

FOR THE AMERICAN VETERAN

AN INDEPENDENT GUIDE



VETERAN FIELD MANUAL

ARMY • NAVY • AIR FORCE • MARINE CORPS • COAST GUARD • SPACE FORCE

VOLUME 1 • VA DISABILITY BENEFITS

The field manual the VA never gave you.

AUTHOR

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VETERAN FIELD MANUAL

VOLUME 1 · VA DISABILITY BENEFITS

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Free to every veteran.

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Veteran Field Manual — Vol. 1 · Start Here

This manual covers every layer of the VA disability compensation system: what the benefit is, how to file, what happens after a decision, and the connected benefits most veterans never collect. A veteran with zero VA knowledge can start at page one and build a complete, working understanding. Someone who already knows the system can keep this on the shelf and use the Table of Contents and reference appendices as a quick-lookup tool, with the exact rule and exact citation right where they are needed.

How to Use This Field Manual

Every chapter opens with a BLUF (Bottom Line Up Front): two to four sentences that give the whole chapter in a nutshell. Read the BLUF, decide whether the chapter covers new ground, and either move on or keep going.

The how-to chapters are built as a field-manual play: a short numbered sequence of moves (The Play), then each move broken out with the exact steps and the exact VA.gov pages to use, a Traps That Cost Veterans Money section, a one-line The Rule, Briefly that names the governing law (full text in Appendix A1), Field Notes for a quick recap, and a Do This Now checklist of the actions to take today. The explainer chapters (the legal framework, the rating math, how conditions are rated) teach the concept in plain English, cite the rule in one line, and close with Field Notes. Either way, the law is cited so a veteran can verify it, but the manual leads with what to *do*, not with walls of quoted regulation.

Two reading paths:

1. New to all this — read cover to cover, or follow the Quick-Start below. Part 1 (Ch. 1–3) lays the foundation. Part 2 (Ch. 4–10) covers the legal framework, not to turn veterans into lawyers, but so they understand why the rules work the way they do and can read the regulations themselves. Parts 3–5 cover the math, the filing process, and the pathways. Parts 6–8 cover what happens after the decision. The Quick-Start below identifies the five actions a new claimant should take immediately.
 2. Experienced — use the Table of Contents and the reference appendices as a lookup. The four key reference appendices are: - Appendix A1 — Master Citation Index — every statute, CFR section, and VA Manual provision cited in this volume, with URLs. - Appendix A2 — Glossary & Acronyms — plain-English definitions of every term of art that appears in the body chapters. - Appendix A3 — Key Forms & Where to Find Them — the forms veterans will actually need, what each does, and where to get them. - Appendix A6 — Deadlines & Quick-Reference Cards — filing windows, appeal deadlines, and one-page cards for the most time-critical rules.
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Quick-Start: Do These Five Things First

A veteran who is overwhelmed and does not know where to begin should do these five things, in this order.

1. Confirm eligibility and discharge status. Before anything else, verify that the period of service qualifies and that the character of discharge does not block the claim. Read Ch. 2 — Who Qualifies: Eligibility & Discharge Status.
2. File an Intent to File TODAY. An Intent to File (ITF) locks in a potential effective date: the date from which back pay begins if the claim is granted. It takes minutes online and costs nothing. Every day without one is a day of potential back pay lost. Read Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates.

3. List every condition and its link to service. A claim needs two things: a current diagnosis and a connection to active service. Veterans should write out every condition they believe is service-connected (injuries, illnesses, anything that started in service or got worse because of it). Read Ch. 15 — The Elements of Service Connection and Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation.
4. Gather evidence and, where needed, get a nexus opinion. Evidence is what wins claims: service records, treatment records, buddy statements, and for conditions that are not presumptive, a nexus opinion from a qualified medical provider. Read Ch. 18 — Evidence That Wins Claims. Sample language and templates are in Appendix A5 — Templates & Sample Language.
5. Get free help from an accredited VSO. Veterans Service Organizations provide free, accredited claims assistance. For most claimants this is not a nice-to-have; it meaningfully improves outcomes. A VSO can review a claim before submission and catch errors that cost veterans money. Read Ch. 36 — VSOs, Attorneys, and Claim Sharks before paying anyone for claims help.

Find the Right Situation

Table FM-1. Where to Start.

If a veteran is...	Start at
Never filed — starting from scratch	Ch. 1 — What VA Disability Compensation Actually Is, then the Quick-Start above
National Guard or Reserve service	Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection
Mid-claim — waiting for a decision	Ch. 19 — The C&P Exam: What to Expect and How to Prepare; Ch. 20 — Fully Developed Claim vs. Standard Claim
Got a decision they disagree with	Ch. 26 — Reading the Rating Decision Letter; Ch. 27 — The Appeals Process Under the AMA
Already rated but a condition is worse	Ch. 28 — Increasing an Existing Rating
Trying to understand their pay or the math	Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%; Ch. 12 — Compensation Rate Tables and Dependent Add-Ons
Rated at 100% or P&T and exploring more	Ch. 30 — What a 100% P&T Rating Unlocks; Ch. 31 — Special Monthly Compensation (SMC)
Worried about a rating reduction	Ch. 29 — Protected Ratings; Ch. 37 — Avoiding a Rating Reduction
Affected by burn pits or toxic exposure	Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure; Ch. 23 — Agent Orange, Gulf War Illness & Camp Lejeune

A Veteran's Journey (the big picture in one page)

Consider a service member we will call Ray.

Ray separated after eight years of active duty. He came home with a bad knee, a meniscus tear from a training accident, and a ringing in his ears that never stopped. He did not file because nobody told him he could, and he assumed the VA was only for the badly wounded.

Three years later, a friend told him to look into it. Ray started with Ch. 1 — What VA Disability Compensation Actually Is, which told him the benefit is not charity. It is a tax-free entitlement the law says the VA *will* pay if a veteran meets the elements. Ch. 2 — Who Qualifies: Eligibility & Discharge Status confirmed his discharge

was honorable and his service qualified.

He filed an Intent to File the same day, locking in his effective date under the rules in Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates. Ch. 15 — The Elements of Service Connection laid out what he had to prove: a current diagnosis, evidence of the in-service event, and a medical link between the two. His knee was a direct connection; service records documented the injury. His tinnitus was a presumptive condition under certain service criteria, covered in Ch. 21 — Presumptive Conditions Explained.

Ray gathered his records using the guidance in Ch. 18 — Evidence That Wins Claims and submitted a Fully Developed Claim after reading Ch. 20 — Fully Developed Claim vs. Standard Claim. Weeks later he was scheduled for a Compensation and Pension exam. Ch. 19 — The C&P Exam: What to Expect and How to Prepare walked him through what the examiner was looking for and how to describe his symptoms accurately.

The VA rated his knee at 10% and his tinnitus at 10%. He read the decision using Ch. 26 — Reading the Rating Decision Letter and decided the knee rating was too low given his range-of-motion loss. He appealed through the Supplemental Claim lane described in Ch. 27 — The Appeals Process Under the AMA and got the rating corrected.

Ray's path is not exceptional. It is the standard sequence: understand the system, file with evidence, attend the exam, read the decision, appeal if the rating is wrong. This manual covers every one of those steps.

The One Rule That Matters Most

Accuracy and deadlines win claims. Missed deadlines cost back pay that cannot be recovered. Inaccurate or incomplete evidence leads to denials that take months or years to reverse.

The law is not ambiguous: when a veteran meets the elements, the United States *will* pay. The system has real problems, but the underlying legal entitlement is solid. This manual teaches the rules that unlock it. Veterans should verify every current figure (dollar rates, COLA amounts, covered-condition lists) against live primary sources before acting on them. Those figures change. The rules that govern them do not change nearly as often, and this manual teaches the rules. For verification tools and primary-source URLs, see Appendix A4 — Verification Sources & Staying Current.

Ch. 1 — What VA Disability Compensation Actually Is

BLUF: VA disability compensation is a tax-free monthly payment the government owes a veteran for a service-connected condition. It is not charity, a pension, or retirement pay. What sets the amount is one thing: how disabling the condition is. Income, savings, and time in service have nothing to do with it.

The Ground Truth

Start with the word itself. Compensation. A veteran is being paid back for a loss, and the loss is the way a service-connected injury or illness wears down the ability to work and get through a normal day. That one word frames everything this benefit is, and everything it is not.

Three things define it.

First, it is for a service-connected condition. The injury or illness has to trace back to active military service, either caused by it or made worse by it. No service link, no compensation. How a veteran proves that link is a chapter of its own; here we are just naming the rule.

Second, it runs on severity, not need. The VA rates the condition from 0 to 100 percent, in steps of ten, and that rating sets the dollar figure. A wealthy veteran and a broke veteran with the same rating draw the same check. The bank account never enters into it.

Third, it is tax-free and protected by law. A veteran does not report it as income, and in most situations creditors cannot reach it.

Two other benefits get tangled up with this one constantly, and the mix-up costs people real money.

A VA pension is not compensation. Pension is a separate, need-based program for low-income wartime veterans who are elderly or permanently disabled, and it carries income and net-worth limits. A veteran who works and earns a decent living might be shut out of pension entirely. None of that touches disability compensation, which has no income test at all.

Military retired pay is not compensation either. Retired pay is earned by years of service, usually twenty or more, or by a medical retirement. The Defense Department pays it through DFAS, and unlike VA compensation it is taxable. Two systems. Two checks. Two separate rulebooks.

Strip it down and the foundation is simple: a tax-free check, tied to a service-connected condition, sized by how bad that condition is, sitting apart from both pension and retirement.

