

## Section 1151 and FTCA Intake Form

*You may be entitled to compensation for injury caused by VA medical care, VA vocational rehabilitation, or participation in a VA compensated work therapy program (section 1151 benefits). The following questions will help you and your advocate organize the information you will need to apply for section 1151 benefits. If additional room is needed to complete an answer, please attach a separate piece of paper. Do not send this form to the VA; give it to your accredited service officer.*

Date \_\_\_\_\_

(1) Name of veteran: \_\_\_\_\_  
First Middle Last

(2) Name used in service if different: \_\_\_\_\_

(3) Applicant if other than the veteran:  
\_\_\_\_\_  
First Middle Last

(4) Relationship to veteran: \_\_\_\_\_

(5) Address: \_\_\_\_\_  
Number Street Apt. No.  
\_\_\_\_\_  
City State Zip Code

(6) Mailing address: \_\_\_\_\_  
Number Street Apt. No.  
\_\_\_\_\_  
City State Zip Code

(7) Telephone:  
Home ( ) \_\_\_\_\_  
Work ( ) \_\_\_\_\_

(8) Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

(9) Social Security number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

(10) Single( ) Married( ) Separated( ) Divorced( ) Widowed( )

(11) Are you currently employed? yes( ) no( )  
If yes, what is your occupation? \_\_\_\_\_

(12) If not employed, are you able to work? yes( ) no( )

(13) If you are not employed, is it because of medical problems related to your military service or to VA medical treatment or VA vocational rehabilitation?      yes( ) no( )

(14) Are you receiving Social Security Disability, Supplemental Social Security, or other forms of government assistance? If you are, please specify:

\_\_\_\_\_

(15) Do you have dependents?  
yes( ) no( )

If yes, how many? \_\_\_\_\_

Please list your dependents' names, how they are related to the veteran, dates of birth, and Social Security numbers:

\_\_\_\_\_  
\_\_\_\_\_

**Information Related to Service**

(16) Are you a veteran of the U.S. armed forces?  
yes( ) no( )

*If you are a veteran, please attach a copy of your discharge form, the DD 214. If you do not have a copy of your DD 214, please obtain from your advocate and complete and attach Standard Form (SF) 180, Request Pertaining to Military Records, to obtain a copy of your DD 214.*

(17) To what branch of the service (army, navy, air force, marines, coast guard, merchant marine) did you belong?

\_\_\_\_\_

(18) In what era (Korea, Vietnam, Persian Gulf, OEF/OIF, or other) was your service?

\_\_\_\_\_

(19) Please list your dates of service:

Entry \_\_\_\_\_ Discharge \_\_\_\_\_

Entry \_\_\_\_\_ Discharge \_\_\_\_\_

Entry \_\_\_\_\_ Discharge \_\_\_\_\_

(20) Please state your type of discharge:

\_\_\_\_\_

(21) Were you in combat?  
yes( ) no( )

(22) Were you wounded?  
yes( ) no( )

If so, where on the body?

\_\_\_\_\_



If yes, please specify when and where:

\_\_\_\_\_

(31) In your opinion, have you (or has the veteran) suffered an injury caused by VA medical care or as the result of VA vocational rehabilitation?

yes( ) no( )

(32) In your opinion, was the injury caused by VA medical negligence?

yes( ) no( )

(33) When did this injury occur and at what VA medical facility?

\_\_\_\_\_

(34) Please describe this injury:

\_\_\_\_\_

\_\_\_\_\_

(35) Has a claim for VA benefits based on this injury been made in the past?

yes( ) no( )

If you answered yes, please describe what happened:

\_\_\_\_\_

\_\_\_\_\_

(36) Were you asked to sign an informed consent form prior to receiving the VA medical care that you believe caused the injury?

yes ( ) no ( )

(37) Have you seen an attorney about this injury?

yes( ) no( )