DATE(S) OF NEW ADDRESS *(If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent,** please enter your effective date in the beginning date only)*

BEGINNING DATE: Month Day Year

ENDING DATE: Month Day Year

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 15A through 15F) should ***only*** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

15A. ARE YOU CURRENTLY HOMELESS?	15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
☐ YES *(If "Yes," complete Item 15B regarding your living situation)* ☐ NO	☐ LIVING IN A HOMELESS SHELTER ☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent) ☐ STAYING WITH ANOTHER PERSON ☐ FLEEING CURRENT RESIDENCE ☐ OTHER (Specify):
15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?	15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
☐ YES *(If "Yes," complete Item 15D regarding your living situation)* ☐ NO	☐ HOUSING WILL BE LOST IN 30 DAYS ☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeles shelter) ☐ OTHER (Specify):
15E. POINT OF CONTACT *(Name of person that VA can contact in order to get in touch with you)*	15F. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)* **( )**

SECTION IV: CLAIM INFORMATION

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY
(If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)
NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section IV.**

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	**Unspecified Anxiety Disorder**			**In Service**
2.	**Back Condition**			**In Service**
3.	**Left Shoulder**			**In Service**
4.	**Right Shoulder**			**In Service**
5.	**Migraine Headache**			**In Service**
6.	**Erectile Dysfunction**			**In Service**
7.	**Deviated Septum**			**In Service**
8.	**Asthma**			**In Service**
9				
10.				
11.				
12.				
13.				
14.				
15.				

VETERANS SOCIAL SECURITY NO **011-25-2006**

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT:
NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM/YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW (VA forms are available at www.va.gov/vaforms).

For:	***Required Form(s):***
Supplemental Claims	VA Form 20-0995, *Decision Review Request: Supplemental Claim*
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION V: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," complete Item 18B)* ☑ NO *(If "No," skip to Item 19A)*

18B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

19A. BRANCH OF SERVICE *(Check all that apply)*
☑ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD

19B. COMPONENT *(Check all that apply)*
☑ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE ENTRY DATE *(MM,DD,YYYY)*
Month Day Year
ENTRY DATE: **06-01-1995**
EXIT DATE: **06-01-2018**

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
New York

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☑ YES ☐ NO

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate enlistment and discharge dates, if applicable)*

Enlistment Date(s)	Discharge Date(s)

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES *(If "Yes," complete Items 21B thru 21F)*
☑ NO *(If "No," skip to Item 22A)*

21B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

21C. OBLIGATION TERM OF SERVICE
Month Day Year
From:
Month Day Year
To:

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*
( )

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES *(If "Yes," complete Items 22B & 22C)*
☑ NO

22B. DATE OF ACTIVATION: *(MM,DD,YYYY)*
Month Day Year

22C. ANTICIPATED SEPARATION DATE: *(MM,DD,YYYY)*
Month Day Year

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES *(If "Yes," complete Item 23B)*
☑ NO

23B. DATES OF CONFINEMENT (MM,DD,YYYY)

From:	To:
Month Day Year	Month Day Year
Month Day Year	Month Day Year

SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?

☐ YES *(If "Yes," complete Items 24C and 24D)*

☑ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?

☐ YES *(If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)*

☐ NO

24C. BRANCH OF SERVICE	24D. MONTHLY AMOUNT	25. RETIRED STATUS
	$	☐ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST ☐ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26. Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.**

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which ***may*** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

☐ YES *(If "Yes," complete Items 27B through 27D)*

☑ NO

27B. DATE PAYMENT RECEIVED *(MM,DD,YYYY)*	27C. BRANCH OF SERVICE	27D. AMOUNT RECEIVED *(Provide pre-tax amount)*
Month Day Year		$

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:
You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

SECTION VII: DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT *(If you check this box skip to Section VIII)*

30. ACCOUNT NUMBER *(Check only one box below and provide the account number)*

Account No.: ☐ Checking ☐ Savings

31. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	32. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits***.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE **(REQUIRED)** *(Sign in ink)*	33B. DATE SIGNED *(MM,DD,YYYY)*
Clint Barton	**06-03-2022**

SECTION IX: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS *(Sign in ink)* (**Note**: *Only sign if veteran signed in Item 33A using an "X")*	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS *(Sign in ink)* (**Note**: *Only sign if veteran signed in Item 33A using an "X")*	35B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE **(REQUIRED)** *(Sign in ink)*	36B. DATE SIGNED *(MM,DD,YYYY)*

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE

(NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge. **NOTE**: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual As Claimant's Representative,* indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE *(Sign in ink)*	37B. DATE SIGNED *(MM,DD,YYYY)*

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 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.

