

BRAZORIA COUNTY VETERANS SERVICE OFFICE

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ANGLETON, TEXAS 77515



JOHN E. JERABECK
VETERANS SERVICE OFFICER



SONYA BROADWAY
ASST. VETERANS SERVICE OFFICER

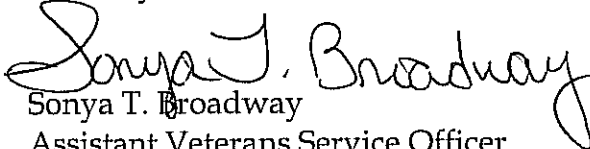
2009 DEPENDENCY & INDEMNITY COMPENSATION

Surviving Spouse:

Please find enclosed information about Dependency and Indemnity Compensation; VA Form 21-534- Application for Dependency and Indemnity Compensation; VA Form 21-22- Appointment of Veterans Service Organization as Claimant's Representative; and VA Form 21-4138- Statement in Support of Claim. When you have completed all necessary documents **please call our office at (979) 864-1289** to set up an appointment to visit with one of our Veteran Service Officers.

If you have any questions please call.

Sincerely,


Sonya T. Broadway
Assistant Veterans Service Officer
Brazoria County

Enclosures

(979) 864-1289 (979) 388-1289 (281) 756-1289

Fax: (979) 864-1032

E-mail: johnj@brazoria-county.com or sonyat@brazoria-county.com or kimberlyw@brazoria-county.com

Website: <http://www.brazoria-county.com/veterans>

Dependency and Indemnity Compensation (DIC)- FOR THE SURVIVING SPOUSE

What Is DIC?

DIC is a monthly benefit paid to eligible survivors of a

- military service member who died while on active duty, active duty for training, or inactive duty training, OR
- veteran whose death resulted from a service-related injury or disease, OR
- veteran whose death resulted from a non service-related injury or disease, and who was receiving, or was entitled to receive, VA Compensation for service-connected disability that was rated as totally disabling
 - for at least 10 years immediately before death, OR
 - since the veteran's release from active duty and for at least five years immediately preceding death, OR
 - for at least one year before death if the veteran was a former prisoner of war who died after September 30, 1999.

Who Is Eligible?

The ***surviving spouse*** if he or she:

- validly married the veteran before January 1, 1957, OR
- was married to a service member who died on active duty, active duty for training, or inactive duty training, OR
- married the veteran within 15 years of discharge from the period of military service in which the disease or injury that caused the veteran's death began or was aggravated, OR
- was married to the veteran for at least one year, OR
- had a child with the veteran, AND
- cohabited with the veteran continuously until the veteran's death or, if separated, was not at fault for the separation, AND
- is not currently remarried.*

Note: *A surviving spouse who remarries on or after December 16, 2003, and on or after attaining age 57, is entitled to continue to receive DIC.*

The ***surviving child(ren)***, if he/she is:

- not included on the surviving spouse's DIC
- unmarried AND
- under age 18, or between the ages of 18 and 23 and attending school.

Note: *Certain helpless adult children are entitled to DIC. Call the toll-free number below for the eligibility requirements.*

The ***surviving parent(s)*** may be eligible for an income-based benefit. See our fact sheet, *Parents' DIC*.

How Much Does VA Pay?

The basic monthly rate of DIC is \$1,154 for an eligible surviving spouse. The rate is increased for each dependent child, and also if the surviving spouse is housebound or in need of aid and attendance. VA also adds a transitional benefit of \$286 to the surviving spouse's monthly DIC if there are children under age 18. The amount is based on a family unit, not individual children. Benefit rate tables, including those for children alone and parents, can be found on the Internet at <http://www.vba.va.gov/bln/21/Rates>.

How Should a Claimant Apply?

Claimants should complete VA Form 21-534 *Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child*.

What Are Some Related Benefits?

Health Care (CHAMPVA)
Home Loan Guaranty

Federal Employment Preference
Survivors' & Dependents' Educational Assistance

For More Information, Contact Brazoria County Veterans Services 979-864-1289

Compensation and Pension Service – December 2008



**Department of
Veterans Affairs**

OMB Approved No. 2900-0004
Respondent Burden: 1 hour 15 minutes

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable)
VA Form 21-534

Please read the attached "General Instructions" before you fill out this form.

