Mapping Your Future: A Guide to Successful Reentry
2016-17 Edition
Produced by the Education Justice Project,
University of Illinois

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BIRTH RECORD REQUEST FORM

To obtain a copy of a birth record from the Cook County Clerk’s Office, please read the following: Certified copies of birth records cost $15 for the first copy, which is nonrefundable if no record is found and a Certification That No Record Was Found is issued, and $4 for each additional copy of the same record.

Four ways to obtain a birth record:

Mail your request to:
Bureau of Vital Records
PO Box 641070
Chicago, Il 60664-1070

Fill out the form on the reverse side and include:
- A check or money order payable to the Cook County Clerk
- A photocopy of your photo identification (e.g. driver’s license, or State issued identification, etc.)
- A self-addressed stamped envelope

Call our Vital Chek Hotline:
(866) 252-8974
Charge your order to a major credit card for an additional fee.

Go to a Local Currency Exchange:
Call (847) 759-8905 for Currency Exchange locations and hours
Obtain your record for an additional $5 fee.

Visit us in person and pay with cash or debit card
(Sorry, we can’t accept Visa):
50 West Washington Street, Chicago, Illinois, Room CL-25
Or, visit one of our five suburban offices.
Call (312) 603-7790 for locations and hours.

Under Illinois law [410 ILCS 53/25 (4) (b)] a certified copy of a birth record is only available to persons with a “direct and tangible interest” in the record, such as one’s self, parent, guardian or legal representative. Anyone who willfully and knowingly uses or attempts to use any certificate and/or certification for the purposes of deception is guilty of a Class 4 felony [410 ILCS 53/27 (c), (f)] punishable up to three years in prison.

Your Name
 signature

Mailing Address

How would you like to receive this document?

- [ ] Mail it to me
- [ ] I’ll wait for it
- [ ] I’ll pick it up later

David Orr
Cook County Clerk
Bureau of Vital Records
50 West Washington Street, Room CL-25
Chicago, Illinois 60602
(312) 603-7790 / VITAL_RECORDS@cookcountyil.gov
www.cookcounty clerk.com
Application for Search of Birth Record Files

The Division of Vital Records offers two types of birth certificates available for legal purposes. Please indicate your choice below and return this form with the proper fee and a legible copy of your non-expired, government issued photo ID.

Illinois Law (ILCS410/535/25(1)) requires advanced payment for the search of birth record files. This $10.00 search fee, included in the price of the copy(ies) you are requesting, is non-refundable.

DO NOT SEND CASH – Make check or money order payable to: ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Birth certificate (with the following items: name, date of birth, sex, place of birth, mother/co-parent's maiden name, mother/co-parent's place of birth, mother/co-parent's age, father/co-parent's name, father/co-parent's place of birth, father/co-parent's age, file date, date issued and State File number)

$10.00 first copy $2.00 each additional copy

Amount enclosed $__________ for ________ total copies

Birth certificate (with available information collected at time of birth - information has varied throughout the years)

$15.00 first copy $2.00 each additional copy

Amount enclosed $__________ for ________ total copies

Foreign birth (births of adopted persons born outside of the U.S. who were re-adopted in Illinois) OR
ADMINISTRATIVE FOREIGN BIRTH RECORD

$5.00 each copy

Amount enclosed $__________ for ________ total copies

Genealogical (uncertified) (records 75 years old and older)

$10 first copy $2 each additional copy

Amount enclosed $__________ for ________ total copies

FULL NAME (First, Middle, Last Prior to First Marriage/Civil Union)

PLACE OF BIRTH (Hospital, City or Town, County, State)

DATE OF BIRTH (Month, Day, Year) SEX BIRTH CERTIFICATE NUMBER (if known)

FATHER/CO-PARENT’S NAME (First, Middle, Last Prior to First Marriage/Civil Union, Current Legal Last Name)

MOTHER/CO-PARENT’S NAME (First, Middle, Last Prior to First Marriage/Civil Union, Current Legal Last Name)

INDIVIDUAL REQUESTING COPIES

MAIL RECORD(S) TO: (If other than applicant)

PRINT NAME ____________________________ NAME ____________________________

STREET ADDRESS ____________________________ AGENCY ____________________________

CITY_________ STATE ________ ZIP ________ STREEX ADDRESS________________________

YOUR RELATIONSHIP TO PERSON ____________________________ CITY_________

INTENDED USE ____________________________ STATE ________ ZIP ________

SIGNATURE ____________________________

NOTE: Birth Certificates are confidential records and copies can only be issued to persons entitled to receive them (for a complete list, see other side). The application must indicate the requestor’s relationship to the person and the intended use of the document. (SEE OTHER SIDE)

MAIL TO: Illinois Department of Public Health, Division of Vital Records, 925 E. Ridgely Avenue, Springfield, IL 62702-2737

For more information - www.idph.state.il.us/vitalrecords/index.htm

VR 180 (Rev. 2/15) Printed by Authority of the State of Illinois P.O.#1415146 3M 2/15 IOCI 15-571
September 10, 2012

Sally Jenkins
ABC Company
123 Main St.
City, ST 20202

Dear Ms. Jenkins,

I am writing to inquire about possible openings at ABC Company for a research assistant. I am interested in a senior level position offering the opportunity for travel and advanced research assignments.

As a professional administrative assistant with excellent research skills, I am eager to contribute my abilities and experience to ABC Company. Given my extensive training and background, I believe I can help ABC Company meet its goal of providing only the most accurate and timely information to its clients.

Please find enclosed my resume and a list of my references. Feel free to call me at 100.200.3000 to arrange a time to meet. I look forward to hearing from you.

Sincerely,

Mary Green
John Albert Johnson

WORK EXPERIENCE

Adult Learning Center, Our Town, IL
English Teacher. Coordinate community outreach efforts and administer institutional examinations.
February 2015 – Present

Friendly Temp Agency, Our Town, IL
Various assignments involving administrative and clerical roles.
March 2013 – December 2014

Illinois Central Community College, Decatur, IL
ESL Teacher, peer tutor.
August 2010 - January 2013

EDUCATION

Associates Degree, awarded 2011
Illinois Central Community College
Education course work:
- Advanced mathematics
- Linguistics for language teachers
- Political and historical perspectives in Education
- Sociology of Education and Philosophy of Education

Certificate, Peer Counseling
Illinois Central Community College
2012

Certificate, Horticulture
Northern Illinois Community College
2009
REFERENCES
Sharon Mendez, Coordinator
Adult Learning Center
1010 Central Street
Our Town, IL 60000
sharonmendez@email.com
555.555.5555

William Smith, Director
Friendly Temp Agency
40 North Ave.
Our Town, IL 66666
williamsmith@email.com
555.555.5555
Mr. Earl M. Walker
(872) 395-0704
walkerearl78@yahoo.com

Brilliant communicator, possessing attention-demanding presence, leadership skills, and the ability to positively impact any situation

Education:
- **Chicago State University**, Chicago, IL
  - Psychology Major
  - Present
- **Kennedy-King College**, Chicago, IL
  - Physical Education Major
  - 2014
- **University of Illinois – Education Justice Project**, Urbana, IL
  - Social Justice Major
  - 2011
- **Lake Land College**, Mattoon, IL
  - *Associates in Science
    - Psychology/Sociology Major
  - 2006
  - *Small Business Management Certification
    - 2004