The Rule, Briefly

The entitlement comes from 38 U.S.C. § 1110 (wartime) and § 1131 (peacetime): for a disability incurred or aggravated in the line of duty in active service, the United States "will pay" compensation to any veteran discharged under conditions other than dishonorable. The two sections are word-for-word identical except for the war-versus-peacetime phrase, so together they cover every era of service, and the operative words are *will pay*, not *may pay*. Section 5301(a) then makes those payments exempt from taxation and shielded from creditors. Only two things bar compensation outright: a dishonorable discharge from the period the condition arose, or a disability caused by the veteran's own willful misconduct or alcohol or drug abuse. Everything past those is a question of proof and degree, not basic eligibility. The exact text of each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

That phrase, *will pay*, should change how a veteran walks into the whole process. This is collecting on a promise Congress wrote into law, not asking for a handout, and that posture carries through every stage of a claim.

Tax-free is also worth more than it looks. A dollar of VA compensation is a whole dollar, while a dollar of wages or taxable retired pay shrinks the moment tax comes out, so the only fair way to weigh this benefit against another is after tax. And the most expensive myth in the whole field is that earning a good income disqualifies a veteran. It doesn't. Compensation isn't need-based, so a veteran can work full-time, pull a strong salary, and still draw every dollar the rating supports. The one wrinkle, TDIU, comes later and is the exception that proves the rule.

A few practical things follow from all this. File for the right program from the start, because compensation and pension are different doors: compensation is for a service-connected condition, pension is need-based and income-tested, and walking through the wrong one costs months. Know too that the money is hard to touch; under § 5301 it's largely shielded from creditors and lawsuits, with only narrow exceptions for debts owed to the federal government and certain court-ordered family support. And for a veteran who is also a military retiree, the old rule that forced a retiree to waive retired pay dollar-for-dollar to take VA compensation no longer always applies, since CRDP and CRSC now let many retirees draw both; the mechanics are in Vol. 6 — Retirement & Military Pay, and that question is best set aside until then. Guard and Reserve members still drilling face a related limit, since a member cannot draw VA compensation and military pay for the same day, and that's handled through the drill-pay waiver in Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 U.S.C. § 1110 — Basic entitlement (wartime). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1110&num=0&edition=prelim>
- 38 U.S.C. § 1131 — Basic entitlement (peacetime). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1131&num=0&edition=prelim>
- 38 U.S.C. § 5301(a) — Nonassignability and exempt status of benefits (tax-exempt, creditor-protected). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5301&num=0&edition=prelim>
- VA.gov — *VA disability compensation* ("monthly tax-free payment ... service-connected"). <https://www.va.gov/disability/>
- VA.gov — *Eligibility for Veterans Pension* (need-based; income/net-worth limits; wartime service). <https://www.va.gov/pension/eligibility/>
- DFAS — *Concurrent Military Retired Pay and VA Disability Compensation (CRDP) and CRSC vs CRDP comparison*. <https://www.dfas.mil/retiredmilitary/disability/crdp/> · <https://www.dfas.mil/retiredmilitary/disability/comparison/>

Ch. 2 — Who Qualifies: Eligibility & Discharge Status

BLUF: Two gates stand between a veteran and a disability claim: active military service, and a discharge "other than dishonorable." Most veterans clear both. The thing to understand — because it changes what a veteran does next — is that "other than dishonorable" is a VA *legal standard*, not the word printed on a DD-214. An Other Than Honorable (OTH) discharge is not an automatic dead end; filing triggers a VA review that often finds the service eligible. Walking away guarantees nothing. This chapter is how to read that gate and what to do at each one.

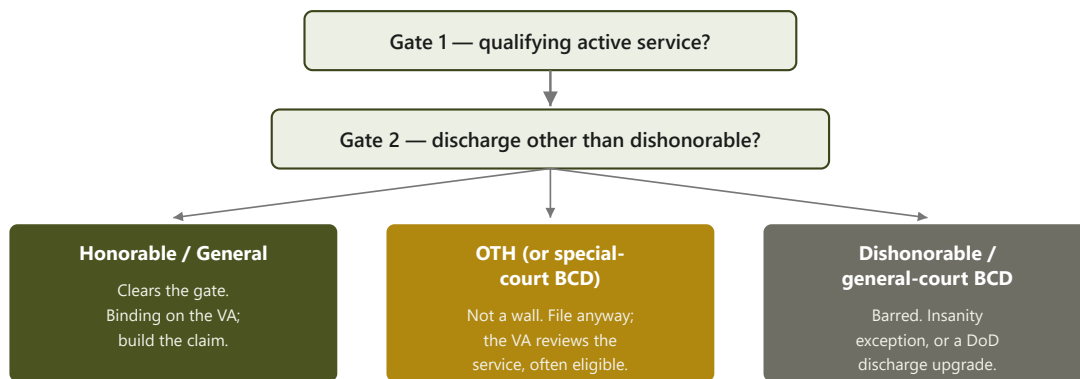
Confirm Qualifying Service

Before the VA looks at a veteran's knee or PTSD, it asks: is this a veteran the law lets us pay? The benefit is built on active service — active duty in any branch. For Guard and Reserve, the rule is tighter: weekend drilling alone doesn't make a service member a "veteran" for compensation. Veteran status comes from a period of active duty, active duty for training (ACDUTRA), or inactive duty training (INACDUTRA) in which the service member was hurt or got sick in the line of duty — and the condition has to trace back to one of those periods. Pin that period down before filing.

Guard & Reserve note: Veteran status is earned one duty period at a time, and what counts depends on the type. A full training period (ACDUTRA) covers a disease or an injury; a drill period (INACDUTRA) generally covers only an injury. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Read the Discharge

Every separation has a character of service, and it sets the gate. The legal test is "other than dishonorable," which is *wider* than "Honorable" — that gap is where character-of-discharge determinations live. Find the "Character of Service" block on the DD-214 (pull it at va.gov/records/get-military-service-records/ if it's not on hand) and match it to Table 2-1.



An OTH is a checkpoint, not a dead end — filing is what triggers the VA's review.

Figure 2-1. Two gates decide eligibility. The discharge gate turns on the VA's legal standard ("other than dishonorable"), not the label alone, which is why an OTH so often clears once the VA reviews the underlying service.

Table 2-1. Character of discharge and VA eligibility.

If the character of discharge is...	Effect on eligibility	What to do
Honorable	Clears the gate; binding on the VA (§ 3.12(a)) — it won't reopen the question	Confirm the block reads "Honorable" and build the claim
General (Under Honorable Conditions)	Clears the gate; treated like Honorable (§ 3.12(a))	Same as above; confirm the block and proceed
Other Than Honorable (OTH), or BCD from a <i>special</i> court-martial	Not an automatic bar — triggers a VA character-of-discharge determination (§ 3.12); the VA reviews the underlying service, not the label	File the claim (that triggers the review). If the OTH traces to undiagnosed PTSD/TBI, document compelling circumstances (§ 3.12(d)–(e))
BCD from a <i>general</i> court-martial	Statutory bar (§ 5303(a) / § 3.12(c)); insanity exception (§ 3.354) may apply	See an accredited rep; assess the insanity exception; separately pursue a DoD discharge upgrade (Vol. 11)
Dishonorable (general court-martial sentence)	Statutory bar (§ 5303(a) / § 3.12(c)); no compelling-circumstances exit; insanity exception may apply	See an accredited rep; the only route is a DoD discharge upgrade (Vol. 11)

The OTH Play: a Checkpoint, Not a Wall

Having an OTH doesn't mean automatic disqualification, because filing the claim is exactly what triggers the VA's character-of-discharge determination — a review that judges the service on its own merits and often finds it "not dishonorable." Two things matter here. The first is that "compelling circumstances" is a legal argument, not a sympathy plea: if the separation involved AWOL, misconduct, or a felony-type offense, the VA has to weigh mitigating factors like combat service, mental-health conditions such as undiagnosed PTSD or TBI, hardship, and the length and quality of the veteran's good service, so document them and pull the veteran's treatment records and service history. The second is not to confuse two different doors. A VA character-of-discharge determination only decides VA eligibility and leaves the label alone, while a discharge *upgrade* through a Discharge Review Board or Board for Correction of Military Records is a DoD process that changes the label itself (start at va.gov/discharge-upgrade-instructions/introduction/, with full treatment in Vol. 11 — Records & Corrections). A veteran can pursue either or both.

The 24-Month Minimum and Its Carve-Out

For anyone who first entered service after September 7, 1980, the general rule is 24 months of continuous active duty (or the full period of the call-up) to draw benefits from that service. But the carve-out matters: this minimum does not block a claim for a disability actually incurred or made worse in the line of duty. A short post-1980 stint is worth examining, not writing off.

Traps That Cost Veterans Money

- Reading the DD-214 label as the final word. The VA standard is "other than dishonorable," which is broader than "Honorable."
- Walking away from an OTH. Filing triggers the review that can find the veteran eligible; not filing guarantees nothing.
- Confusing a VA character-of-discharge determination with a DoD discharge upgrade — different agencies, different effects.
- Treating an AWOL/misconduct OTH as hopeless without raising compelling circumstances (especially undiagnosed PTSD/TBI).

- Assuming a short post-1980 enlistment disqualifies the veteran — a line-of-duty disability beats the 24-month rule.