SECTION I Tell us what you are applying for and what you and the deceased veteran have applied for	1. Did the veteran ever file a claim with VA? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 2)	2. What is the VA file number? _____
	3. Has the surviving spouse or child ever filed a claim with VA? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 4 through 6)	4. What is the VA file number? _____
	5. What is the name of the person on whose service the claim was filed? _____	
	6. What is your relationship to that person? _____	
	7. Are you claiming service connection for cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	8. What is the veteran's name? _____	
	9. What is the veteran's Social Security number? _____	
SECTION II Tell us about you and the deceased veteran Attach a copy of the death certificate unless the veteran died in active service of the Army, Navy, Air Force, Marine Corps, or Coast Guard, or in a U.S. government institution.	10a. Did the veteran serve under another name? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 10b)	11. What is the veteran's date of birth? _____ mo day yr
	10b. Please list the other name(s) the veteran served under: _____ _____	12. What is the veteran's date of death? _____ mo day yr
	13. Was the veteran a former prisoner of war? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. What is your name? (First, Middle, Last Name)
	15. What is your relationship to the veteran? (check one) <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Child	16. What is your address? _____
	Street address, Rural Route, or P.O. Box _____ Apt. number _____	
	City _____ State _____ ZIP Code _____ Country _____	
	17. What are your telephone numbers? (Include Area Code) Daytime _____ Evening _____	18. What is your e-mail address? _____
	19. What is your Social Security number? _____	20. What is your date of birth? _____ mo day yr

SECTION III Tell us about the veteran's active duty service

1. Enter complete information for all periods of service. If more space is needed use Item 48 "Remarks."

2. If the veteran never filed a claim with VA, attach the original DD214 or a certified copy for each period of service listed. We will return original documents to you.

Note: Skip to Section IV if the veteran was receiving VA compensation or pension at the time of his/her death.

21a. Entered Active Service (first period) _____ mo day yr	21b. Place	21c. Service Number	
21d. Left This Active Service _____ mo day yr	21e. Place	21f. Branch of Service	21g. Grade, Rank, or Rating
21h. Entered Active Service (second period) _____ mo day yr	21i. Place	21j. Service Number	
21k. Left This Active Service _____ mo day yr	21l. Place	21m. Branch of Service	21n. Grade, Rank, or Rating

SECTION IV Tell us about your and the veteran's marital history

Attach a copy of your marriage certificate showing your marriage to the veteran.

Note: Skip to Section V if the veteran was receiving additional VA benefits for you as his/her spouse at the time of his/her death *unless* you remarried after the veteran's death.

You must furnish complete information about all marriages of the surviving spouse and the veteran. If you need additional space, please attach a separate sheet of paper providing the requested information about the marriages.

The veteran's marriages

22a. How many times was the veteran married? _____

22b. Date of Marriage _____ mo day yr	22c. Place (city/state or country)	22d. To whom married (first, middle initial, last name)	22e. Date marriage ended _____ mo day yr	22f. Place (city/state or country)	22g. How marriage ended (death, divorce)

The surviving spouse's marriages. Note: Items 23a through 27 should be completed by the veteran's surviving spouse. If the claimant is not the surviving spouse, skip to Section V.

23a. How many times were you married? _____ 23b. Have you remarried since the death of the veteran? Yes No

23c. Date of Marriage _____ mo day yr	23d. Place (city/state or country)	23e. To whom married (first, middle initial, last name)	23f. Date marriage ended _____ mo day yr	23g. Place (city/state or country)	23h. How marriage ended (death, divorce)

SECTION IV Tell us about your and the veteran's marital history (continued)

Answer Item 24 only if you were married to the veteran for less than one year.	24. Was a child born to you and the veteran during your marriage or prior to your marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Are you expecting the birth of a child of the veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
	26. Did you live continuously with the veteran from the date of marriage to the date of his/her death? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "No", answer Item 27)</i>	27. What was the cause of the separation? Give the reason, date(s), and duration of the separation. If the separation was by court order, attach a copy of the order.