Accomplishments: Leadership

- **Just Leadership USA**
  - *Emerging Leader for Returning Citizens*
    - 2015
- **National Council for Student Leadership**
  - *Certified Future Leader*
    - 2014
- **Kennedy-King College**
  - *SGA Vice-President/ Senator*
    - 2013 – 2014
  - *Student Ambassador/ Dean’s List*
    - 2013 – 2014
  - *Phi Theta Kappa Honors Society Inductee*
    - 2014

Author –

- *Twice Published via the U of I Education Justice Project*
  - “Why Momma Cry” – Beyond the Pen
    - 2013
  - “Visiting Day” – Winter Harvest
    - 2012
  - *Writing for Change Symposium*
    - 2010
Community: **Motivational Speaker/Social Justice/Community Activist**

- **University of Chicago** – *Prison Abolition Panel* – Panelist 2016
- **Daily Illini of UIUC** – *Published Article: Education Justice Project Frees Incarcerated Minds* 2016
- **Education Justice Project** – *EJP Expo* – Panelist 2016
- **Community Renewal Society** – *Occupy Palm Sunday Protest Against Police Brutality* – Organizer & Activist 2016
- **Chicago Aldermanic Black Caucus Town Hall** – Activist 2016
- **Chicago Town Hall** – *Advocated Against Committee Appointing Chicago Police Superintendent* – Activist 2016
- **Lequan McDonald Protest** – *Interviewed by NBC Affiliate* 2015
- **Stop Mass Incarceration Movement** – *Marched in Bud Billiken Parade to Protest Police Brutality* – Participant 2015
- **Education Justice Project** – *Symposium on Higher Education in Prison University of Illinois* – Moderator 2014
- **Education Justice Project** – *Reception: Hosted by the President of the University of Illinois* – Presenter 2014
- **Education Justice Project** – *FACE Event* – Guest Speaker 2014
- **Prison Justice Project** – *Forum on Social Justice* – Panelist 2013
- **Life Builders United** – *Peace Keepers Back 2 School Rally* – Guest Speaker and Volunteer 2013
- **Safer Foundation** – *Job Readiness Program* – Volunteer 2013
### Federal Aid Eligibility

<table>
<thead>
<tr>
<th>Offense</th>
<th>Possession of Illegal Drugs</th>
<th>Sale of Illegal Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>1 year of ineligibility from date of conviction</td>
<td>2 years of ineligibility from date of conviction</td>
</tr>
<tr>
<td>Second</td>
<td>2 years of ineligibility from date of conviction</td>
<td>Indefinite period of ineligibility*</td>
</tr>
<tr>
<td>Third or more</td>
<td>Indefinite period of ineligibility*</td>
<td>Indefinite period of ineligibility*</td>
</tr>
</tbody>
</table>

*Under the law, an indefinite period of ineligibility continues unless your conviction is overturned or otherwise rendered invalid or you meet one of the two early reinstatement requirements specified above.*
PRO SE PETITION TO MODIFY CHILD SUPPORT

STATE OF ILLINOIS
IN THE CIRCUIT COURT OF THE _______ JUDICIAL CIRCUIT
___________ COUNTY

____________________, Plaintiff

and

____________________, Defendant

PETITION FOR MODIFICATION OF CHILD SUPPORT

I, ______________________________, without the assistance of an attorney, ask this Court to modify an existing order of child support. In support of my Petition, I state the following items are true to the best of my knowledge:

1. This Court has jurisdiction over the subject matter and the parties.

2. I am ____ years old; my address is: ________________________________; I live in __________ County; and I have lived in Illinois for at least 90 days before I filed this Petition.

3. The other parent’s name is __________________________, he/she is ____ years old; his/her address is: ______________________________; and he/she is __ is not __ a resident of Illinois.

4. On ________________, 20 ___ an order was entered by this Court (see attached) to pay $____________ per __________ in child support.
PRO SE PETITION TO MODIFY CHILD SUPPORT

5. Since the entry of this Order, there have been substantial changes in circumstances which justify the immediate modification of the child support order including:

(check all that apply)

( ) The supporting parent’s income has changed from $_______ per month to $_______ per month.

( ) The custodial parent’s income has changed from $_______ per month to $_______ per month.

( ) There has been a change in the physical custody of the minor child/ren.

( ) That one or more of the children are now emancipated (over 18 years of age).

( ) That: (write additional reasons here) __________________________________________

______________________________________________________________________________

WHEREFORE, I request:

A. That the Court determine the parties’ financial obligations and conditions and their existing abilities to contribute toward the expenses of the minor child/ren.

B. That the Court ___ increase ___ decrease the existing level of child support to reflect the changes in the parties’ obligations, conditions, and abilities to support the minor child(ren).

C. That the Court ____ (shall) ____ (shall not) require the supporting parent to maintain health insurance for the minor child(ren) if available through his/her employment.

__________________________,

Plaintiff

Under penalties as provided by law pursuant to Section 5/1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to Matters therein stated to be on information and belief and as to such matters the undersigned certifies as foresaid that she/he verily believes the same to be true.

__________________________,

Plaintiff

__________________________, pro se

Plaintiff
STATE OF ILLINOIS

IN THE CIRCUIT COURT OF THE _______ JUDICIAL CIRCUIT

___________ COUNTY

_____________________, Plaintiff

No. ____-- ___--____

_____________________, Defendant

PETITION FOR MODIFICATION OF CUSTODY

I, ________________________________, without the assistance of an attorney, ask this
Court to modify an existing order of custody. In support of my Petition, I state the following items
are true to the best of my knowledge:

1. This Court has jurisdiction over the subject matter and the parties.

2. I am ____ years old; my address is: ________________________________ ; I live
in ____________ County; and I have lived in Illinois for at least 90 days before I filed this Petition.

3. The other parent's name is ______________________, he/she is ____ years old;
his/her address is: ________________________________; and he/she is __ is not __ a
resident of Illinois.

4. On _________________, 20 ___ an order was entered by this Court (see attached)
regarding custody and visitation.
5. Since the entry of this Order, there have been substantial changes in circumstances which justify the immediate modification of the child custody, visitation, and child support order and which are described in the attached affidavit including:____________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________.

WHEREFORE, I request: that the Court modify the custody order to reflect the changes in the parties' circumstances.

________________________________________
Plaintiff

Under penalties as provided by law pursuant to Section 5/1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she/he verily believes the same to be true.

________________________________________
Plaintiff
INFORMATION REGARDING APPORTIONMENT OF BENEFICIARY'S AWARD

INSTRUCTIONS: All or part of a veteran's disability award may be apportioned (paid) to the veteran's spouse, child, or dependent parent. A surviving spouse's award may also be apportioned for the veteran's child or children. Print all answers clearly. If an answer is "none" or "0," write that or line through the space provided. For additional space, attach a separate sheet, indicating the item number to which the answers apply. Make sure to write the veteran's name and VA claim number on any attachments to the form.