The Rule, Briefly

Who counts as a veteran comes from 38 U.S.C. § 101(2) and 38 CFR § 3.1(d): someone who served in active service and was discharged "under conditions other than dishonorable." Honorable and General discharges are binding on the VA under § 3.12(a), while the statutory bars are in 38 U.S.C. § 5303(a) and § 3.12(c), with the compelling-circumstances and insanity exceptions at § 3.12(d)–(e) and § 3.354. The minimum-service rule is 38 U.S.C. § 5303A and § 3.12a (24 months or the full period called, with the line-of-duty-disability exception). Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

Do This Now

1. Pull the DD-214 (va.gov/records/get-military-service-records/) and read the Character of Service block.
2. Match it to Table 2-1 to find the gate and next move.
3. If it's OTH, file the disability claim anyway to trigger the character-of-discharge review — and document compelling circumstances if misconduct traces to undiagnosed PTSD/TBI.
4. Guard/Reserve: identify the exact activation/training period the condition traces to before filing.
5. If barred by the label, start a DoD discharge upgrade at va.gov/discharge-upgrade-instructions/introduction/ (Vol. 11).

Cited Sources

Verify all citations and figures against current primary sources before acting. The § 3.12 character-of-discharge framework was recently revised — confirm the current paragraph structure. VA.gov reorganizes pages; confirm a link if it moves.

- 38 U.S.C. § 101 — Definitions of "veteran," ACDUTRA, INACDUTRA. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section101&num=0&edition=prelim>
- 38 U.S.C. § 5303 — Bars to benefits; insanity exception. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5303&num=0&edition=prelim>
- 38 U.S.C. § 5303A — Minimum active-duty service requirement (24 months / full period; exceptions). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5303A&num=0&edition=prelim>
- 38 CFR § 3.1 / § 3.12 / § 3.12a / § 3.354 — "Veteran" definition; character-of-discharge bars and exceptions; minimum-service companion; insanity determinations. <https://www.ecfr.gov/current/title-38/section-3.12>
- VA.gov — Eligibility for VA disability benefits. <https://www.va.gov/disability/eligibility/>
- VA.gov — Get your military service records (DD-214). <https://www.va.gov/records/get-military-service-records/>
- VA.gov — Discharge upgrade instructions. <https://www.va.gov/discharge-upgrade-instructions/introduction/>
- Ch. 2A — cross-reference named inline; Vol. 11 — Records & Corrections (discharge upgrades).

Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection

BLUF: For a Guard or Reserve member, not every day in uniform counts as the service that earns veteran status — the claim turns on tying the condition to the right kind of duty period. On a full training period (ACDUTRA), both a disease and an injury can count. On a drill period (INACDUTRA), generally only an injury counts (plus a heart attack, cardiac arrest, or stroke during the drill). A federal (Title 10) activation is treated like full active duty. Get the period and the cause right or the best medical evidence won't connect. And once rated, a separate money rule kicks in: a veteran can't draw VA compensation and military pay for the same day, so paid duty days are waived day for day. This chapter is how to work all of it.

Pin the Duty Status (the Authority on the Orders Controls)

A career active-duty soldier is a "veteran" for the whole enlistment. A Guard or Reserve member earns veteran status period by period, only for a stretch in which they were disabled (or died) from a qualifying cause, in the line of duty. So the first move on any claim is to name the exact period and prove what kind it was. There are four statuses, and the legal authority printed on the orders decides which rules apply. Title 10 federal active duty (mobilization, deployment, or contingency activation, with orders citing something like 10 U.S.C. § 12301(d), § 12302, or § 12304) is treated as full active duty with full presumptions, the strongest footing of the four. ACDUTRA, active duty for training, is full-time training such as annual training, service schools, and initial entry; it covers both disease and injury, though the active-duty presumptions generally don't apply. INACDUTRA, inactive duty training, is the drill weekend and smaller assemblies, and it's the narrowest of the four, for the reason the injury-vs-disease split below lays out. State Active Duty, ordered under state law alone and state-funded for flood, hurricane, or storm response, is generally not federal service, so it usually can't establish veteran status for a VA claim at all, though it may carry state benefits (Ch. 33 — State-Level Veteran Benefits).

Full-time National Guard duty under Title 32 is federally funded but commanded by the governor; for VA purposes it generally runs through the ACDUTRA/INACDUTRA rules, so the disease-vs-injury split still controls.

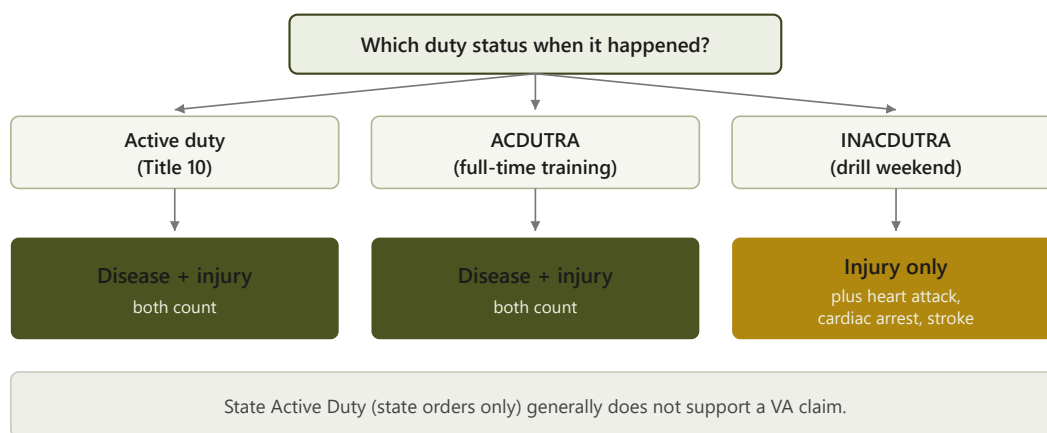


Figure 2A-1. The disease-versus-injury split is what decides most Guard and Reserve claims. A disease that only shows up on a drill weekend generally isn't covered; move it onto active duty or

ACDUTRA and it is.

Table 2A-1. Does it count? Duty status and VA coverage.

If the disability arose on...	What counts	Presumptions?	Evidence that anchors the period	Footing
Active duty (Title 10 / federalized)	Disease and injury, in line of duty	Yes, in full	Title 10 mobilization/deployment orders; the DD-214 for that period	Strongest
ACDUTRA (annual training, schools)	Disease and injury, in line of duty	Generally not	Annual-training/school orders; NGB Form 23 points; line-of-duty determination	Moderate
INACDUTRA (the drill weekend)	Injury only — plus a heart attack, cardiac arrest, or stroke during the drill	Generally not	Drill/unit records; the line-of-duty determination (critical)	Narrow
State Active Duty (state orders only)	Generally nothing — not federal service	No	State activation orders; pursue state benefits (Ch. 33)	Generally no federal claim

Sort Injury vs. Disease (the Split That Decides Drill Claims)

This single distinction decides most Guard/Reserve claims. On ACDUTRA, both a disease and an injury can count. On INACDUTRA, generally only an injury counts — the lone exception being a heart attack, cardiac arrest, or stroke during the drill itself.

Picture two members at the same drill weekend. One blows out a knee in PT — that's an injury on INACDUTRA, and it can support a claim. The other feels chest tightness that turns out to be an early heart condition — a *disease* surfacing on a drill, generally not covered from INACDUTRA. Same weekend, two outcomes. Move that heart condition onto two-week annual training (ACDUTRA) and now it's covered, because disease counts there. The calendar entry decides the case — so for any drill-year disease, check whether it can attach to an annual-training or activation period instead.

Anchor to the Strongest Period (and Don't Assume the Presumptions)

A Title 10 activation is the strongest footing — full active-duty rules and presumptions. Pin the claim to it when one exists. Where it doesn't, plan to prove service connection directly — current diagnosis, the in-service event in that specific period, and a medical link — because the presumptions that help active-duty veterans (soundness and aggravation) generally don't attach to ACDUTRA/INACDUTRA-only service until veteran status is established for that period. The one-year chronic-disease presumption generally doesn't reach training service either. There's no point leaning on help that won't be there.

Get the Line-of-Duty Record

For a training-period injury, whether the unit recorded it as "in line of duty" is often the whole ballgame — it's evidence, not paperwork. Track it down; if one was never done, ask the unit or records center about completing or reconstructing it. And the law reaches the road: an injury while traveling directly to or from training is treated as if it happened during the duty.

The Drill-Pay Waiver (Two Paychecks, One Day)

Once a veteran is rated and drawing compensation, the law won't pay VA compensation and military pay for the same day. It's not a penalty — it's a choice: one day of VA compensation is waived for each day of military pay taken (drill, annual training, or active-duty pay). For almost everyone a duty day of military pay beats a day of VA compensation, so most members keep the military pay and waive the compensation for those days — but the member decides, and in the rare case the compensation pays more, it can be kept and the military pay declined.

The VA runs this on VA Form 21-8951-2 (Notice of Waiver of VA Compensation to Receive Military Pay). Once a year the VA and DFAS line up the member's paid duty days against the compensation already sent; the form is returned to make the election. Ignore it and the overlapping days grow into an overpayment the VA later recoups as a debt. Two things to keep straight: this only shaves the overlapping days (it never lowers the rating), and it's a *different question* from whether the duty counts for service connection. (Retirees: a different offset applies to retired pay, with CRDP/CRSC possibly restoring it — that's Vol. 6 — Retirement & Military Pay, not this waiver.)

Table 2A-2. Concurrent pay: when military pay and VA compensation collide.