SECTION V Tell us about the unmarried children of the veteran

Note: You should provide a copy of the public record of birth or a copy of the court record of adoption for each child listed in Item 28a *unless* the veteran was receiving additional VA benefits for the child.

If you need additional space, please attach a separate sheet of paper providing the requested information about each child.

Note: Skip to Section VI if you are not claiming benefits for any children that meet the following criteria.

VA recognizes the veteran's biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 29e) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note to surviving spouse: If entitlement to DIC is established, a "seriously disabled" child over age 18 is entitled to receive DIC benefits in his or her own right. A veteran's child who is seriously disabled and over age 18 must submit a separate VA Form 21-534 to apply for benefits.

28a. Name of child (First, middle initial, Last)	28b. Date and place of birth (City/State or Country)	28c. Social Security Number	29a. Biological	29b. Adopted	29c. Stepchild	29d. 18 - 23 yrs old and in school	29e. Seriously disabled	29f. Child previously married
	_____ mo day yr		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION V Tell us about the unmarried children of the veteran (continued)

Tell us about the children listed above that don't live with you.

30a. Name of child (first, middle initial, last)	30b. Child's Complete Address	30c. Name of person the child lives with (if applicable)	30d. Monthly amount you contribute to child's support
			\$
			\$
			\$

SECTION VI Tell us if you are housebound, in a nursing home or require aid and attendance

If you answered "yes" to Item 31 and are not in a nursing home, submit a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, the amount you pay out-of-pocket for your care, and whether Medicaid covers all or part of your nursing home costs.

<p>31. Are you claiming aid and attendance allowance and/or housebound benefits because you need the regular assistance of another person, are having severe visual problems, or are housebound?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If "No," skip to section VII)</i></p>	<p>32a. Are you now in a nursing home?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If "Yes," answer Items 32b and 32c also)</i></p>
<p>32b. What is the name and complete mailing address of the facility?</p>	<p>32c. Does Medicaid cover all or part of your nursing home costs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If "No," answer Item 32d also)</i></p>
<p>32d. Have you applied for Medicaid?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

SECTION VII Tell us the net worth of you and your dependents

Note: If you are filing this application on behalf of a minor or incompetent child of the veteran and you are the child's custodian, you must report your net worth as well as the net worth of the child for whom benefits are claimed.

VA cannot pay you pension if your net worth is sizeable. Net worth is the market value of all interest and rights you have in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture. You must report net worth for yourself and all persons for whom you are claiming benefits.

For Items 33a through 33f, provide the amounts. If none, write "0" or "None."

Source	Surviving spouse or Custodian of children	Child(ren)		
		Name: <i>(first, middle initial, last)</i>	Name: <i>(first, middle initial, last)</i>	Name: <i>(first, middle initial, last)</i>
33a. Cash, bank accounts, certificates of deposit (CDs)				
33b. IRAs, Keogh Plans, etc.				
33c. Stocks, bonds, mutual funds				
33d. Value of business assets				
33e. Real property (not your home)				
33f. All other property				

SECTION VIII Tell us about the income of you and your dependents

Payments from any source will be counted, unless the law says that they don't need to be counted. Report all income, and VA will determine any amount that does not count.

Note: If you are filing this application on behalf of a minor of whom you are the custodian, you must report your income as well as the income of each child for whom benefits are claimed.

Report the total amounts before you take but deductions for taxes, insurance, etc. Do not report the same information in both tables. If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space. If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space. If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

34a. Have you claimed or are you receiving benefits from the Social Security Administration on your own behalf or on behalf of child(ren) in your custody? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," answer item 34b)</i>	34b. Is Social Security based on your own employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
35. Has a surviving spouse or child filed a claim for compensation from the Office of Worker's Compensation Programs based on the death of the veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	36. Has a court awarded damages based on the death of the veteran or is a claim or legal action for damages pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
37. Have you claimed or are you receiving Survivor Benefit Plan (SBP) annuity from a service department based on the death of the veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION VIII Tell us about the income of you and your dependents (continued)