IMPORTANT: If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

1. FIRST, MIDDLE, LAST NAME OF VETERAN
2. VA FILE NUMBER
3. VA FORM NOV 2014 21-0788
4. WHO ARE YOU REQUESTING AN APPORTIONMENT FOR? (List first, middle, and last names)
5. HOW MUCH IS THE VETERAN OR VETERAN'S SURVIVING SPOUSE CONTRIBUTING TO THE PERSON(S) FOR WHOM AN APPORTIONMENT IS BEING CLAIMED?
6. IF THE SPOUSE IS CLAIMING AN APPORTIONMENT, IS HE/SHE LIVING WITH ANOTHER PERSON AND HOLDING HIMSELF/HERSELF OUT OPENLY TO THE PUBLIC AS THE SPOUSE OF THE OTHER PERSON? (If "Yes," provide an explanation)
7. HAS THE VETERAN'S CHILD(REN) BEEN LEGALLY ADOPTED BY ANOTHER PERSON?

PART I - INCOME AND NET WORTH

Report all income and net worth. Report the gross amounts before you take out deductions for taxes, insurance, etc. If you do not receive income or net worth from a particular source, write "0" or "none" in the space provided. Do not leave the space blank. Note: If you are the veteran or surviving spouse, report only your income and net worth. If you are the claimant or are filing on behalf of the claimant(s), report all income and net worth for all persons for whom an apportionment is being claimed. If you are claiming an apportionment as the custodian of the veteran's child or children, report your income and net worth and the income and net worth of the child(ren).

MONTHLY INCOME

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>VETERAN OR SURVIVING SPOUSE</th>
<th>CUSTODIAN</th>
<th>PERSON APPORTIONMENT IS CLAIMED FOR</th>
<th>PERSON APPORTIONMENT IS CLAIMED FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. GROSS WAGES FROM ALL EMPLOYMENT</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>1B. SOCIAL SECURITY</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>1C. RETIREMENT OR ANNUITIES</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1D. SUPPLEMENTAL SECURITY INCOME (SSI) / PUBLIC ASSISTANCE</td>
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<tr>
<td>1E. OTHER INCOME (Show source)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1F. OTHER INCOME (Show source)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

NET WORTH

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>VETERAN OR SURVIVING SPOUSE</th>
<th>CUSTODIAN</th>
<th>PERSON APPORTIONMENT IS CLAIMED FOR</th>
<th>PERSON APPORTIONMENT IS CLAIMED FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A. CASH/NON-INTEREST-BEARING BANK ACCOUNTS</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<tr>
<td>2B. INTEREST-BEARING BANK ACCOUNTS</td>
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<tr>
<td>2C. IRAS, KEOGH PLANS, ETC.</td>
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<tr>
<td>2D. STOCKS, BONDS, MUTUAL FUNDS, ETC.</td>
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<tr>
<td>2E. REAL PROPERTY (Not your home)</td>
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<tr>
<td>2F. ALL OTHER PROPERTY AND ASSETS</td>
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</table>
### PART II - MONTHLY LIVING EXPENSES

Show your monthly living expenses, including any monthly installment payments. If you do not have expenses from a particular source, write "0" or "none" in the space provided. Do not leave the space blank.

Note: If you are the veteran or surviving spouse, report only your expenses. If you are the claimant or are filing on behalf of the claimant(s), report expenses for all persons for whom an apportionment is being claimed. If you are claiming an apportionment as the custodian of the veteran’s child or children, report your expenses and the expenses of the child(ren).

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>VETERAN OR SURVIVING SPOUSE</th>
<th>CUSTODIAN</th>
<th>PERSON APPORTIONMENT IS CLAIMED FOR</th>
<th>PERSON APPORTIONMENT IS CLAIMED FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. RENT OR HOUSE PAYMENT</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<tr>
<td>1B. FOOD</td>
<td></td>
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<tr>
<td>1C. UTILITIES</td>
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<tr>
<td>(Water, gas, electricity)</td>
<td></td>
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<tr>
<td>1D. TELEPHONE</td>
<td></td>
<td></td>
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<tr>
<td>1E. CLOTHING</td>
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<tr>
<td>1F. MEDICAL EXPENSES</td>
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<tr>
<td>1G. SCHOOL EXPENSES</td>
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<tr>
<td>1H. OTHER EXPENSES</td>
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<tr>
<td>(Show source)</td>
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<tr>
<td>1I. OTHER EXPENSES</td>
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<td>(Show source)</td>
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### PART III - CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statements are true and correct to the best of my knowledge and belief.

1. SIGNATURE OF VETERAN OR CLAIMANT                        2. DATE SIGNED

**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 is false, or fraudulent acceptance of any payment to which you are not entitled.

**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, 58VA 21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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 determine whether an apportionment of VA disability or death benefits may be made (38 U.S.C. 5307). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 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.
NOTICE TO VETERAN/SERVICE MEMBER
OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR VETERANS DISABILITY
COMPENSATION AND RELATED COMPENSATION BENEFITS

(This notice is applicable to claims for: Disability Service Connection • Secondary Service Connection • Increased Disability Compensation • Temporary Total Disability Rating • Individual Unemployability • Compensation under 38 U.S.C. 1151 • Special Monthly Compensation • Specially Adapted Housing/Special Home Adaptation • Automobile Allowance/Adaptive Equipment • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for veterans disability compensation and related compensation benefits. This notice informs you of the evidence necessary to substantiate your claim. After you submit your claim, you will not receive an initial letter regarding your claim. You do not need to resubmit another application.

May I apply electronically? You can apply for VA disability compensation and pension online through eBenefits at www.ebenefits.va.gov. For disability compensation claims, you can also upload all supporting evidence you may have and make your claim a Fully Developed Claim. To file a claim for VA disability compensation electronically, go to eBenefits, select Apply for Benefits and then Apply for Disability Compensation. You will need to create an eBenefits account to apply for disability compensation online. To file a claim for VA pension electronically, go to eBenefits, select Apply for Benefits, and then select Apply for Veterans Benefits via VONAPP. Once you submit your claim, you can track the status using eBenefits.

NOTE: You can contact an accredited Veteran Service Officer to assist you with your application.

Want your claim processed faster? The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed and there is no risk to participate! To participate in the FDC Program, if you are making a claim for veterans disability compensation or related compensation benefits, simply submit your claim in accordance with the "FDC Criteria" shown below. If you are making a claim for veterans non service-connected pension benefits, use VA Form 21-527EZ, Application for Pension. If you are making a claim for survivor benefits, use VA Form 21-534EZ, Application for DIC, Death Pension, and/or Accrued Benefits. VA forms are available at www.va.gov/vaforms.

