

2025

COMPENSATION

PACKET

BRAZORIA COUNTY VETERANS SERVICE OFFICE
111 E. Locust, Bldg. A-29, Suite 120 • Angleton, Texas 77515
Telephone Number (979)864-1289 • Fax (979)864-1032



Sonya T. Broadway
Veteran Service Officer

Jose "JC" Cumpian
Assistant Veteran Service Officer

Kimberly Westbrook
Administrative Assistant

2025

Dear Veteran:

Please find enclosed VA Form 21-526EZ-Veteran's Application for Compensation. When you have gathered all necessary information on the enclosed checklist, please contact our office.

Respectfully,

Veteran Service Office
Brazoria County

Enclosure

***** PLEASE NOTE *****

The Brazoria County Veterans Service Office is a County Agency.

WE ARE NOT THE VA.

The (VA) Department of Veterans Affairs is a Federal Agency,
which has the POWER to Grant or Deny VA Claims.

Checklist to file Compensation- Brazoria County VSO 2025:

- _____ Certified Copy of veterans DD214
- _____ Full current name of veteran
- _____ Mailing address where VA correspondence will be properly received
- _____ Day and Evening telephone number
- _____ Best email address where your VA forms will be sent for your final review and signature
- _____ Social Security Number of Veteran
- _____ Date of Birth of Veteran
- _____ Place of Birth of veteran
- _____ Branch of Service
- _____ **VOIDED CHECK**-for Direct Deposit Purposes (if not already on VA record)
- _____ Does veteran currently get Medical Care through VA? – If yes, what VA facility?
- _____ Has veteran ever filed a VA Claim

THREE ITEMS NECESSARY TO HELP MAKE YOUR COMPENSATION CLAIM A SUCCESS!

1. A CURRENT DIAGNOSIS OF THE DISABILITY YOU ARE CLAIMING:

You would not file a claim for "Broken Right Leg" if your right leg is not currently broken. INSTEAD, if a doctor has diagnosed you with Degenerative Arthritis in your Right Leg, you would file for "Degenerative Arthritis in Right Leg, secondary to broken Right Leg in the service".

2. AN EVENT WHICH HAPPENDED IN THE SERVICE, THAT CAUSED OR CONTRIBUTED TO YOUR CURRENT DIAGNOSED DISABILITY:

In the above example, your service medical records would show that you were treated for a broken right leg. In a hearing loss claim, your service records may reflect that you were a Jet Engine Mechanic during a time period when there was no hearing protection program in place.

3. A NEXUS/MEDICAL EVIDENCE

A Medical Link between the in-service event, and the current diagnosis. The veteran has to prove a relationship between the thing which happened in service, and the present disability. No problem, right? Any dummy can understand that the broken right leg in-service led to the degenerative arthritis, right? WRONG!

The VA requires MEDICAL EVIDENCE, which positively links the two. A doctor must state, that based on her/his examination of the leg, it is more likely than not that, the current diagnosis is related to the in-service injury.

SECTION V: CLAIM INFORMATION (Continued) (For additional space, use Section XIII: Claim Information (Addendum))			
CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENERD
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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. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.			
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	
	<input type="text"/> - <input type="text"/>	<input type="checkbox"/> Don't have date	
	<input type="text"/> - <input type="text"/>	<input type="checkbox"/> Don't have date	
	<input type="text"/> - <input type="text"/>	<input type="checkbox"/> 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		
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 or 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 VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," complete Item 18B) <input type="checkbox"/> NO (If "No," skip to Item 19A)		18B. LIST THE OTHER NAME(S) YOU SERVED UNDER: _____ _____ _____	
19A. BRANCH OF SERVICE <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS		19B. COMPONENT <input type="checkbox"/> ACTIVE <input type="checkbox"/> RESERVES <input type="checkbox"/> NATIONAL GUARD	
20A. MOST RECENT ACTIVE SERVICE DATES ENTRY DATE: Month Day Year [] [] [] - [] [] [] - [] [] [] EXIT DATE: Month Day Year [] [] [] - [] [] [] - [] [] []		20B. PLACE OF LAST OR ANTICIPATED SEPARATION _____ _____ _____	
20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input type="checkbox"/> NO		20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable) FROM: Month Day Year [] [] [] - [] [] [] - [] [] [] TO: Month Day Year [] [] [] - [] [] [] - [] [] []	
21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES (If "Yes," complete Items 21B through 21F) <input type="checkbox"/> NO (If "No," skip to Item 22A)		21B. COMPONENT <input type="checkbox"/> NATIONAL GUARD <input type="checkbox"/> RESERVES	21C. OBLIGATION TERM OF SERVICE FROM: Month Day Year [] [] [] - [] [] [] - [] [] [] TO: Month Day Year [] [] [] - [] [] [] - [] [] []
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? <input type="checkbox"/> YES <input type="checkbox"/> NO
22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="checkbox"/> YES (If "Yes," complete Items 22B & 22C) <input type="checkbox"/> NO	22B. DATE OF ACTIVATION: Month Day Year [] [] [] - [] [] [] - [] [] []		22C. ANTICIPATED SEPARATION DATE: Month Day Year [] [] [] - [] [] [] - [] [] []
23A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES (If "Yes," complete Item 23B) <input type="checkbox"/> NO	23B. DATES OF CONFINEMENT FROM: Month Day Year TO: Month Day Year [] [] [] - [] [] [] - [] [] [] [] [] [] - [] [] [] - [] [] [] FROM: Month Day Year TO: Month Day Year [] [] [] - [] [] [] - [] [] [] [] [] [] - [] [] [] - [] [] []		

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

24A. ARE YOU RECEIVING MILITARY RETIRED PAY? <input type="checkbox"/> YES (If "Yes," complete Items 24C and 24D) <input type="checkbox"/> NO		24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)) <input type="checkbox"/> YES <input type="checkbox"/> NO	
24C. BRANCH OF SERVICE <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS		24D. MONTHLY AMOUNT \$ [] [] [] , [] [] [] .00	25. RETIRED STATUS <input type="checkbox"/> RETIRED <input type="checkbox"/> PERMANENT DISABILITY RETIRED LIST <input type="checkbox"/> 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.

SECTION XI: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

NOTE: An alternate signer signature will not be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

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)

36B. DATE SIGNED (MM-DD-YYYY)

[] [] - [] [] - [] [] [] [] [] []

SECTION XII: 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

37B. DATE SIGNED (MM-DD-YYYY)

[] [] - [] [] - [] [] [] [] [] []

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 the fraudulent acceptance of any payment to which you are not entitled.

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 Veteran Readiness 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.

SECTION XIII: CLAIM INFORMATION (ADDENDUM)

(Please submit this page with the completed application if you have additional disabilities to add to your claim. If more space is needed, please make additional copies of this page to submit with your application.)

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 on guidance on how to complete Section XIII.

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATES 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, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENERD
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