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 tobe false, or for the fraudulent acceptance of any payment to which you are not entitled.

THE CENTERS FOR ADVANCED ENT CARE

Alidad Arabshahi, M.D. Ramin Ipakchi, M.D. Alex Cheng, M.D. Nilofar Ariasaif, PA-C

14000 Crown Ct, #201 New York, NY 10004 6371 Little River Turnpike, 1" New York, NY 10012

385 Garrisonvile Rd, Stes. 208 & 209 New York NY 10003
212.499.8787 (phone) 212.499.8222 (fax)

March 8, 2022

Veteran: Barton, Clint
Veteran's SSN#xxx-xx-2006

To Whom It May Concern:

I am Dr. Alidad Arabshahi, board-certified Otolaryngologist. Below you will find my full credentials.

I have been treating Clint Barton (DOB 1/11/1977) for 3 years now due to his various respiratory conditions. While treating Mr. Barton, I have reviewed his medical records past and present to include his service treatment records and would like to provide you with the etiology of Mr. Barton's Deviated Septum.

While serving at Ft. Riley, KS Mr. Barton was conducting a field training exercise that consisted of nighttime mounted tank maneuvers. Due to poor visibility and high grass an order was given to re-position that tank which resulted in the tank dropping into a steep ditch. This flung Mr. Barton face-first into the .50 Cal mount where he sustained a bloody nose. Since no medics were on-site during the training exercise and there was no loss of consciousness, Mr. Barton continued the exercise.

Shortly after this, Mr. Barton started to experience breathing difficulties.

It is in my professional opinion that Mr. Barton's Deviated Septum is at least as likely as not caused or created by the above-mentioned incident. This opinion is based on over 23 years of specializing in ENT medicine and seeing numerous patients with deviated septum.

Signed,

Alidad Arabshahi, M.D.
Otolaryngologist
VA License: 0101234863
NPI: 1235200155

OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

LAY/WITNESS STATEMENT

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

Clint D Barton

2. SOCIAL SECURITY NUMBER

011-25-2006

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH

Month 01 – Day 11 – Year 1977

5. VA INSURANCE FILE NUMBER (If applicable)

6. CURRENT MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street: 890 Fifth Avenue

Apt./Unit Number:

City: New York

State/Province: NY

Country: US

ZIP Code/Postal Code: 10001 –

7. TELEPHONE NUMBER (Include Area Code)

336-867-5309

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

Hawkeye222@gmail.com

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER

– –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH

Month – Day – Year

13. VA INSURANCE FILE NUMBER (If applicable)

14. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

15. TELEPHONE NUMBER (Include Area Code)

– –

Enter International Phone Number (If applicable)

16. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SOCIAL SECURITY NUMBER 0 1 1 – 2 5 – 2 0 0 6

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

On the night in question, I, SPC Steve Rodgers was the assigned driver of tank C23. My crew consisting of SSG Clint Barton , SGT Romanoff and PFC Banner and I were maneuvering in total darkness somewhere in the training area of Ft. Riley, KS. The drivers night vision device was installed and functioning properly. In addition, SSG Barton and PFC Banner were assisting my navigation efforts by using our assigned AN/PVS-7B night vision devices, also the vehicle headlights were on and operating with infrared lens covers installed. I believe we were attempting to rejoin the rest of our platoon that was located only a few kilometers away. As we were creeping along, we were tracking along a tree line that was on our left. We then saw a break in the tree line that appeared to offer passage in the general direction that we wished to travel. Upon command from SSG Barton, I halted the tank so that we could assess the situation. The break in the trees provided ample clearance for the tank to pass through. SSG Barton and PFC Banner both stated that the path looked clear. All that could be seen was chest-high prairie grass that was of a uniform height. SSG Barton then told me to proceed slowly to the left and through the gap in the trees. Looking into my night vision device, I concurred that the path looked clear, but all that I could see was grass. Upon instruction, I continued to proceed slowly into the gap, noticed more trees approximately 20-30 yards dead ahead. At this time, SSG Barton and PFC Banner also noticed the trees and I was then instructed to begin a slow right turn to continue to follow the trees. Then, without warning, the tank abruptly nosed down at about a 65A° angle and began to slide uncontrollably. Instantly realizing what had happened, I applied the service brake with both feet but to no avail. After a few seconds, the tank came to a halt, still nosed down at a steep angle with a 1A0 cant to the right. The tank sustained no damage due to the mine plow digging into the creek bed and absorbing the impact. SGT Romanoff, PFC Banner and myself sustained no serious injuries aside from minor bumps and scrapes. SSG Barton did not fare as well. When the tank came to a halt, his face impacted the .50 caliber machine gun resulting in a broken nose I believe. We exited the tank, looked each other over quickly and then made an immediate inventory of weapons and sensitive items, all were present. We had no medics on site so a correct diagnosis could not be made. To me it looked like SSG Barton just had a bloody nose.

