Dec. 9. 2013 3:34PM NETWORK OFFICE

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No. 3859 P. 2

OMB Number: 2900-0260 Estimated Burden: 2 minutes Expiration Date: 11/30/2007

Department of Veterans Affairs	UEST FOR AND AU RECORDS	JTHORIZATION TO RELEASE MEDICAL OR HEALTH INFORMATION				
The Paperwork Reduction Act of 1995 requires us to notify you that this inform Act. We may not conduct or sponsor, and you are not required to respond to, a expended by all individuals completing this form will average 2 minutes. This is purpose of this form is to specifically outline the circumstances under which we	collection of information un ncludes the time to read inst may disclose data.	ess it displays a valid OMB number. We expect that the time ructions, gather the necessary facts and fill out the form. The				
The execution of this form does not authorize the release of information other the under Title 38, U.S.C. The form authorizes release of information in accordance 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure including Social Security Number (SSN) (the SSN will be used to locate record will be unable to comply with the request. The Veterans Health Administration authorization.	e with the Health Insurance : of the information requested a for release) is not furnished may not condition treatmen	Fortability and Accountability Act, 45 CFR Farts 150 and 164, on this form is voluntary. However, if the information I completely and accurately, Department of Veterans Affairs t, payment, enrollment or eligibility on signing the				
ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECU	CALL STATE OF THE OWNER OWN					
TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Mic	dle initial)				
	Moura, Raymond	1				
VA Greater Los Angeles Healthcare System	SOCIAL SECURITY NUMBER					
	563-65-8617					
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHO	OM INFORMATION IS TO BE REL	EASED				
New Directions for Veterans						
VETERAN'S REQUEST: I request and authorize Department of Vet individual named on this request. I understand that the information to l	crans Affairs to release the released includes infor	te information specified below to the organization, or mation regarding the following condition(s):				
		N IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA				
TNFORMATION REQUESTED (Check applicable box(es) and state t approximate dates covered by each)	• .					
VA eligibility, Mental Health and addiction		iformation				
*						
PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL	O WHOM INFORMATION IS TO	BE RELEASED				
Exploring tréatment options for Mr. Moura	to address his	addictions treatment needs.				
NOTE: ADDITIONAL ITEMS OF INFORMATION	DESIRED MAY BE LIST	ED ON THE BACK OF THIS FORM				
AUTHORIZATION: I certify that this request has been made freely accurate and complete to the best of my knowledge. I understand the in writing, at any time except to the extent that action has already bee Release of Information Unit at the facility housing the records. Redis information may be accomplished without my further written authorit authorization will automatically expire: (1) upon satisfaction of the ne under the following condition(s):	at I will receive a copy of n taken to comply with it colosure of my medical re ration and may no longer	this form after I sign it. I may revoke this autorization, Written revocation is effective upon receipt by the cords by those receiving the above authorized be properted. Without my express revocation, the				
Range V. Man	n					
I understand that the VA health care practitioner'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.						
DATE SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)						
	VA USE ONLY TYPE AND EXTENT OF MATE	R/AL RELEASED				
IMPRINT PATIENT DATA CARD (Name, Address, Social Security Number)		a man su				
	DATE RELEASED	RELEASED BY				

THIS SUPERSEDES VA FORM 10-5345, DATED JUN 2001, WHICH WILL NOT BE USED.