Situation	Both for the same days?	What gives	Do this
Rated veteran still drilling (drill, annual training, short active orders)	No	One day of VA compensation waived per paid duty day	File 21-8951-2; keep a running count of paid duty days
Rated veteran mobilized on Title 10 active duty	No	VA compensation waived for each active-duty day	Report the activation dates; waive comp or repay the overlap
Drew both and elected nothing	No	The overlap becomes an overpayment	Answer the debt notice; set up the waiver so it stops
Military retiree (20+ yrs) drawing pension + VA comp	Different rule	Retired pay offset by VA comp, unless restored	CRDP is automatic; apply for CRSC if combat-related (Vol. 6)

Traps That Cost Veterans Money

- Claiming "time in service" instead of naming the exact period — Guard/Reserve status is earned period by period.
- Filing a drill-period *disease* as INACDUTRA — generally not covered; see if it attaches to ACDUTRA or a Title 10 period.
- Assuming the soundness/aggravation/one-year presumptions apply — they generally don't to training-only service.
- Skipping the line-of-duty determination for a training injury — it's often the decisive evidence.
- Ignoring the 21-8951-2 — overlapping paid days turn into a recouped VA debt.
- Treating State Active Duty as federal service — it generally can't support a VA claim.

The Rule, Briefly

What counts is 38 CFR § 3.6(a): active duty, plus ACDUTRA disability from disease or injury, plus INACDUTRA disability from injury (and a heart attack, cardiac arrest, or stroke during it). The duty-period definitions are at 38 U.S.C. § 101(22)–(24), and travel to or from training counts under § 3.6(e)(2). The authority on the orders controls: 10 U.S.C. §§ 12301–12304 carry Title 10 active duty with full presumptions, 32 U.S.C. § 502 governs Title 32, and State Active Duty generally doesn't count. And there's no double pay,

because under 38 CFR § 3.700 and 38 U.S.C. § 5304 the VA won't pay compensation for a day covered by active-service pay, so reservists waive it day for day on Form 21-8951-2, with § 5304 naming the 10 U.S.C. § 1414 CRDP retiree exception (Vol. 6). These sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. Pull the documents that prove the *period*: Title 10/Title 32 orders, NGB Form 23 points, annual-training/drill schedules, and any line-of-duty determination.
2. Read the authority cited on each set of orders and label every period (Title 10 / ACDUTRA / INACDUTRA / State Active Duty).
3. Sort each claimed condition into injury or disease and match it to a period that covers it; anchor to a Title 10 activation when possible.
4. Track down (or request) the line-of-duty determination for any training injury.
5. If rated and still drilling, file VA Form 21-8951-2 and keep a running count of paid duty days. Use a VSO who handles Guard/Reserve claims (Ch. 36 — VSOs, Attorneys, and Claim Sharks).

Cited Sources

Verify all citations and figures against current primary sources before acting. The ACDUTRA/INACDUTRA presumption limits rest on federal court decisions — confirm current case law before relying on the soundness/aggravation point in a live claim. Confirm the precise Title 32 duty-status treatment for any specific period, and run any day-for-day dollar comparison against the current-year rate. VA.gov reorganizes pages; confirm a link if it moves.

- 38 U.S.C. § 101(21)–(24) — active duty, ACDUTRA, INACDUTRA, and "active military service" definitions. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section101&num=0&edition=prelim>
- 38 CFR § 3.6 — duty periods (the disease-vs-injury rule; travel to/from training). <https://www.ecfr.gov/current/title-38/section-3.6>
- 10 U.S.C. §§ 12301, 12302, 12304 — authorities for Title 10 federal active duty. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title10-section12301&num=0&edition=prelim>
- 32 U.S.C. § 502 — National Guard drills and full-time duty (Title 32). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title32-section502&num=0&edition=prelim>
- 38 U.S.C. § 1111 / § 1153 — presumptions of soundness and aggravation. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1111&num=0&edition=prelim> · <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1153&num=0&edition=prelim>
- 38 CFR § 3.700 — one award at a time; no VA comp for a day covered by active service pay; the reservist waiver. <https://www.ecfr.gov/current/title-38/section-3.700>

- 38 U.S.C. § 5304 / § 5305 — prohibition on duplication; waiver of retired pay (§ 5304 names the 10 U.S.C. § 1414 CRDP exception). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5304&num=0&edition=prelim> · <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5305&num=0&edition=prelim>
- VA Form 21-8951-2 — Notice of Waiver of VA Compensation to Receive Military Pay (annual drill-pay election). <https://www.va.gov/find-forms/about-form-21-8951-2/>
- 10 U.S.C. § 1414 (CRDP) / § 1413a (CRSC) — concurrent receipt and combat-related special compensation for retirees; full treatment in Vol. 6 — Retirement & Military Pay.
- VA.gov — Eligibility for VA disability benefits (National Guard and Reserve service). <https://www.va.gov/disability/eligibility/>
- Ch. 33 / Ch. 36 — cross-references named inline.

Ch. 3 — How VA Disability Ratings Work (0–100%)

BLUF: The VA assigns a disability rating, from 0% to 100% in 10-point steps, to every service-connected condition. The rating is not a medical severity score. It is the regulation's best estimate of how much the condition cuts into a veteran's ability to earn a living in a civilian job. A 0% rating is not nothing: it proves service connection and unlocks other benefits. When a veteran has more than one condition, the ratings combine using a separate formula, covered in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%.

The Ground Truth

Every service-connected condition gets a number. That number is the disability rating, a percentage between 0% and 100% that captures how badly the condition limits the ability to work. The VA does not hand out custom percentages. The rating must land on one of the steps the regulation allows: 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, or 100 percent.

Understanding what that number actually measures is the most important thing a veteran can know before filing or appealing.

What the rating measures

The regulation calls it "average impairment of earning capacity" in civilian work. That phrase comes straight out of § 4.1, and understanding it changes everything about how a veteran should approach a claim.

The rating is not personal. It reflects how the condition affects a typical person in civilian employment — not this particular veteran's job, income, or life situation. Two veterans with the same diagnosis and the same functional limitations should get the same rating, whether one is a retired executive or the other has never held a civilian job.

It is also not a medical severity score. A doctor grades conditions by pathology: how far a disease has progressed, how abnormal the lab values are. The VA rates conditions by functional impact, specifically impact on the ability to work. A condition can be medically serious but functionally mild, or medically stable but functionally devastating. The rating follows function, not pathology.

A 0% rating is not a denial. It means the condition is service-connected but not yet compensable. The regulation considers it too mild, right now, to cause average wage loss. That verdict still matters. It places the condition permanently on the veteran's VA record, so if it worsens, the veteran can file for an increased rating without starting from scratch. A 0% can also open access to VA health care and other ancillary benefits. Veterans should never treat it as a closed door.

What the tiers mean in plain terms

The rating steps are not arbitrary. Each represents a band of functional limitation that the rating schedule equates to a corresponding level of average wage loss. The breakdown below reflects the general framework. The actual criteria for any given condition come from its diagnostic code in the schedule (38 C.F.R. Part 4):

Table 3-1. Rating Tiers and What Each Generally Reflects.

Rating	What it generally reflects
0%	Service-connected; minimal or no measurable functional impact at this time
10%	Noticeable symptoms; minor interference with work on a consistent basis

Rating	What it generally reflects
20–30%	Moderate limitation; the condition causes real, regular interference with work tasks
40–50%	Marked limitation; significant loss of working ability in most occupations
60–70%	Severe limitation; the condition dominates the veteran's work life
80–90%	Very severe limitation; most sustained employment is not feasible
100%	Total disability; the condition is severe enough to preclude any substantially gainful employment

A few things to hold onto. The 100% ceiling does not mean the veteran is "more than totally disabled" — it means the rating schedule has assigned total occupational impairment. For veterans whose combined rating falls below 100% but who cannot hold a job because of their service-connected conditions, there is a separate path to pay at the 100% rate. That path is Total Disability based on Individual Unemployability (TDIU), covered fully in Ch. 14 — TDIU: Paid at 100% Without a 100% Rating. And the dollar figure tied to each rating changes every year with a cost-of-living adjustment. Any specific dollar amount printed outside the current VA.gov rate table is likely stale. See Ch. 12 — Compensation Rate Tables and Dependent Add-Ons and verify the current-year table before relying on any number.

Multiple conditions

Most veterans have more than one service-connected condition. Each condition gets its own rating. Those ratings do not simply add up. The VA uses a specific mathematical formula, called the combined ratings table, to calculate a single combined rating from multiple individual ratings. The logic is that each successive condition affects a body already limited by the previous one. Understanding that math is critical to understanding a multi-condition rating decision. It is covered in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%, cross-referenced here, not duplicated.

The Rule, Briefly

Three regulations set what a rating is. Under 38 CFR § 4.1, percentage ratings represent the *average impairment in earning capacity* in civilian occupations — the standardized average, not maximum impairment and not this particular veteran's impairment — and they're meant to compensate for working time lost to flare-ups, not just the permanent baseline. Under § 4.10, every evaluation, in any body system, turns on the ability to function under the ordinary conditions of daily life including employment, so the examiner's job is to describe what the condition stops the veteran from doing, not merely to name it. And § 4.2 fixes the lens: each disability is considered "from the point of view of the veteran working or seeking work," not lifestyle, comfort, or prognosis. The text of each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

The rating follows function, not diagnosis. A veteran whose knee injury limits walking, standing, and stair-climbing should focus the C&P (Compensation and Pension) examination on those functional limitations: how far, how long, how often, and what happens afterward. Diagnosis alone does not move the needle. The examiner's job is to document the *effect*.