<table>
<thead>
<tr>
<th>FDC Criteria (Claim(s) for Veterans Disability Compensation and Related Compensation Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Submit your claim on a signed and completed VA Form 21-526EZ, Application for Disability Compensation and Related Compensation Benefits (Attached).</td>
</tr>
<tr>
<td>2. Submit simultaneously with your claim: • All, if any, relevant, private medical treatment records; AND • An identification of any relevant medical treatment records available at a Federal facility, such as a VA medical center.</td>
</tr>
<tr>
<td>Special Circumstances</td>
</tr>
<tr>
<td>Under the special circumstances shown below, you must also submit simultaneously with your claim: • For National Guard and Reserve members, any and all Service Treatment and Personnel Records in the custody of your Unit(s) • If claiming dependents, a completed VA Form 21-686c, Declaration of Status of Dependents. If claiming a child in school between the ages of 18 and 23, you must also submit a completed VA Form 21-674, Request for Approval of School Attendance. If claiming benefits for a seriously disabled (helpless) child, you must also submit all, relevant, private medical treatment records pertaining to the child's pertinent disabilities • If claiming Individual Unemployability, a completed VA Form 21-8940, Veteran's Application for Increased Compensation Based on Unemployability, and a completed VA Form 21-4192, Request for Employment Information in Connection with Claim for Disability Benefits • If claiming Post-Traumatic Stress Disorder (PTSD), a completed VA Form 21-0781, Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder, or if claiming PTSD based on personal assault, a completed VA Form 21-0781a, Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder Secondary to Personal Assault • If claiming Specially Adapted Housing or Special Home Adaptation, a completed VA Form 26-4555, Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant • If claiming Auto Allowance, a completed VA Form 21-4502, Application for Automobile or Other Conveyance and Adaptive Equipment • If claiming additional benefits because you or your spouse require Aid and Attendance, a completed VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance, or if claiming Aid and Attendance based on nursing home attendance, a VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance</td>
</tr>
<tr>
<td>3. Report for any VA medical examinations that VA determines are necessary to decide your claim.</td>
</tr>
</tbody>
</table>
The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate!
Participation in the FDC Program is optional and will not affect the quality of care you receive or the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. See below for more information. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process). If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

WHAT YOU NEED TO DO
You must submit all relevant evidence in your possession and provide the VA information sufficient to enable it to obtain all relevant evidence not in your possession. If your claim involves a disability that you had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before your entry into service.

<table>
<thead>
<tr>
<th>FDC Program (Optional Expedited Process)</th>
<th>Standard Claim Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must:</td>
<td>You must:</td>
</tr>
<tr>
<td>• Submit your claim in accordance with the &quot;FDC Criteria&quot; (see page 1)</td>
<td>• If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it</td>
</tr>
<tr>
<td></td>
<td>If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. <em>It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.</em></td>
</tr>
</tbody>
</table>

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

<table>
<thead>
<tr>
<th>FDC Program (Optional Expedited Process)</th>
<th>Standard Claim Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA will:</td>
<td>VA will:</td>
</tr>
<tr>
<td>• Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain</td>
<td>• Retrieve relevant records from a Federal facility such as a VA medical center, that you adequately identify and authorize VA to obtain</td>
</tr>
<tr>
<td>• Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim</td>
<td>• Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim</td>
</tr>
<tr>
<td></td>
<td>• Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records from current or former employers</td>
</tr>
</tbody>
</table>

WHEN YOU SHOULD SEND WHAT WE NEED

<table>
<thead>
<tr>
<th>FDC Program (Optional Expedited Process)</th>
<th>Standard Claim Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must:</td>
<td>You are strongly encouraged to:</td>
</tr>
<tr>
<td>• Send the information and evidence simultaneously with your claim</td>
<td>• Send any information or evidence as soon as you can</td>
</tr>
<tr>
<td>If you submit additional information or evidence after you submit your &quot;fully developed&quot; claim, then VA will remove the claim from the FDC Program Expedited Process and process it in the Standard Claim Process. If we decide your claim before one year from the date we receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.</td>
<td>You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we receive the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.</td>
</tr>
</tbody>
</table>

WHERE TO SEND INFORMATION AND EVIDENCE
Mail or take your application and any evidence in support of your claim to the closest VA regional office. VA regional office addresses are available on the Internet at [www.va.gov/directory](http://www.va.gov/directory).
WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

<table>
<thead>
<tr>
<th>If you are claiming...</th>
<th>See the evidence table titled...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have a disability that was caused or aggravated by your service</td>
<td>Disability Service Connection</td>
</tr>
<tr>
<td>Your service connected disability caused or aggravated an additional disability</td>
<td>Secondary Service Connection</td>
</tr>
<tr>
<td>Your service connected disability has worsened</td>
<td>Increased Disability Compensation</td>
</tr>
<tr>
<td>Your service connected disability caused you to be hospitalized or to undergo surgery or other treatment</td>
<td>Temporary Total Disability Rating</td>
</tr>
<tr>
<td>Your service connected disability(ies) prevents you from getting or keeping substantial employment</td>
<td>Individual Unemployability</td>
</tr>
<tr>
<td>You have a disability caused or aggravated by VA medical treatment, vocational rehabilitation, or compensated work therapy</td>
<td>Compensation Under 38 U.S.C. 1151</td>
</tr>
<tr>
<td>Your service connected disability(ies) causes you to be in need of aid and attendance or to be confined to your residence</td>
<td>Special Monthly Compensation</td>
</tr>
</tbody>
</table>

IMPORTANT: If you are claiming homelessness see page 6 of the Instructions for more information on expediting claims for homeless veterans.

<table>
<thead>
<tr>
<th>If you are claiming benefits...</th>
<th>See the evidence table titled...</th>
</tr>
</thead>
<tbody>
<tr>
<td>For adapting and/or purchasing a residence</td>
<td>Special Adapted Housing or Special Home Adaptation</td>
</tr>
<tr>
<td>For adapting and/or purchasing a vehicle</td>
<td>Auto Allowance</td>
</tr>
<tr>
<td>Because your spouse is severely disabled</td>
<td>Special Monthly Compensation</td>
</tr>
<tr>
<td>Because your child is severely disabled</td>
<td>Helpless Child</td>
</tr>
</tbody>
</table>

EVIDENCE TABLES

**Disability Service Connection**

To support a claim for service connection, the evidence must show:

- You had an injury in service, or a disease that began in or was made permanently worse during service, or there was an event in service that caused an injury or disease; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- A relationship exists between your current disability and an injury, disease, symptoms, or event in service. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

However, under certain circumstances, VA may presume that certain current disabilities were caused by service, even if there is no specific evidence proving this in your particular claim. The cause of a disability is presumed for the following veterans who have certain diseases:

- Former prisoners of war;
- Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
- Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
- Veterans who were exposed to certain herbicides, such as by serving in Vietnam; or
- Veterans who served in the Southwest Asia theater of operations during the Gulf War.

To support a claim for service connection based upon a period of active duty for training, the evidence must show:

- You were disabled during active duty for training due to disease or injury incurred or aggravated in the line of duty; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- There is a relationship between your current disability and the disease or injury incurred or aggravated during active duty for training. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support a claim for service connection based upon a period of inactive duty training, the evidence must show:

- You were disabled during inactive duty training due to an injury incurred or aggravated in the line of duty or an acute myocardial infarction, cardiac arrest, or cerebrovascular accident during inactive duty training; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- There is a relationship between your current disability and your inactive duty training. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.
**EVIDENCE TABLES (Continued)**

**Disability Service Connection (Continued)**

In order to reopen a claim previously denied by VA, we need new and material evidence. New and material evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.

- To qualify as new, the evidence must currently exist and be submitted to VA for the first time.
- In order to be considered material, the additional existing evidence must pertain to the reason your claim was previously denied.

**Secondary Service Connection**

To support a claim for compensation based upon an additional disability that was caused or aggravated by a service-connected disability, the evidence must show:

- You currently have a physical or mental disability shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable, in addition to your service-connected disability; **AND**
- Your service-connected disability either caused or aggravated your additional disability. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence. However, VA may presume service-connection for cardiovascular disease developing in a claimant with certain service-connected amputation(s) of one or both lower extremities.