SOCIAL SECURITY NUMBER 011-25-2006

SECTION III: STATEMENT (Continued)
(Use this section to submit your statement, or a statement from someone else writing on your behalf)

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

SECTION IV: WITNESS CONTACT INFORMATION
(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME (First, Middle Initial, Last)

Steve L Rodgers

19. RELATIONSHIP TO VETERAN/CLAIMANT (Check all that apply)

- (●) SERVED WITH VETERAN/CLAIMANT
- ( ) FAMILY/FRIEND OF VETERAN/CLAIMANT
- ( ) COWORKER/SUPERVISOR OF VETERAN/CLAIMANT
- ( ) OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

336-926-6430

Enter International Phone Number (If applicable)

21. E-MAIL ADDRESS

CptAmerica@gmail.com

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

Steve Rodgers

22B. DATE SIGNED

Month 05 – Day 01 – Year 2022

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, or for fraudulent receipt of any document to which you are not entitled.

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 Veteran Readiness and Employment Records -VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: This form is used to submit a statement that supports a claim already pending or already established with VA. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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.

OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

LAY/WITNESS STATEMENT

VA DATE STAMP
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Clint D Barton

2. SOCIAL SECURITY NUMBER

011-25-2006

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4. DATE OF BIRTH

Month 01 – Day 11 – Year 1977

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Apt./Unit Number:

City: New York

State/Province: NY

Country: US

ZIP Code/Postal Code: 10001 –

7. TELEPHONE NUMBER (Include Area Code)

336-867-5309

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

Hawkeye222@gmail.com

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER

– –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH

Month – Day – Year

13. VA INSURANCE FILE NUMBER (If applicable)

14. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

15. TELEPHONE NUMBER (Include Area Code)

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Enter International Phone Number (If applicable)

16. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SOCIAL SECURITY NUMBER 0 1 1 – 2 5 – 2 0 0 6

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

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17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

During my time stationed at Ft. Riley, KS, I served with the claimant, then Staff Sergeant Barton. SSG Barton was my tank commander in C Co. 2/34 Armor. I was assigned as his gunner.

Our unit was conducting a field training exercise at Ft. Riley and part of that exercise consisted of nighttime mounted tank maneuvers. To simulate battlefield conditions these maneuvers were conducted with little to no light and made use of night vision or thermal devices, making it difficult to see certain terrain features. Our tank was traveling through some very tall weeds further obscuring terrain features. From my position in the gunner's seat it appeared that we were traveling across flat terrain, the tops of the weeds seemed to be at the same level all along our path. As were were driving along, the tank did a nose dive and slammed to a stop as we entered a very deep ditch. I was thrust into the sight panel in front of me and all other members of the crew were thrown into anything that was in front of them. SSG Barton was thrown forward and hit his face on the .50 machine gun and mount. His face was bloodied. Our loader was almost fully ejected from his hatch and many things in our storage racks were thrown out. I can say the force left us all very sore for quite some time. During this small unit exercise, we did not have on-site support from any medics and received no treatment. There were no injuries, at the time, that required medical evacuation and we were instructed to recover the vehicle, repair any damage and continue training

SOCIAL SECURITY NUMBER 011-25-2006

SECTION III: STATEMENT (Continued)
(Use this section to submit your statement, or a statement from someone else writing on your behalf)

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

SECTION IV: WITNESS CONTACT INFORMATION
(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME (First, Middle Initial, Last)

Tony D Stark

19. RELATIONSHIP TO VETERAN/CLAIMANT (Check all that apply)

- (●) SERVED WITH VETERAN/CLAIMANT
- ( ) FAMILY/FRIEND OF VETERAN/CLAIMANT
- ( ) COWORKER/SUPERVISOR OF VETERAN/CLAIMANT
- ( ) OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

336-575-6463

Enter International Phone Number (If applicable)

21. E-MAIL ADDRESS

iamironman@gmail.com

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

Tony Stark

22B. DATE SIGNED

Month Day Year

05-11-2022

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