A 0% rating is worth keeping and documenting. Service connection at 0% is the foundation for any future increase. Veterans should not ignore a 0% decision or skip follow-up care. If a condition worsens, the documented history of continuous treatment supports a claim for a higher rating.

Exacerbations count. Under § 4.1, the rating accounts for lost working time from flare-ups, not just the baseline state. Veterans with episodic conditions, such as migraines, flare-based musculoskeletal disorders, or mental health conditions with acute episodes, should document every significant flare and its impact on the ability to function at work.

The exam narrative matters as much as the numbers. Under § 4.2, the VA rater reads the C&P examiner's description of functional impact. A report that says only "mild limitation" without specifics gives the rater little to work with. Veterans should review their examination reports for completeness. A Disability Benefits Questionnaire (DBQ) that is vague or incomplete can be challenged or supplemented.

A schedular 100% and TDIU are not the same thing. A schedular 100% means the condition itself is rated at its maximum under the schedule. TDIU lets a veteran rated below 100% collect pay at the 100% rate if the service-connected conditions prevent substantially gainful employment. Veterans approaching 70% or higher combined and struggling to hold a job should read Ch. 14 — TDIU: Paid at 100% Without a 100% Rating before deciding their options are exhausted.

One more caution: dollar amounts change every year with the COLA. Figures printed anywhere other than the current VA.gov rate table are likely stale. The structure of the system is durable; the numbers are not. See Ch. 12 — Compensation Rate Tables and Dependent Add-Ons.

So a few things follow for any veteran building a claim. List every service-connected condition, including any rated at 0%, because a 0% is service connection locked in and the foundation for a future increase, not something to abandon. A veteran shouldn't estimate the total by adding percentages; the ratings combine through a formula that produces a different number (Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%), and expecting the wrong total just sets up a surprise at the decision letter. And going into every C&P exam ready to describe specific functional limitations rather than just a diagnosis matters, because under §§ 4.1, 4.2, and 4.10 the rating follows what the condition keeps the veteran from doing at work and in daily life.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 CFR § 4.1 — Essentials of evaluative rating ("average impairment in earning capacity ... in civil occupations"). <https://www.ecfr.gov/current/title-38/section-4.1>
- 38 CFR § 4.2 — Interpretation of examination reports ("from the point of view of the veteran working or seeking work"). <https://www.ecfr.gov/current/title-38/section-4.2>
- 38 CFR § 4.10 — Functional impairment ("ability of the body ... to function under the ordinary conditions of daily life including employment"). <https://www.ecfr.gov/current/title-38/section-4.10>
- 38 CFR Part 4 — Schedule for Rating Disabilities (full diagnostic code table). <https://www.ecfr.gov/current/title-38/part-4>
- VA.gov — *VA disability compensation rates* (the current-year payment table). <https://www.va.gov/disability/compensation-rates/veteran-rates/>
- VA.gov — *How VA assigns disability ratings*. <https://www.va.gov/disability/about-disability-ratings/>

Ch. 4 — The Hierarchy of Authority: U.S.C., CFR, and M21-1

BLUF: Veterans law runs on a pyramid. At the top is federal statute, the law Congress wrote. Below that sit the VA's own regulations. Below those sits the VA's internal manual. Courts sit above the whole stack and can strike any layer that violates the one above it. Knowing this hierarchy is real ammunition on appeal, because "the M21-1 says so" is not the end of the argument if the statute or regulation says otherwise.

The Ground Truth

Every VA claim gets decided by someone applying rules. But not all rules carry the same weight. A rater at the regional office, a member of the Board of Veterans' Appeals, and a federal judge are all working from the same legal stack. They are not equal positions in it.

Think of it as an operating system. The hardware is the U.S. Constitution. The operating system is the federal statute. The drivers are the agency regulations. The user manual is the VA's internal guidance. The system administrator, the one who can override any bad configuration, is the federal courts.

The pyramid runs from bottom to top.

The U.S. Constitution is the foundation. Everything in federal law has to clear this bar. Veterans cases rarely hinge on constitutional arguments, but the foundation is there.

Title 38 of the United States Code (38 U.S.C.) is the actual law. Congress wrote it, voted on it, and the President signed it. It defines who qualifies for benefits, what the VA must do, and what rights veterans have. When people say "the law says," this is what they mean. No agency can override it.

Title 38 of the Code of Federal Regulations (38 C.F.R.) sits below the statute. The VA wrote these rules to carry out the statute, and Congress gave the Secretary authority to do so — but only to implement the law, not to contradict it. A regulation that conflicts with the statute it was built on is invalid. Part 3 of Title 38 CFR governs disability compensation and is the ruleset a rater actually applies to a claim. Part 3 gets its own full chapter at Ch. 6 — 38 CFR Part 3: The Adjudication Rules.

The M21-1 Adjudication Procedures Manual sits at the bottom of the binding-law stack. It is the VA's internal how-to for claims processors and raters. Detailed and useful, but not law. A rater can follow M21-1 guidance word for word and still issue a decision that violates the CFR or the statute. The manual is guidance. The regulation is the rule.

Above all of this sit the federal courts. The Court of Appeals for Veterans Claims (CAVC) reviews Board of Veterans' Appeals decisions. The U.S. Court of Appeals for the Federal Circuit reviews CAVC decisions on questions of law. The U.S. Supreme Court sits at the top. When the courts find that a regulation contradicts the statute, the regulation either gets changed or stops being applied that way. CAVC precedential opinions are binding on the VA going forward.

The Rule, Briefly

Rulemaking is tethered: under 38 U.S.C. § 501(a) the Secretary may prescribe regulations only "consistent with those laws," a load-bearing clause that means the CFR has to stay consistent with the statute and a regulation that drifts can be challenged and struck. The Board is bound, too — § 7104(c) ties it to the Department's regulations, the Secretary's instructions, and the General Counsel's precedent opinions, so a BVA decision that ignores an applicable regulation can be appealed and reversed (and notice what's *absent*

from that list: the M21-1 manual, which is the whole point). And review runs one way: under § 7252(a) the Court of Appeals for Veterans Claims has exclusive jurisdiction over BVA decisions, and the Secretary can't appeal a Board ruling that goes in the veteran's favor. Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

When a rater cites the M21-1 to deny a claim, that is not the end of the argument. The manual can simplify and explain the regulation, but it cannot override it. If the M21-1 guidance conflicts with what the CFR actually says, the regulation wins — every time.

The CFR, in turn, has to be consistent with the statute. Courts have invalidated VA regulations before, and the VA has had to rewrite them. A denial that gets the statute wrong can be challenged all the way up the court chain. Understanding which layer the denial rests on tells a veteran exactly how strong the footing is.

Knowing the hierarchy shapes the appeal strategy. A denial grounded only in M21-1 guidance, with no CFR citation behind it, is the weakest kind of denial. A denial that gets the CFR wrong is reversible error.

Under § 7104(c), the Board is bound by the CFR and by the VA General Counsel's precedent opinions. If a Board member skips a regulation or misreads it, the CAVC can reverse or remand. The BVA is not a free agent. It is constrained by the same legal stack as the rater below it.

When the CAVC issues a precedential opinion, the VA must follow it in future cases. That is how court decisions reshape the claims process over time. A veteran who wins a key legal argument at the CAVC can change the rules for thousands of others in similar situations. Court cases and how to use them are covered in Ch. 9 — Landmark Court Cases That Shaped Veteran Rights.

One more point on strategy: when building an argument for a claim or appeal, the strongest citation stack goes statute first, then the CFR section that implements it, then the M21-1 as supporting context — never the other way around. A brief that only cites the manual is standing on the weakest layer.

Finally, the courts cannot review the rating schedule itself. Under § 7252(b), the CAVC reviews how the schedule was applied to a specific claim, not whether the schedule is correct in the abstract. The schedule is set by the Secretary under 38 U.S.C. § 1155. That distinction matters when deciding where to focus an appeal.

In practice that shapes how a veteran fights a denial. Figure out which layer it rests on first: a denial grounded only in M21-1 guidance, with no CFR citation behind it, is the weakest kind and a strong candidate to challenge. Build the appeal from the statute down, leading with the 38 U.S.C. provision, then the CFR section that implements it, then the M21-1 only as supporting context — citing the manual alone concedes ground that doesn't have to be given up. And check whether a CAVC precedential opinion already covers the legal question at issue, because favorable court decisions bind the VA in future cases; Ch. 9 — Landmark Court Cases That Shaped Veteran Rights helps find the ones that may already support the argument, and the Part 3 regulations themselves are in Ch. 6 — 38 CFR Part 3: The Adjudication Rules.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 U.S.C. § 501 — Rules and regulations (Secretary's rulemaking authority; regulations must be "consistent with" the statute). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section501&num=0&edition=prelim>

- 38 U.S.C. § 7104 — Jurisdiction of the Board; decisions; notice (BVA bound by regulations and General Counsel precedent). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section7104&num=0&edition=prelim>
- 38 U.S.C. § 7252 — Jurisdiction; finality of decisions (CAVC exclusive jurisdiction over BVA; Secretary may not appeal). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section7252&num=0&edition=prelim>
- 38 CFR Part 3 — Adjudication (the regulatory rulebook for disability compensation claims). <https://www.ecfr.gov/current/title-38/part-3>
- 38 U.S.C. § 511 — Decisions of the Secretary; finality (Secretary's decisions on laws administered by VA; basis for Board appellate review under § 7104). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section511&num=0&edition=prelim>
- 38 U.S.C. § 7292 — Review by Court of Appeals for the Federal Circuit (Federal Circuit review of CAVC decisions on questions of law). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section7292&num=0&edition=prelim>
- VA M21-1 Adjudication Procedures Manual — Internal VA guidance for claims processors; not binding law.
https://www.knowva.ebenefits.va.gov/system/templates/selfservice/va_ssnew/help/customer/locale/en-US/portal/554400000001018/content/554400000149088/M21-1-Adjudication-Procedures-Manual (VA reorganizes M21-1 access periodically; if the link moves, search "M21-1")

Ch. 5 — The Rating Schedule (VASRD) and Diagnostic Codes

BLUF: The VA does not rate conditions by gut feeling. It uses a federal rulebook — 38 CFR Part 4, the Schedule for Rating Disabilities (VASRD) — that assigns a percentage to every recognized condition based on documented severity. Each condition gets a four-digit Diagnostic Code that points to the criteria rows a rater uses to pick 0%, 10%, 20%, and so on up to 100%. Veterans who understand how that rulebook is organized — and the five cross-cutting rules woven through it — are better equipped to build a claim that lands at the right rating.

