



You can speak to a National Service Officer Monday through Friday, 9 a.m. to 4 p.m. EDT

by calling: 1-888-604-0234 or 1-317-916-3615

Email: [DAV.VBAINDY@VA.GOV](mailto:DAV.VBAINDY@VA.GOV)

## Complete the form correctly!

Department of Veterans Affairs

VA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)

OMB Control No. 2900-0021  
Respondent Burden: 5 minutes  
Revision Date: 02/26/2022

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

**IMPORTANT:** Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

**NOTE:** If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, Appointment of Individual as Claimant's Representative. When completed you can mail or fax this form to the appropriate intake center address shown on Page 4. VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms).

**SECTION I: VETERAN'S INFORMATION**

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

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

2. VETERAN'S SOCIAL SECURITY NUMBER (SSN)

3. VA FILE NUMBER (if applicable)

4. VETERAN'S DATE OF BIRTH  
Month - Day - Year

5. VETERAN'S SERVICE NUMBER (if applicable)

6. INSURANCE NUMBER(S) (if applicable) (Include letter prefix)

7. VETERAN'S MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  
No. & Street  
Apt./Unit Number City  
State/Province Country ZIP Code/Postal Code

8. VETERAN'S TELEPHONE NUMBER (Include Area Code)

9. VETERAN'S EMAIL ADDRESS (Optional)

**SECTION II: CLAIMANT'S INFORMATION (if other than veteran)**

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

11. CLAIMANT'S MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)  
No. & Street  
Apt./Unit Number City  
State/Province Country ZIP Code/Postal Code

12. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)

13. CLAIMANT'S EMAIL ADDRESS (Optional)

14. RELATIONSHIP TO VETERAN

**SECTION III: SERVICE ORGANIZATION INFORMATION**

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS (See list on Page 3 before selecting organization)

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 (This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT (MM/DD/YYYY)

VA FORM 21-22 FEB 2019 SUPERSEDES VA FORM 21-22, AUG 2015. Page 1

➤ Leave 15, 16A, 16B and 17 Blank!

➤ Insert today's date in Box 18!

Leave Blank

Leave Blank

Leave Blank

Leave Blank!

Insert Today's date

Complete the form correctly!

VETERAN'S SOCIAL SECURITY NUMBER [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ]

**SECTION IV: AUTHORIZATION INFORMATION**

19. AUTHORIZATION FOR REPRESENTATION - By checking the box below I authorize VA to disclose to the service organization named in Item 15 any records that may be in my file relating to treatment for drug abuse, alcoholism or infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

I authorize the service organization named in Item 15 to represent me before the Department of Veterans Affairs (VA) on my behalf. I understand that the service organization named in Item 15 is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

DRUG ABUSE  INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)  
 ALCOHOLISM OR ALCOHOL ABUSE  SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

I authorize any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 or 10, hereby appoint the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match. Signed and accepted subject to the foregoing conditions.

**SECTION V: SIGNATURES**

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

22A. SIGNATURE OF VETERAN OR CLAIMANT (Do Not Print) \_\_\_\_\_ 22B. DATE SIGNED (MM/DD/YYYY) \_\_\_\_\_

23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (Do Not Print) \_\_\_\_\_ 23B. DATE SIGNED \_\_\_\_\_

**NOTE:** As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for the preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with any portion thereof.

**VA USE ONLY**

COPY OF VA FORM 21-22 SENT TO:

VR&E FILE  EDU FILE  DATE SENT \_\_\_\_\_  ACKNOWLEDGED (Date) \_\_\_\_\_  REVOKED (Reason and date) \_\_\_\_\_

LG FILE  INSURANCE FILE \_\_\_\_\_

**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

Check Box!

➤ Check the box in 19!

➤ Leave 23A and 23B Blank!

Leave Blank!