**Increased Disability Compensation**

If VA previously granted service connection for your disability and you are seeking an increased evaluation of your service-connected disability, we need medical or lay evidence to show a worsening or increase in severity and the effect that worsening or increase has on your ability to work.

**Temporary Total Disability Rating**

In order to support a claim for a temporary total disability rating due to hospitalization, the evidence must show:

- You were treated for more than 21 days for a service-connected disability at a VA or other approved hospital; **OR**
- You underwent hospital observation at VA expense for a service-connected disability for more than 21 days.

In order to support a claim for a temporary total disability rating due to surgical or other treatment performed by a VA or other approved hospital or outpatient facility, the evidence must show:

- The surgery or treatment was for a service-connected disability; **AND**
- The surgery required convalescence of at least one month; **OR**
- The surgery resulted in severe postoperative residuals, such as incompletely healed surgical wounds, stumps of recent amputations, therapeutic immobilizations, house confinement, or the required use of a wheelchair or crutches; **OR**
- One major joint or more was immobilized by a cast without surgery.

**Individual Unemployability**

In order to support a claim for a total disability rating based on individual unemployability, the evidence must show:

- That your service-connected disability or disabilities are sufficient, without regard to other factors, to prevent you from performing the mental and/or physical tasks required to get or keep substantially gainful employment; **AND**
- Generally, you meet certain disability percentage requirements as specified in 38 Code of Federal Regulations 4.16 (i.e. one disability ratable at 60 percent or more, OR more than one disability with one disability ratable at 40 percent or more and a combined rating of 70 percent or more).

In order to support a claim for an extra-schedular evaluation based on exceptional circumstances, the evidence must show:

- That your service-connected disability or disabilities present such an exceptional or unusual disability picture, due to such factors as marked interference with employment or frequent periods of hospitalization, that application of the regular schedular standards is impractical.

**Compensation Under 38 U.S.C. 1151**

In order to support a claim for compensation under 38 U.S.C. 1151, the evidence must show that, as a result of VA hospitalization, medical or surgical treatment, examination, or training, you have:

- An additional disability or disabilities; **OR**
- An aggravation of an existing injury or disease; **AND**
- The disability was the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment, or not a reasonably expected result or complication of the VA care or treatment; **OR**
- The direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program.
EVIDENCE TABLES (Continued)

<table>
<thead>
<tr>
<th>Special Monthly Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to support a claim for increased benefits based on the need for aid and attendance, the evidence must show that, due to your service-connected disability or disabilities:</td>
</tr>
<tr>
<td>• You require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulation 3.352(a)); OR</td>
</tr>
<tr>
<td>• You are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulation 3.352(a)).</td>
</tr>
<tr>
<td>In order to support a claim for increased benefits based on an additional disability or being housebound, the evidence must show:</td>
</tr>
<tr>
<td>• You have a single service-connected disability evaluated as 100 percent disabling AND an additional service-connected disability, or disabilities, evaluated as 60 percent or more disabling; OR</td>
</tr>
<tr>
<td>• You have a single service-connected disability evaluated as 100 percent disabling AND, due solely to your service-connected disability or disabilities, you are permanently and substantially confined to your immediate premises.</td>
</tr>
<tr>
<td>In order to support a claim for increased benefits based on your spouse’s need for aid and attendance, per the provisions of 38 C.F.R. § 3.351(c), the evidence must show:</td>
</tr>
<tr>
<td>• Your spouse is blind or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less; OR</td>
</tr>
<tr>
<td>• Your spouse is a patient in a nursing home because of mental or physical incapacity; OR</td>
</tr>
<tr>
<td>• Your spouse requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him or her from the hazards of his or her daily environment (See 38 C.F.R. § 3.352(a) for complete explanation).</td>
</tr>
</tbody>
</table>

**IMPORTANT:** For additional benefits to be payable for a spouse, the veteran must be entitled to compensation and evaluated as 30 percent or more disabling.

<table>
<thead>
<tr>
<th>Specially Adapted Housing or Special Home Adaptation</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support your claim for specially adapted housing (SAH), the evidence must show you are a:</td>
</tr>
<tr>
<td>• Veteran entitled to compensation under 38 U.S.C. Chapter 11 for a permanent and totally disabling qualifying condition; OR</td>
</tr>
<tr>
<td>• Service member on active duty who has a permanent and totally disabling qualifying condition incurred or aggravated in the line of duty.</td>
</tr>
<tr>
<td>To support that you have a qualifying condition for SAH the evidence must show:</td>
</tr>
<tr>
<td>• Amyotrophic lateral sclerosis (ALS); OR</td>
</tr>
<tr>
<td>• Loss (amputation) or loss of use of</td>
</tr>
<tr>
<td>• both lower extremities; OR</td>
</tr>
<tr>
<td>• one lower extremity and one upper extremity affecting balance or propulsion; OR</td>
</tr>
<tr>
<td>• one lower extremity plus residuals of organic disease or injury affecting balance or propulsion creating a need for regular, constant use of a wheelchair, braces, crutches or canes as a normal mode of getting around (although getting around by other methods may be occasionally possible); OR</td>
</tr>
<tr>
<td>• Loss or loss of use of both upper extremities precluding use of the arms at or above the elbow; OR</td>
</tr>
<tr>
<td>• Blindness in both eyes, with light perception only and the loss or loss of use of one lower extremity; OR</td>
</tr>
<tr>
<td>• A severe burn injury, meaning full thickness or subdermal burns that have resulted in contractures with limitation of motion of</td>
</tr>
<tr>
<td>• two or more extremities; OR</td>
</tr>
<tr>
<td>• at least one extremity and the trunk.</td>
</tr>
<tr>
<td>To support your claim for SAH the evidence may alternatively show you are a:</td>
</tr>
<tr>
<td>• Veteran who served and became permanently disabled from a qualifying condition on or after September 11, 2001; OR</td>
</tr>
<tr>
<td>• Service member on active duty who was permanently disabled in the line of duty from a qualifying condition on or after the same date.</td>
</tr>
<tr>
<td>To support that you have a qualifying condition under the alternative service criteria the evidence must show:</td>
</tr>
<tr>
<td>• Loss (amputation) or loss of use of</td>
</tr>
<tr>
<td>• one or more lower extremities, severely affecting the functions of balance or propulsion and creating a need for regular, constant use of a wheelchair, braces, crutches or canes as a normal mode of getting around (although getting around by other methods may be occasionally possible).</td>
</tr>
<tr>
<td>To support your claim for a special home adaptation (SHA) grant the evidence must show you are a:</td>
</tr>
<tr>
<td>• Veteran entitled to compensation under 38 U.S.C. Chapter 11 for a qualifying condition; OR</td>
</tr>
<tr>
<td>• Service member on active duty who has a qualifying condition incurred or aggravated in the line of duty.</td>
</tr>
</tbody>
</table>
EVIDENCE TABLES (Continued)