The Ground Truth

Think of 38 CFR Part 4 as the VA's rating bible. It lists nearly every condition a veteran might claim. It says exactly which symptoms and measurements push a condition to each percentage level. A rater does not make up the criteria. The law makes them up, in advance, in writing.

The Schedule for Rating Disabilities is the official federal regulation — part of Title 38 of the Code of Federal Regulations — that determines how severe a service-connected disability is and, therefore, how much compensation a veteran receives. The VA cannot deviate from it without a regulatory change. A rater who ignores the VASRD is making a legal error.

Part 4 is divided into body systems: musculoskeletal conditions (bones, joints, muscles), mental disorders, eyes, ears, heart, lungs, digestive system, skin, infectious diseases, and more. Each body-system subpart opens with a "General Rating Formula" explaining how to measure severity across all conditions in that group. Then come the individual diagnostic codes, which are the specific entries for each condition within the group.

A Diagnostic Code, usually called a DC, is a four-digit number. The first two digits generally indicate the body system; the last two narrow it to the specific condition. DC 5003 covers degenerative arthritis. DC 6204 covers peripheral vestibular disorders (inner-ear balance problems).

Here is a point that trips up almost everyone. The decision letter the VA mails a veteran does not list the Diagnostic Code. That letter is a summary: the conditions granted or denied, the percentage assigned to each, the effective dates, and the monthly payment. The DC itself lives on a separate internal document called the rating code sheet, and the VA does not send it automatically. To get the DC, a veteran has two paths. A veteran can request the code sheet from the VA Regional Office — in person, or in writing through a FOIA/Privacy Act request — since the code sheet lists each condition with the exact DC the rater applied. Or a veteran can find the DC directly by matching the condition in 38 CFR Part 4. Either way, once the DC is in hand it is the starting point for any disagreement: pull up those criteria rows and compare them to what the medical evidence actually shows.

Some body systems share a single rating ladder rather than building a separate one for every possible condition. The formula for mental disorders under § 4.130 is one of the most important. It describes symptom levels — occupational and social impairment ranging from none to total — and assigns percentages to those levels (0, 10, 30, 50, 70, 100). A PTSD claim and a major depressive disorder claim both run through the same formula. The rater finds where the veteran's symptoms fit on the ladder and assigns the percentage at that rung.

Musculoskeletal conditions under § 4.71a work differently. Many of them use range-of-motion measurements as the criteria trigger. But range of motion is not the whole story — more on that in the cross-cutting rules below.

The rater's workflow is straightforward in principle. First, identify the condition and find the matching DC. Second, read the criteria for each percentage level under that DC. Third, look at the evidence (C&P exam results, treatment records, lay statements) and find the percentage whose criteria the disability picture "more nearly approximates." Fourth, apply any cross-cutting rules that modify the base result. Those rules are the rest of this chapter.

Worked Example: Finding and Reading a Diagnostic Code

A veteran claims a knee condition. The rater identifies the condition and locates the musculoskeletal subpart of 38 CFR Part 4, the body-system section for bones and joints. Within that subpart, the rater finds the matching Diagnostic Code for that knee condition.

The DC entry lists criteria rows from lowest to highest rating. Each row describes the severity level that earns that percentage. The rater reads every row, not just the one that seems likely, because the goal is to find the highest tier that the documented symptoms fully support.

The rater then compares the medical evidence to the criteria rows. If the veteran's documented symptoms sit between two tiers, § 4.7 controls: the higher rating is assigned when the disability picture more nearly approximates its criteria. The rater does not need the veteran to meet every single criterion at a tier — the question is whether the overall picture is closer to the higher rung than the lower one.

Specific range-of-motion thresholds for knee conditions must be verified against the current eCFR; criteria have been revised through VASRD modernization updates.

This process repeats for every claimed condition. The mechanics are the same regardless of body system. How specific common conditions run through this process is covered in Ch. 24 — How Common Conditions Are Rated. How multiple ratings combine is covered in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%.

The Rule, Briefly

Five provisions cut across the whole schedule, and they're the levers that move a rating up. Section 4.3 sends reasonable doubt to the veteran: when the evidence supports two percentage levels about equally, the VA must assign the higher one, so at the border between 30% and 50% with evidence either way, the rule says 50%. Section 4.7 is related but its own thing — when two evaluations could apply, the higher one applies if the veteran's symptoms *more nearly resemble* its criteria, even without hitting every single box, because the criteria are approximations, not checklists. Section 4.14, the anti-pyramiding rule, stops the VA from rating the *same symptom* twice under different codes, but it does not block rating two genuinely separate conditions that happen to share a symptom (a knee and a low back can both be rated for pain because they're distinct structures), so a rater should not misuse it to deny a separate condition. Section 4.59 makes painful motion count: pain itself is disabling for joints, not just the degrees, and "actually painful, unstable, or malaligned joints" get at least the minimum compensable rating, so full range achieved while grimacing and guarding is not a zero. And §§ 4.40 and 4.45 make functional loss matter, requiring raters to weigh what the veteran can't do — weakened movement, pain on movement, less movement, disturbed locomotion — rather than a single tape-measure reading. The text of each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

The decision letter shows the percentage, not the Diagnostic Code behind it. To check the VA's work, get the DC first — request the rating code sheet from the Regional Office, or look the condition up in the VASRD — then pull up that code and read the criteria rows the rater used. If the medical evidence is stronger than the percentage assigned, that gap is the basis for a higher-level review or supplemental claim.

For mental health claims under § 4.130 and many musculoskeletal claims under § 4.71a, the General Rating Formula at the top of the subpart does most of the work. If the written reasoning in the decision never engages that formula, the analysis may have been incomplete.

When a veteran's symptom picture sits between two ratings, § 4.7 is the argument tool. The question is not "do I check every box for the higher one?" It is "does the disability picture more nearly approximate the higher one?" Veterans and their representatives should frame evidence arguments around that exact language.

Anti-pyramiding under § 4.14 is often misread as a ceiling on how many conditions can be rated. It is not. A veteran with five separate service-connected conditions — each with its own distinct symptom profile — gets rated for all five. The rule blocks rating the same symptom under two codes, not rating two conditions that happen to share some overlap. The combined rating from multiple conditions is calculated using VA math, covered in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%.

For musculoskeletal claims, an examiner who only measures degrees of motion and does not assess pain behavior, muscle spasm, or functional loss on repetitive use is providing an incomplete record under §§ 4.40, 4.45, and 4.59. Veterans can flag this in a rebuttal if the exam is inadequate.

Section 4.3 requires the VA to resolve doubt in the veteran's favor, but only on the evidence that exists. Thorough evidence submission is what gives the system something to work with. Reasonable doubt is not passive.

Cross-references for deeper coverage: how individual conditions run through the specific DC criteria is in Ch. 24 — How Common Conditions Are Rated; how multiple ratings combine is in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%. This chapter is the foundation both build on.

So the move after any decision is to get the Diagnostic Code — from the rating code sheet if a veteran requests it, or by matching the condition in 38 CFR Part 4 — and read the criteria rows directly: the gap between what those rows require and what the medical evidence shows is the basis for a higher-level review or a supplemental claim. Read the General Rating Formula for the body system, not just the individual DC entry, since for mental-health claims under § 4.130 the formula does most of the work and a decision that skips it may have applied an incomplete analysis. For any musculoskeletal condition, confirm the C&P examiner documented pain behavior and functional loss and not just degrees of motion, because §§ 4.40, 4.45, and 4.59 require those to be factored in and an exam that only records degrees is incomplete and can be challenged. And when a veteran's disability picture sits between two tiers, frame the argument under § 4.7 — the question isn't whether every box is checked for the higher rating, it's whether the total picture more nearly approximates it. How individual conditions run through the specific criteria is in Ch. 24 — How Common Conditions Are Rated, and how multiple ratings combine is in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 CFR Part 4 — Schedule for Rating Disabilities (VASRD). <https://www.ecfr.gov/current/title-38/chapter-I/part-4>
- 38 CFR § 4.3 — Resolution of reasonable doubt. <https://www.ecfr.gov/current/title-38/section-4.3>
- 38 CFR § 4.7 — Higher of two evaluations. <https://www.ecfr.gov/current/title-38/section-4.7>
- 38 CFR § 4.14 — Avoidance of pyramiding. <https://www.ecfr.gov/current/title-38/section-4.14>
- 38 CFR § 4.40 — Functional loss. <https://www.ecfr.gov/current/title-38/section-4.40>
- 38 CFR § 4.45 — The joints. <https://www.ecfr.gov/current/title-38/section-4.45>
- 38 CFR § 4.59 — Painful motion. <https://www.ecfr.gov/current/title-38/section-4.59>
- 38 CFR § 4.71a — Schedule of ratings — musculoskeletal system (rating formulas and individual DCs). <https://www.ecfr.gov/current/title-38/section-4.71a>
- 38 CFR § 4.130 — Schedule of ratings — mental disorders (General Rating Formula for Mental Disorders). <https://www.ecfr.gov/current/title-38/section-4.130>
- Rating code sheet — how to obtain it. The Diagnostic Code for each rated condition appears on the VA's internal rating code sheet, not on the decision/notification letter the veteran is mailed. The code sheet is requested from the veteran's VA Regional Office in person, or in writing through a FOIA/Privacy Act request. VA FOIA/Privacy Act requests: <https://department.va.gov/foia/> · VA records: <https://www.va.gov/records/> · Background (veteran-law explainer): Cuddigan Law, <https://www.cuddiganlaw.com/blog/getting-your-va-rating-code-sheet-is-crucially-important.cfm>

Ch. 6 — 38 CFR Part 3: The Adjudication Rules

BLUF: Part 4 of Title 38 sets the rating percentages. Part 3 sets the rules that decide *whether* a veteran wins at all — service connection, reasonable doubt, presumptives, secondary conditions, effective dates, and rating protection. These are the gates a claim must pass. Understanding them is the difference between filing blind and filing with a plan.