Dec. 9. 2013 3:34PM NETWORK OFFICE

No. 3859 P. 3

OMB Number: 2900-0260 Estimated Burden: 2 minutes Expiration Date: 11/30/2007

È	Department of Veterans Affairs	EG	UEST FOR AND AU RECORDS	JTHORIZATION TO RELEASE MEDICAL OR HEALTH INFORMATION		
Act. We expended purpose	erwork Reduction Act of 1995 requires us to notify you that this information in the second second to the second to a sponsor, and you are not required to respond to a by all individuals completing this form will average 2 minutes. The of this form is to specifically outline the circumstances under which	his i we	ncludes the time to read inst may disclose data.	tess it displays a valid OMB humber. We expect that his inter- ructions, gather the necessary facts and fill out the form. The		
under Ti 5 U.S.C.		ance ure ords tion	e with the Health Insurance of the information requested s for release) is not furnished may not condition treatmen	Portability and Accountability Act, 45 CFR Parts 100 and 104, on this form is voluntary. However, if the information I completely and accurately, Department of Veterans Affairs i, payment, enrollment or eligibility on signing the		
	ENTER BELOW THE PATIENT'S NAME AND SOCIAL SE	CU	RITY NUMBER IF THE P	ATIENT DATA CARD IMPRINT IS NOT USED.		
TO: DEPA care facilit	RTMENT OF VETERANS AFFAIRS (Print or type name and address of health		PATIENT NAME (Last, First, Mic	idie Initial)		
VA Greater Los Angeles Healthcare System		Moura, Raymond				
		SOCIAL SECURITY NUMBER				
		)	563-65-8617			
NAME AN	D ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO	WHO	OM INFORMATION IS TO BE REL	.EASED		
Off: 301	ice of Congresswoman Lois Capps E. Carrillo, Ste A, Santa Barbara, (	CA	93101 (805) 730	0-1710		
VETE: individ	RAN'S REQUEST: I request and authorize Department of ual named on this request. I understand that the information	to t	be released includes infor	mation regarding the following condition(s):		
	RUG ABUSE 💢 ALCOHOLISM OR ALCOHOL ABUSE 🔲 TESTIN	NG F	OR OR INFECTION WITH HUMA	N IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA		
INFOR	MATION REQUESTED (Check applicable box(es) and sta imate dates covered by each)	te f	he extent or nature of the	information to be disclosed, giving the dates or		
	COPY OF HOSPITAL SUMMARY	IENT	TNOTE(S) X OTHER (S	Specify)		
VA	eligibility, Mental Health and addic	tid	ong treatment in	nformation		
PURPOS	E(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDU	JAL 1	TO WHOM INFORMATION IS TO	BE RELEASED		
Exp	loring treatment options for Mr. Mou	ra	to address his	addictions treatment needs.		
1.acm.ar.n	NOTE: ADDITIONAL ITEMS OF INFORMATI	ION	DESIRED MAY BE LIST	TED ON THE BACK OF THIS FORM		
inform author	HORIZATION: I certify that this request has been made free and complete to the best of my knowledge. I understand ting, at any time except to the extent that action has already se of information Unit at the facility housing the records. Re- nation may be accomplished without my further written auth rization will automatically expire: (1) upon satisfaction of the the following condition(s):	ecly the bes cdis torizent	, voluntarily and without at I will receive a copy of n taken to comply with it closure of my medical re zation and may no longer sed for disclosure; (2) on	coercion and that the information given above is this form after I sign it. I may revoke this authorization, Written revocation is effective upon receipt by the cords by those receiving the above authorized be protected. Without my express revocation, the 3/9/14 (date supplied by patient); (3)		
	Rand V. M.	-	~			
other	lerstand that the VA health care practitioner's opinions a • VA benefits or, if I receive VA benefits, their amount. T e at a VA Regional Office that specializes in benefit decis	The	y may, however, be cons	cial VA decísions regarding whether I will receive sidered with other evidence when these decisions are		
DATE SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to algn, a.g., POA)						
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IMPOINT	T PATIENT DATA CARD (Name, Address, Social Security Number)	OR	VAUSE ONLY TYPE AND EXTENT OF MATE	RIAL RELEASED		
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THIS SUPERSEDES VA FORM 10-5345, DATED JUN 2001, WHICH WILL NOT BE USED.

# Department of Veterans Affairs

### INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

### Please Read Before You Start ... What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

### Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at http://www.va.gov and select "Contact the VA."
- · Contact the Enrollment Coordinator at your local VA health care facility.
- · Contact a National or State Veterans Service Organization.

#### Definitions of terms used on this form:

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation. NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

### **Getting Started:**

### ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

#### Directions for Sections IV - VII:

### Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- · those in receipt of a Purple Heart; or
- · a recently discharged Combat Veteran; or
- · those discharged for a disability incurred or aggravated in the line of duty; or
- · those receiving VA SC disability compensation; or
- · those receiving VA pension; or
- · those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between January 1, 1957 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

# Continued ...

Section IV - Dependent Information: Include the following:

- · Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- · Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children. Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

# Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI)and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

# Section VI - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

# Section VII - Previous Calendar Year Net Worth.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

# Section VIII - Submitting your application.

- 1. Read Paperwork Reduction and Privacy Act Information, Section VIII Consent to Copays and Assignment of Benefits.
- 2. In Section VIII, you or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
- 3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

# Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200 Atlanta, GA 30329.

# FATTER DOR REDUCTION AND AND ADD ACTIVED AND ADD

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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**Privacy Act Information:** VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. 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 systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Dec. 9. 2013 3:35PM NETWORK OFFICE

No. 3859 P. 6

OMB Approved No. 2900-0091 Estimated Burden Avg. 30 min.

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# Dec. 9. 2013 3:35PM NETWORK OFFICE

No. 3859 P. 7

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME (Las	SOCIAL SECURITY NUMBER					
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1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH (mm/dd/yyyy) 2B. CHILD'S SOCIAL SECURITY NUMBER						
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1C. DATE OF MARRIAGE (mm/dd/y999)		2D. CHILD'S RELATIONSHIP TO YOU (Check one)						
		SON DAUGHTER STEPSON STEPDAUGHTER						
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1D. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (Street, City, State, ZIP - if different from Veteran's)		YES	D NO					
		2F. IF CHILD IS BETWI CALENDAR YEAR?	EEN 18 AND 23	YEARS OF AGE, DID	CHILD ATTEND SCHOOL LAST			
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