<table>
<thead>
<tr>
<th>Specially Adapted Housing or Special Home Adaptation (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support that you have a qualifying condition for SHA the evidence must show:</td>
</tr>
<tr>
<td>• Blindness with central visual acuity of 20/200 or worse in each eye using a standard correcting lens; OR</td>
</tr>
<tr>
<td>• Blindness such that the visual field in each eye subtends an angle no greater than 20 degrees; OR</td>
</tr>
<tr>
<td>• Permanent and total disability from loss, or loss of use, of both hands; OR</td>
</tr>
<tr>
<td>• Permanent and total disability from a severe burn injury meaning</td>
</tr>
<tr>
<td>• deep partial thickness burns that have resulted in contractures with limitation of motion of two or more extremities or of at least one extremity and the trunk; OR</td>
</tr>
<tr>
<td>• full thickness or subdermal burns that have resulted in contracture(s) with limitation of motion of one or more extremities of the trunk and preclude effective operation of an automobile; OR</td>
</tr>
<tr>
<td>• residuals of inhalation injury (including, but not limited to, pulmonary fibrosis, asthma, and chronic obstructive pulmonary disease).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Auto Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support a claim for automobile allowance or adaptive equipment, the evidence must show that you have a service-connected disability resulting in:</td>
</tr>
<tr>
<td>(1) the loss, or permanent loss of use, of at least a foot or a hand; OR</td>
</tr>
<tr>
<td>(2) permanent impairment of vision of both eyes, resulting in:</td>
</tr>
<tr>
<td>(a) vision of 20/200 or less in the better eye with corrective glasses; OR</td>
</tr>
<tr>
<td>(b) vision of 20/200 or better, if there is a severe defect in your peripheral vision; OR</td>
</tr>
<tr>
<td>(3) deep partial thickness or full thickness burns resulting in scar formation that cause contractures and limit motion of one or more extremities of the trunk and preclude effective operation of an automobile; OR</td>
</tr>
<tr>
<td>(4) amyotrophic lateral sclerosis (ALS).</td>
</tr>
<tr>
<td><strong>NOTE</strong> - You may be entitled to only adaptive equipment if you have ankylosis (&quot;freezing&quot;) of at least one knee or one hip due to service-connected disability. Medical evidence, including a VA examination, will show these things. VA will provide an examination if it determines that one is necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Helpless Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support a claim for benefits based on a veteran's child being helpless, the evidence must show that the child, before his or her 18th birthday, became permanently incapable of self-support due to a mental or physical disability.</td>
</tr>
<tr>
<td><strong>IMPORTANT</strong> - For additional benefits to be payable for a child, the veteran must be entitled to compensation and evaluated as 30 percent or more disabling.</td>
</tr>
</tbody>
</table>

**HOW VA DETERMINES THE EFFECTIVE DATE.**
If we grant your claim, the beginning date of your entitlement or increased entitlement to benefits will generally be based on the following factors:
• When we received your claim, OR
• When the evidence shows a level of disability that supports a certain rating under the rating schedule
If VA received your claim prior to or within one year of your separation from the military, entitlement will be from the day following the date of your separation.

**HOW VA DETERMINES THE DISABILITY RATING.**
When we find disabilities to be service-connected, we assign a disability rating. That rating can be changed if there are changes in your condition. Depending on the disability involved, we will assign a rating from 0 percent to as much as 100 percent. VA uses a schedule for evaluating disabilities that is published as title 38, Code of Federal Regulations, Part 4. In rare cases, we can assign a disability level other than the levels found in the schedule for a specific condition if your impairment is not adequately covered by the schedule.

Examples of evidence of the following in determining disability rating:
• Nature and symptoms of the condition;
• Severity and duration of the symptoms; AND
• Impact of the condition and symptoms on employment.

Examples of evidence that you should tell us or give to us that may affect how we assign a disability evaluation include the following:
• Information about on-going treatment records, including VA or other Federal treatment records, you have not previously told us about;
• Social Security determinations;
• Statements from employers as to job performance, lost time, or other information regarding how your condition(s) affect your ability to work; OR
• Statements discussing your disability symptoms from people who have witnessed how the symptoms affect you.

For more information on the FDC Program, visit our web site at [http://benefits.va.gov/trafformation/fastclaims/](http://benefits.va.gov/trafformation/fastclaims/).
For more information on VA benefits, visit our web site at [www.va.gov](http://www.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](http://www.va.gov/vaforms).

**ARE YOU REQUESTING EXPEDITED PROCESSING DUE TO BEING HOMELESS OR IN DANGER OF BECOMING HOMELESS?**
To support a request for homeless processing, you must show:
• You are presently homeless or in danger of becoming homeless
• You must have the following service qualifications:
  • 90 days of consecutive service; OR
  • 90 days of combined service; OR
  • were discharged prior to 90 days of service due to injury; AND
  • Have other than dishonorable military service
• You have a documented disability. You are considered having a documented disability if medical evidence shows:
  • Current diagnoses of a disease, disorder, injury, or illness; OR
  • Receiving Social Security disability benefits; OR
  • Have a disability reasonably certain to continue throughout your lifetime
• Your net worth and income do not exceed certain requirements

**IMPORTANT**
If you wish to make a claim for veterans non-service-connected pension benefits because you have little or no income, use VA Form 21-527EZ, Application for Pension. VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms). If you cannot access this form, write the word "Pension" in Item 13, or at the top of the attached application and VA will send you the form.
## APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

### SECTION I: IDENTIFICATION AND CLAIM INFORMATION

1. **VETERAN/SERVICE MEMBER NAME** (First, Middle Initial, Last)
   
2. **VETERAN'S SOCIAL SECURITY NUMBER**
   
3. **HAVE YOU EVER FILED A CLAIM WITH VA?**
   - [ ] YES
   - [ ] NO  
   *(If "YES," provide your file number in Item 4)*

4. **VA FILE NUMBER**

5. **DATE OF BIRTH (MM,DD,YYYY)**
   - **Month:** [ ]
   - **Day:** [ ]
   - **Year:** [ ]

6. **SEX**
   - [ ] MALE
   - [ ] FEMALE

7. **VETERAN'S SERVICE NUMBER (if applicable)**

8. **ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?**
   - [ ] YES
   - [ ] NO  
   *(If "YES," complete Items 8B & 8C)*

8A. **SERVICE** (Check all that apply)
   - [ ] ARMY
   - [ ] NAVY
   - [ ] MARINE CORPS
   - [ ] AIR FORCE
   - [ ] COAST GUARD

8B. **POINT OF CONTACT** (Name of person that VA can contact in order to get in touch with you)

8C. **POINT OF CONTACT TELEPHONE NUMBER** (Include Area Code)

9. **SERVICE** (Check all that apply)
   - [ ] ACTIVE
   - [ ] RESERVES
   - [ ] NATIONAL GUARD

10. **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:**
   - **ZIP Code/Postal Code:**

11. **FORWARDING ADDRESS AND EFFECTIVE DATE** (Provide the date you will be living at this address)
   - **No. & Street:**
   - **Apt./Unit Number:**
   - **City:**
   - **State/Province:**
   - **ZIP Code/Postal Code:**

   **EFFECTIVE DATE:**
   - **Month:** [ ]
   - **Day:** [ ]
   - **Year:** [ ]

12. **PREFERRED TELEPHONE NUMBER**

12A. **PREFERRED E-MAIL ADDRESS (if applicable)**

12B. **ALTERNATE E-MAIL ADDRESS (if applicable)**
13. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).