The Ground Truth

Most veterans know Part 4. Part 4 is the rating schedule — the big table that says a bad knee is worth 10% or 20% or 30%. What most veterans do *not* know is Part 3.

Part 3 is the rulebook the VA uses to adjudicate a claim. Adjudicate means decide. These are the regulations the rater sits with when reading a claim file and deciding whether to grant or deny — and at what level.

Part 3 covers every major decision point. Did the condition start in service? Does the benefit of the doubt apply? Can a condition the veteran already had before service be connected? Can a new disease caused by a service-connected disease be covered? When does the money start? How hard is it to take a rating away once it is granted?

Every one of those questions has a specific regulation with a specific answer. The regulations do not favor the government. Several of them tilt hard toward the veteran. The veteran who knows these rules can use them. The veteran who does not know them gets whatever the rater feels like doing.

This chapter walks through the twelve load-bearing sections — each one explained as a gate the claim must pass or a lever the veteran can pull.

The Adjudication Rules, Briefly

Gate 1 — § 3.102: Reasonable Doubt

When the positive and negative evidence are in approximate balance — neither clearly proving nor disproving the claim — § 3.102 requires the VA to resolve the doubt in the veteran's favor, on service origin, degree of disability, or any other point. This is the most powerful sentence in Part 3. The evidence does not have to be perfect. It does not have to be overwhelming. When the scales are roughly even, when the evidence neither clearly proves nor clearly disproves, the VA must give the benefit of the doubt to the veteran. This applies to service origin, to degree of disability, and to any other point in the claim. It is not a loophole. It is the written policy of the entire department.

Gate 2 — § 3.303: Direct Service Connection

Direct service connection is the standard path. The veteran shows three things: a current disability, an in-service event or exposure, and a medical link between the two. That link is called a nexus. It usually comes from a doctor's opinion. The condition does not have to appear in service records. Lay statements from the veteran or fellow service members about what happened in service count as evidence. The VA must review all of it.

Gate 3 — § 3.304(b): Presumption of Soundness

Before service, the military runs an entrance exam. If the exam found no condition, the law presumes the veteran entered service healthy. This is the presumption of soundness. The VA cannot point to a pre-service condition to deny a claim unless it can show by *clear and unmistakable evidence* that the condition existed before service *and* was not aggravated by service. That is a very high bar — and it is the government's bar to clear, not the veteran's.

Gate 4 — § 3.304(f): PTSD Stressor Rules

PTSD has its own service connection rules under § 3.304(f). The standard path requires a confirmed stressor — a traumatic event in service — supported by service records or other credible evidence. For combat veterans, the standard is relaxed: if the veteran's service records confirm they served in combat, the veteran's own consistent statement about the stressor is generally enough to establish it. There are also specific rules for military sexual trauma (MST) stressors where the evidentiary standard is lowered because reporting rates were historically low. Full detail lives in Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation.

Gate 5 — § 3.306: Aggravation of a Pre-Service Condition

If a condition *did* exist before service, all is not lost. Under § 3.306, if service aggravated that pre-existing condition beyond its natural progression, the veteran is entitled to compensation for the *additional* disability caused by service. The key word is aggravation — service made it measurably worse than it would have been without service. The VA rates only the increase caused by service, not the baseline condition that existed before entry.

Gate 6 — §§ 3.307 & 3.309: Presumptive Conditions

Some conditions do not require proof of a specific in-service event. The law *presumes* service connection for certain diseases based on service location, exposure, or era. A veteran who served in a defined area or time period and later develops a listed disease can be service connected without a nexus opinion.

Common presumptive categories include: chronic diseases appearing within one year of separation from service (§ 3.309(a)), tropical diseases, conditions linked to prisoner of war experience, Agent Orange-related diseases, Gulf War illness conditions, and — with the PACT Act — a large expansion of burn pit and toxic exposure conditions. The specific conditions and lists change as Congress adds new categories. Check the current list before filing. Full treatment lives in Ch. 21 — Presumptive Conditions Explained.

Gate 7 — § 3.310: Secondary Service Connection

A veteran's service-connected knee injury causes the veteran to walk differently. Years later, the veteran develops hip arthritis from the altered gait. Under § 3.310, that hip arthritis can be service connected as a secondary condition — even though the hip itself was never injured in service.

The rule has two parts. First, under § 3.310(a), a disability that is proximately due to or the result of a service-connected condition shall itself be service connected. The secondary condition becomes part of the original condition. Second, under § 3.310(b), even if the secondary condition is not fully caused by the primary condition, any increase in severity that is proximately due to the primary condition is also compensable. The VA must rate the aggravation.

Secondary service connection is one of the most underused tools in the claims playbook. Deep treatment lives in Ch. 25 — Secondary Conditions: The Underused Multiplier.

Gate 8 — § 3.156: New and Relevant Evidence

A denied claim is not a closed case. Under § 3.156, a veteran can reopen a previously denied claim by filing a Supplemental Claim with *new and relevant* evidence. New means evidence not previously considered. Relevant means evidence that tends to prove or disprove a point at issue in the claim. This standard is lower than the old "new and material" standard that preceded the 2017 Appeals Modernization Act. One new medical opinion that meets the criteria can reopen a case that was denied years ago.

There is also a specific rule: if a veteran submits new service records within a year of a decision, the VA must reconsider that decision as if the records had been part of the original file, which can pull the effective date back. Full treatment of the decision-review system lives in Ch. 27 — The Appeals Process Under the AMA.

Gate 9 — § 3.321(b): Extraschedular Ratings

Part 4's rating schedule does not cover every situation. Some veterans have conditions that cause occupational and social impairment far beyond what the rating percentage suggests. Under § 3.321(b), a veteran can be referred for an extraschedular rating when the schedular rating is inadequate to compensate for the actual impact of the condition. This requires a finding that the case presents an exceptional pattern of disability not contemplated by the rating schedule. It is not common, but it is a real lever for veterans whose conditions are genuinely beyond the schedule's reach.

Gate 10 — § 3.344: Rating Stability and Protection

Once a rating is in place, the VA cannot simply reduce it without meeting specific standards. Under § 3.344(a), before the VA reduces a rating that has been in place for five or more years, it must show *material improvement*. A single exam with a lower finding does not cut it; the VA needs evidence that the condition has actually and sustainably improved under the ordinary conditions of life (working, not just resting). For ratings held for twenty or more years, the bar is even higher: reduction requires clear and unmistakable error. And a 100% rating that has been in place for twenty or more years is generally protected from reduction entirely. Full treatment lives in Ch. 29 — Protected Ratings.

Gate 11 — § 3.400: Effective Dates

The effective date is the date the money starts. Under § 3.400, the effective date is generally the *later of* the date the claim was received or the date entitlement arose (meaning the date the disability actually became disabling). For most original claims, this means the check starts from the day the claim was filed — not the day the VA decided it. Money does not accrue during the time the VA takes to process the claim. That is why filing early matters so much. The effective date follows the filing date, so every month a veteran waits to file is a month of back pay that never accrues.

There is one major exception: if a veteran files within one year of separating from service, the effective date can be set to the day *after* separation. This can be worth months of retroactive pay.

What This Means in Practice

Section 3.102 is the default tiebreaker. When the evidence is roughly even, the VA must grant. Veterans should know this rule by name and cite it when evidence is contested.

Direct service connection requires three things: a current diagnosis, an in-service event, and a medical nexus linking the two. All three must be present. A nexus opinion from a private doctor can close the gap if the VA's own exam is inadequate.

The presumption of soundness shifts the burden to the government. The VA must prove clear and unmistakable error to say a condition was pre-existing and not aggravated. Veterans should not assume a pre-service condition blocks a claim.

Secondary conditions deserve their own claims. Veterans who have one service-connected condition should ask their doctors whether any other problems could be related. That conversation can open a new claim under § 3.310, often without additional in-service documentation.