Monthly Income - Tell us the income you and your dependents receive every month

Sources of recurring monthly income	Surviving spouse or Custodian of children	Child(ren)		
		Name: <i>(first, middle initial, last)</i>	Name: <i>(first, middle initial, last)</i>	Name: <i>(first, middle initial, last)</i>
38a. Social Security				
38b. U.S. Civil Service				
38c. U.S. Railroad Retirement				
38d. Military Retirement				
38e. Black Lung Benefits				
38f. Supplemental Security Income (SSI)/ Public Assistance				
38g. Other income received monthly (Please write source below:)				

Expected income next 12 months - Tell us about other income for you and your dependents

Report expected income for the 12 month period following the veteran's death. If the claim is filed more than one year after the veteran died, report the expected income for the 12 month period from the date you sign this application.

Sources of income for the next 12 months	Surviving spouse or Custodian of children	Child(ren)		
		Name: <i>(first, middle initial, last)</i>	Name: <i>(first, middle initial, last)</i>	Name: <i>(first, middle initial, last)</i>
39a. Gross wages and salary				
39b. Total dividends and interest				
39c. Other income expected (Please write source below:)				
39d. Other income expected (Please write source below:)				

SECTION XI Give us your signature

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

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 except protected health information, and I waive any privilege which makes the information confidential.

44. Your signature		45. Today's date _____
46a. Signature of witness (If claimant signed above using an "X")	46b. Printed name and address of witness	
47a. Signature of witness (If claimant signed above using an "X")	47b. Printed name and address of witness	

SECTION XII

Remarks - Use this space for any additional statements that you would like to make concerning your application.

IMPORTANT

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 which you are not entitled to.

48. Remarks (If you need more space to answer a question or have a comment about a specific item number on this form please identify your answer or statement by the part and item number)



**APPOINTMENT OF VETERANS SERVICE ORGANIZATION
AS CLAIMANT'S REPRESENTATIVE**

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, "Appointment of Individual As Claimant's Representative."

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER (Include prefix)
3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on reverse side before selecting organization)	
3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZED TO ACT ON VETERAN'S BEHALF	

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER	5. INSURANCE NUMBER(S) (Include letter prefix)		
6A. SERVICE NUMBER(S)	6B. BRANCH OF SERVICE		
7. NAME OF CLAIMANT (If other than veteran)	8. RELATIONSHIP (If other than veteran)		
9. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)	10. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)		
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 2px;">A. DAYTIME ()</td> <td style="width:50%; padding: 2px;">B. EVENING ()</td> </tr> </table>	A. DAYTIME ()	B. EVENING ()
A. DAYTIME ()	B. EVENING ()		
	11. DATE OF THIS APPOINTMENT		

12. 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 service organization named on this appointment form 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 service organization named in Item 3A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Rediscovery of these records by my service organization 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 service organization named above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - My consent in Item 12 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:

I, the claimant named in Items 1 or 7, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim for any and all benefits from the Department of Veterans Affairs based on the service of the veteran named in Item 1. I authorize the Department of Veterans Affairs to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to that service organization appointed as my representative. It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney. I understand that the service organization I have appointed as my representative may revoke this power of attorney at any time, subject to 38 CFR 20.608. *Additionally, in those cases where a veteran's income is being developed because of an income verification necessitated by an Internal Revenue Service verification match, the assignment of the service organization as the veteran's representative is only valid for five years from the date this form is signed for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

14. SIGNATURE OF CLAIMANT (Do Not Print)	15. DATE SIGNED
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VA USE ONLY	VA FORM 21-22-1 SENT TO: <input type="checkbox"/> CER FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> INSURANCE FILE <input type="checkbox"/> CH. 30 <input type="checkbox"/> DEA FILE <input type="checkbox"/> LG FILE	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)
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NOTE: As long as this appointment is in effect the organization named herein will be recognized as the sole agent for presentation of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.



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, Compensation, Pension, Education and Rehabilitation 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.whitehouse.gov/omb/library/OMBINV.html#VA. 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 (<i>Type or print</i>)	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:

(CONTINUE ON REVERSE)

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 (<i>Include Area Code</i>)		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">DAYTIME</td> <td style="width: 50%; padding: 5px;">EVENING</td> </tr> </table>	DAYTIME	EVENING
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.