Please list your contentions below. See the following examples, for more information:
- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

<table>
<thead>
<tr>
<th>DISABILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
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<tr>
<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<td>9.</td>
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<td>10.</td>
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<tr>
<td>11.</td>
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<tr>
<td>12.</td>
</tr>
<tr>
<td>13.</td>
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<tr>
<td>14.</td>
</tr>
<tr>
<td>15.</td>
</tr>
<tr>
<td>16.</td>
</tr>
<tr>
<td>17.</td>
</tr>
<tr>
<td>18.</td>
</tr>
<tr>
<td>19.</td>
</tr>
<tr>
<td>20.</td>
</tr>
</tbody>
</table>

14. 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) AND PROVIDE TREATMENT DATES:

<table>
<thead>
<tr>
<th>A. NAME AND LOCATION</th>
<th>B. DATE(S) OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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).

<table>
<thead>
<tr>
<th>For:</th>
<th>Required Form(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependents</td>
<td>VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674</td>
</tr>
<tr>
<td>Individual Unemployability</td>
<td>VA Form 21-8940 and 21-4192</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>VA Form 21-0781 and 21-0781a</td>
</tr>
<tr>
<td>Specially Adapted Housing or Special Home Adaptation</td>
<td>VA Form 26-4555</td>
</tr>
<tr>
<td>Auto Allowance</td>
<td>VA Form 21-4502</td>
</tr>
<tr>
<td>Veteran/Spouse Aid and Attendance benefits</td>
<td>VA Form 21-2880 or, if based on nursing home attendance, VA Form 21-0779</td>
</tr>
</tbody>
</table>

### SECTION II: SERVICE INFORMATION

<table>
<thead>
<tr>
<th>15A. DID YOU SERVE UNDER ANOTHER NAME? (If &quot;Yes,&quot; complete Item 15B) (If &quot;No,&quot; skip to Item 16A)</th>
<th>15B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ YES</td>
<td></td>
</tr>
<tr>
<td>☐ NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16A. MOST RECENT ACTIVE SERVICE ENTRY DATE (MM,DD,YYYY)</th>
<th>16B. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE (MM,DD,YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month - Day - Year</td>
<td>Month - Day - Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?</th>
<th>16D. PLACE OF LAST OR ANTICIPATED SEPARATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
</tbody>
</table>

| 17A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? (If "Yes," complete Items 17B thru 17F) (If "No," skip to Item 18A) |
|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| ☐ YES                                                                                          | ☐ NO                                                                       |

<table>
<thead>
<tr>
<th>17B. COMPONENT</th>
<th>17C. OBLIGATION TERM OF SERVICE</th>
<th>17D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONAL GUARD</td>
<td>From: Month - Day - Year</td>
<td>( ) CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)</td>
</tr>
<tr>
<td>RESERVES</td>
<td>To:   Month - Day - Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? (If &quot;Yes,&quot; complete Items 18B &amp; 18C)</th>
<th>18B. DATE OF ACTIVATION: (MM,DD,YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ YES</td>
<td>Month - Day - Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)</th>
<th>19A. HAVE YOU EVER BEEN A PRISONER OF WAR? (If &quot;Yes,&quot; complete Item 19B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month - Day - Year</td>
<td>☐ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19B. DATES OF CONFINEMENT (MM,DD,YYYY)</th>
<th>19C. LIST TYPE (If known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: Month - Day - Year</td>
<td>☐ YES</td>
</tr>
<tr>
<td>To: Month - Day - Year</td>
<td>☐ NO</td>
</tr>
</tbody>
</table>

### SECTION III: SERVICE PAY

<table>
<thead>
<tr>
<th>20A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SERVICE/PAY? (If &quot;Yes,&quot; complete Items 20B and 20C)</th>
<th>20B. LIST AMOUNT (If known)</th>
<th>20C. LIST TYPE (If known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ YES</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

**IMPORTANT:** Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you do not want to receive VA compensation in lieu of military retired pay, you should check the box in Item 22. Please note that if you check the box in Item 21, you will not receive VA compensation, if granted.

☐ 21. I want military retired pay instead of VA compensation

**IMPORTANT:** You may elect to keep the training pay for inactive duty training days 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 22, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

☐ 22. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.
SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all federal benefits paid by direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 23, 24 and 25 to obtain direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard, you must apply at www.usdirectexpress.com, or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

23. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA)

☐ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:

24. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

SECTION V: CLAIM 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. You may use any privilege which makes the information confidential.

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 26, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify 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 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 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.

26. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below ONLY if you DO NOT want your claim considered for rapid processing under the FDC Program because you plan on submitting further evidence in support of your claim:

☐ I DO NOT want my claim considered for rapid processing under the FDC Program because I plan to submit further evidence in support of my claim.

SECTION VI: WITNESSES TO SIGNATURE

28A. SIGNATURE OF WITNESS (If veteran signed above using an “X”) 28B. PRINTED NAME AND ADDRESS OF WITNESS

29A. SIGNATURE OF WITNESS (If veteran signed above using an “X”) 29B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

I certify that the claimant has authorized the undersigned representative to file this supplemental 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 completeness 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 21-222, Appointment of Veterans Service Organization as Claimant’s Representative, or VA Form 21-222a, Appointment of Individual As Claimant’s Representative, indicating the appropriate POA is of record with VA.

30A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE 30B. DATE SIGNED
## Complainant Information:

Name of Aggrieved Person(s) or Organization:  
Telephone No.:  
Address:  
Apt. No.:  
City, State, ZIP:  
County:  
Cell Phone No.:  
E-mail Address:  
Who else can we call if we cannot reach you?  
First Contact's Name:  
Daytime Phone:  
Address, City, State, ZIP:  
Second Contact's Name:  
Daytime Phone:  
Address, City, State, ZIP:  

### 1a. What happened to you? Check all that apply.  

- [ ] Refused an opportunity to rent or buy housing or told housing was not available when it was.  
- [ ] Discriminated against in broker's services.  
- [ ] Refused a request to accommodate policies or practices or modify housing because of a disability.  
- [ ] Treated differently than others seeking housing.  
- [ ] Discriminated against in the terms or conditions of sale, rental occupancy, or in services or facilities.  
- [ ] Denied a loan.  
- [ ] Discriminated against in financing of a home or commercial property.  
- [ ] Intimidated/interfered/coerced in the exercise of my housing rights.  
- Other (explain)  

### 1b. State briefly what happened.  
(Attach an additional page if necessary.)  

### 2a. On what date did the last act of discrimination occur?  

### 2b. Is the action ongoing?  

Yes  
No  

### Protected classes:  
It is a violation of the Illinois Human Rights Act to deny a person housing rights because of any of the following protected classes: race; color; religion; sex (including sexual harassment); pregnancy, national origin; familial status (families with children under 18); disability; aiding/abetting; willful interference and coercion; military status; unfavorable military discharge; retaliation; marital status; ancestry; age (40 and over); sexual orientation (including gender identity); and order of protection status.  

### 3. Why do you believe you are being discriminated against?  
For example: were you denied housing because of your race? Were you denied a mortgage loan because of your religion? Or turned down for an apartment because you have children? Were you harassed because you assisted someone in obtaining their fair housing rights? Briefly explain why you think your housing rights were denied because of any of the protected classes listed above.
### Illinois Department of Human Rights

**HOUSING COMPLAINANT INFORMATION SHEET**

<table>
<thead>
<tr>
<th>4a. Who do you believe discriminated against you?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Phone No.:</strong></td>
</tr>
<tr>
<td><strong>Address, City, State, ZIP:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4b. Mark the applicable box that describes the person named above:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Landlord</td>
<td>[ ] Owner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5a. What kind of house, rental unit or property was involved? Check the appropriate box(es):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Single family home</td>
<td>[ ] Apartment building of more than 4 units</td>
</tr>
<tr>
<td>[ ] Mobile home park</td>
<td>[ ] Commercial space</td>
</tr>
</tbody>
</table>

Number of units on the property: 

<table>
<thead>
<tr>
<th>5b. What is the address of the house, rental unit, or property?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address:</strong></td>
<td><strong>Apt. No.:</strong></td>
</tr>
<tr>
<td><strong>City, State, ZIP:</strong></td>
<td><strong>County:</strong></td>
</tr>
</tbody>
</table>

Is the property still available? [ ] Yes [ ] No [ ] Unknown

<table>
<thead>
<tr>
<th>6. We need some information for statistical purposes:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td><strong>Date of birth (age cases only):</strong></td>
</tr>
</tbody>
</table>

How did you learn of our office?

<table>
<thead>
<tr>
<th>7. Have you filed a charge with any other agency?</th>
<th>If so, which agency?</th>
</tr>
</thead>
</table>

**CONSENT AGREEMENT AND RELEASE**

I have read the provided “Notice to Complainant” and I understand that: 1) In the course of investigating my charge, IDHR will reveal my identity (including my name) and my personal information to named Respondent(s) in my charge to obtain facts and evidence regarding my charge; 2) I do not have to reveal my personal information to IDHR, but IDHR may close my charge if I refuse to reveal information needed to fully investigate my charge; 3) IDHR may be required by law, subpoena, court order, and/or FOIA request to disclose my charge and information in the Department's investigation file concerning my charge to persons outside of IDHR.

If IDHR takes a charge based on the information provided, I consent for IDHR to disclose my identity and personal information as necessary to process and investigate my charge, and I release IDHR from any liability whatsoever concerning disclosure of my identity and any personal information I provided to IDHR or IDHR obtained in processing my charge.

My signature below verifies the accuracy of the information provided herein and my consent and release as indicated above.

**Print Name**

**Signature**

**Date**

NOTE: If there is certain personal information you would like withheld, please discuss your concern with an Intake supervisor.

CIS-H 12/9/2015
The Illinois Human Rights Act defines “substantial evidence” as:

finding of substantial evidence so that credibility may be resolved by the Human Rights Commission at a Public Hearing or in circuit court.

representatives or the witnesses of Respondent where there is conflicting testimony. In other words, if the determination of substantial evidence turns on

3. Business records of one person contradicted by business records of another person.

2. Business records contradicted by oral statements of a person with material first hand knowledge.

1. Statements of a person with material first hand knowledge contradicted by statements of a different person with material first hand knowledge.

The Department cannot assess the credibility of Complainant's testimony, the testimony of Complainant's witnesses or the testimony of Respondent's representatives or the witnesses of Respondent where there is conflicting testimony. In other words, if the determination of substantial evidence turns on issues of credibility, the Department should make a finding of substantial evidence so that a trier of fact may resolve those issues of credibility. This means that if a determination of lack of substantial evidence requires the Department to make a finding of fact as to conflicting evidence, the Department will make a

The Cooper v. Salazar injunction

IDHR is under a federal-court injunction that, among other things, orders IDHR:

‘to cease permanently from relying on credibility determinations made without affording the rights of confrontation and cross-examination’.


Meaning of the Cooper Injunction

The Department cannot assess the credibility of Complainant's testimony, the testimony of Complainant's witnesses or the testimony of Respondent's representatives or the witnesses of Respondent where there is conflicting testimony. In other words, if the determination of substantial evidence turns on issues of credibility, the Department should make a finding of substantial evidence so that a trier of fact may resolve those issues of credibility. This means that if a determination of lack of substantial evidence requires the Department to make a finding of fact as to conflicting evidence, the Department will make a finding of substantial evidence so that credibility may be resolved by the Human Rights Commission at a Public Hearing or in circuit court.

The Illinois Human Rights Act defines “substantial evidence” as:

“evidence which a reasonable mind accepts as sufficient to support a particular conclusion and which consists of more than a mere scintilla but may be somewhat less than a preponderance”. Illinois Human Rights Act §7A-102(D)(2), codified at 775 ILCS 5/7A-102(D)(2).

The Meaning of Credibility

IDHR is an investigatory agency. IDHR's purpose is to gather all of the evidence from each of the parties as to whether Respondent may or may not have discriminated against the Complainant within the meaning of the Illinois Human Rights Act. IDHR's purpose is to review all of the evidence and make a determination based upon the law as to whether there is sufficient evidence of discrimination to file a complaint against the Respondent with the Illinois Human Rights Commission. IDHR will not make a finding that evidence submitted by a party is either believable or not believable. Thus, IDHR will not base its findings on the fact that one of the parties is not telling the truth or that one party's evidence is not believable. If the resolution of the charge of discrimination requires believing the evidence of one party over another party, IDHR will make a finding of Substantial Evidence and refer the matter to the Illinois Human Rights Commission so that a trier of fact may resolve the case.

Conflicting evidence exists when there are

1. Statements of a person with material first hand knowledge contradicted by statements of a different person with material first hand knowledge.

2. Business records contradicted by oral statements of a person with material first hand knowledge.

3. Business records of one person contradicted by business records of another person.
Prisoner Review Board Order

Facility: ___________________________  Date: ___________________________
Offender Name: ______________________  ID#: __________________________

Clinical Services Recommendations for Release:

________________________________________
________________________________________

Counselor: ___________________________  Supervisor: ______________________
Signature                                       Signature

Board Action:

☐ Mandatory Supervised Release Approved Effective When Eligible
☐ Released Prior to Hearing
☐ Statutory Parole Approved

The releasee is obligated to obey the general rules governing parolees or mandatory supervised releasees and the following special order(s):

Conditions:

1. Substance Abuse Counseling - (CD)
   (To include drug and/or alcohol evaluation for need and/or completion of recommended counseling program.)

2. Anger Management Counseling - (CG)
   (To include evaluation for need and/or completion of recommended counseling program.)

3. Sex Offender Counseling - (CX)
   (To include evaluation for need and/or completion of recommended counseling program.)

4. Outpatient Mental Health Counseling - (CP)
   (To include evaluation for need and/or completion of recommended counseling program.)

5. Electronic Monitoring - (CE)
   (Electronic Monitoring shall not be removed prior to the date unless approved by the Prisoner Review Board. Any request for Electronic Monitoring removal shall be submitted to the Illinois Department of Corrections with a current progress report.)

6. No Victim Contact - (CT)

7. Other - (CO)

For the Board:

Signature: ___________________________  Date: ___________________________
Signature: ___________________________  Date: ___________________________
Signature: ___________________________  Date: ___________________________

For use during personal interviews only:

I hereby attest that I have been served the above noted conditions of my parole/mandatory supervised release and understand that failure to follow these conditions may result in the revocation of my parole.

Releasee’s Signature: ___________________________  Date: ___________________________

Distribution: Prisoner Review Board Master File
Prepared: Field or Clinical Services

DOC 0271 (REV. 4/2005)
(Replaces IL 578-0023)
Contact:
Education Justice Project
University of Illinois at Urbana-Champaign
info@educationjustice.net
217.300.5150
www.educationjustice.net