A few of these gates govern timing and money rather than the merits. The filing date is the clock: under § 3.400 money accrues from the date the claim is received, so early filing protects the back-pay date and the one-year-from-separation window should never be missed. Denied claims aren't final either, because under § 3.156 a new medical opinion or newly obtained service records can reopen one year later. Protected ratings are the endgame, since once a rating clears the five-year and twenty-year thresholds under § 3.344 it becomes very hard to reduce, so a veteran should track rating anniversaries. And the presumptive lists keep expanding — the PACT Act added thousands of veterans to coverage — so anyone denied before should check whether their condition is covered now (this list keeps expanding; check the current one before relying on it).

So the practical moves track those gates. A veteran should file an Intent to File before gathering a single page, because under § 3.400 the effective date is the date the claim is received and every day without an ITF on file is a day of potential back pay gone for good. Figuring out which gate governs each condition — direct (§ 3.303), presumptive (§§ 3.307/3.309), secondary (§ 3.310), or aggravation (§ 3.306) — is what tells a veteran what evidence to build and whether a private doctor needs to write a nexus. For anything denied before, a veteran should check whether new and relevant evidence now exists, because under § 3.156 a single new opinion or set of service records can reopen a years-old denial. And when the evidence is contested, a veteran should invoke § 3.102 by name: if it neither clearly proves nor clearly disproves the point, the VA is required by its own policy to resolve that balance in the veteran's favor.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 CFR § 3.102 — Reasonable doubt. <https://www.ecfr.gov/current/title-38/section-3.102>
- 38 CFR § 3.303 — Principles relating to service connection. <https://www.ecfr.gov/current/title-38/section-3.303>
- 38 CFR § 3.304 — Direct service connection; wartime and peacetime (includes § 3.304(b) presumption of soundness, § 3.304(f) PTSD). <https://www.ecfr.gov/current/title-38/section-3.304>
- 38 CFR § 3.306 — Aggravation of preservice disability. <https://www.ecfr.gov/current/title-38/section-3.306>
- 38 CFR § 3.307 — Presumptive service connection for chronic, tropical, or prisoner-of-war-related disability. <https://www.ecfr.gov/current/title-38/section-3.307>

- 38 CFR § 3.309 — Disease subject to presumptive service connection. <https://www.ecfr.gov/current/title-38/section-3.309>
- 38 CFR § 3.310 — Disabilities that are proximately due to, or aggravated by, service-connected disease or injury. <https://www.ecfr.gov/current/title-38/section-3.310>
- 38 CFR § 3.156 — New and relevant evidence. <https://www.ecfr.gov/current/title-38/section-3.156>
- 38 CFR § 3.321(b) — Exceptional cases; extraschedular ratings. <https://www.ecfr.gov/current/title-38/section-3.321>
- 38 CFR § 3.344 — Stabilization of disability evaluations. <https://www.ecfr.gov/current/title-38/section-3.344>
- 38 CFR § 3.400 — General (effective dates). <https://www.ecfr.gov/current/title-38/section-3.400>

Ch. 7 — The Doctrines Working In Their Favor

BLUF: Congress wrote the VA claims system with a thumb on the scale — in the veteran's favor. Five legal doctrines make it so: benefit of the doubt (a tie goes to the veteran), duty to assist (the VA must help gather evidence), the combat presumption (a combat veteran's word carries weight without paperwork), the presumption of soundness (veterans enter service healthy unless the record says otherwise), and the sympathetic-reading rule (the VA must read claims generously). These are not loopholes. They are the law — and veterans who can name them are harder to deny.

The Ground Truth

Most veterans file a claim thinking the system works like a courtroom. The VA is the judge, the veteran is on trial, and the burden of proof is on the veteran to prove everything beyond a reasonable doubt. That picture is wrong. The VA claims system was designed to be non-adversarial — meaning the government is not supposed to be hunting for reasons to deny. Several doctrines baked into the law enforce that design. Understanding them changes how a veteran sees the process.

Doctrine 1: Benefit of the Doubt (equipose)

Civilian courts use two standards. Criminal cases require proof beyond a reasonable doubt. Civil cases require a preponderance of the evidence — more likely than not, greater than 50%. VA law uses neither of those.

When the evidence on a VA claim is roughly equal, some pointing toward service connection and some pointing away, the veteran wins. That balanced state has a name: *equipose*. Think of it as a tie. In any other court, a tie goes to nobody; the party with the burden of proof loses. In the VA system, the tie goes to the veteran. The law says so directly. This is the single most important pro-veteran doctrine in the entire system.

It does not mean the veteran only needs a little evidence. Once the evidence is roughly at a 50-50 balance, the rules shift. A genuine split of credible medical opinions is exactly the kind of situation the doctrine covers — one doctor saying "no" and one saying "maybe" is not the same as a genuine split of equally credible opinions.

Doctrine 2: Duty to Assist and Notify (VCAA)

The VA has a legal obligation to help veterans build their case. Under the Veterans Claims Assistance Act of 2000 (VCAA), codified at 38 U.S.C. § 5103 and § 5103A, the VA must do two things before denying a claim:

1. *Notify* — Tell the veteran what information and evidence is needed to win the claim.
2. *Assist* — Make reasonable efforts to get that evidence. That includes requesting service treatment records, personnel records, and in many cases ordering a VA examination (called a C&P exam) at no cost to the veteran.

If the VA fails to assist and then denies the claim, that failure is a legal error. Veterans can and do win appeals on the grounds that the VA did not meet its duty to assist. The system is not supposed to be a scavenger hunt where the veteran does everything alone.

Doctrine 3: The Combat Presumption

Records get lost. They burn. They get misfiled. In a combat deployment, medical care is sometimes a buddy wrapping a bandage and moving on. A veteran who has no paperwork for an injury that happened downrange is not automatically out of luck.

Under 38 U.S.C. § 1154(b), a veteran who engaged in combat during a period of war can use lay evidence — their own statement, a buddy statement — to establish that an injury or disease was incurred or aggravated in service, even if no official record exists. The key condition: the lay evidence has to be consistent with the circumstances of that service. A statement that fits what actually happened in that theater, at that time, carries weight. The absence of a record does not kill the claim.

This doctrine protects the veteran from the bureaucratic reality that combat does not come with paperwork.

Doctrine 4: Presumption of Soundness and Presumption of Aggravation

Every service member goes through an entrance physical. Under 38 CFR § 3.304(b), a veteran who was found to be physically fit at entry is presumed to have entered service *sound* — without the condition they are now claiming. If a condition shows up during service, the VA cannot simply say "they must have had it before they enlisted" unless the pre-service records show a clear pre-existing defect *noted at entry*.

Aggravation is the related doctrine. It covers veterans who did have a pre-existing condition. Under 38 CFR § 3.306, if service worsened a pre-existing condition beyond its natural progression, that aggravation is service-connected. The VA must affirmatively show that any increase in severity was entirely due to the natural course of the disease, with service playing no role, in order to defeat an aggravation claim. The burden of rebuttal is on the VA, not the veteran.

Together, these two presumptions protect veterans at both ends: those who had nothing wrong at entry, and those who entered with a condition that service made worse.

Doctrine 5: Pro-Claimant and Sympathetic Reading

The VA is required to read a claim generously. If a veteran files a claim for a knee injury but the record also shows symptoms of a related back condition, the VA is supposed to consider whether the claim should be read broadly enough to cover the back. Veterans are not lawyers. Congress did not write the system expecting veterans to use perfect legal precision in describing their conditions. The VA has a duty to look at the entire record and give the claim its most favorable interpretation.

This rule is less precise than the others. It does not have one single statutory home, but it comes from a line of case law and VA policy that treats the non-adversarial system as real. The cases that established and sharpened these doctrines are explored in Ch. 9 — Landmark Court Cases That Shaped Veteran Rights. The Part 3 regulations that implement them are surveyed in Ch. 6 — 38 CFR Part 3: The Adjudication Rules.

The Rule, Briefly

Four doctrines do the heavy lifting. The benefit of the doubt, 38 U.S.C. § 5107(b), means that when the positive and negative evidence are in approximate balance on any material issue, the Secretary gives the benefit of the doubt to the claimant — scales roughly even, and the veteran wins. The reasonable-doubt regulation, 38 CFR § 3.102, reinforces that at the regulatory level, resolving genuine doubt (not guesswork) in the veteran's favor, and a conflict between two credible medical opinions is exactly what it was written for. The combat presumption, § 1154(b), lets a veteran who engaged in combat use satisfactory lay evidence of an in-service event as sufficient proof even without an official record, as long as it fits the circumstances of that service. And the duty to assist, § 5103A(a)(1), says the Secretary *shall* make reasonable efforts to help obtain the evidence — "shall" being mandatory, so a denial that skipped the step is legally defective. Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

When a rating decision ignores competing evidence, veterans and their representatives should cite § 5107(b) and § 3.102 by name in any Notice of Disagreement or Board brief. Naming the rule forces the adjudicator to address it.

A split of medical opinions is not a loss. If the VA's examiner says "no" and the veteran's doctor says "yes," that is an approximate balance. Under the benefit of the doubt doctrine, that tie goes to the veteran. Veterans should not walk away from a one-to-one split without appealing.

If a claim was denied without a VA examination and the veteran submitted credible evidence, that denial is vulnerable on duty-to-assist grounds. A competent VSO or attorney will spot this immediately.

For combat veterans, a statement from someone who witnessed an injury or its aftermath is lay evidence under § 1154(b), so submit it as a formal buddy statement on VA Form 21-10210 rather than leaving it as a verbal account. Pre-existing conditions aren't automatic bars either: the presumption of aggravation under § 3.306 means a veteran with a childhood knee injury who reinjured it in service still has a claim, and the VA has to prove service played zero role, so the default goes to the veteran. And filing broadly protects more ground, because the VA must read claims sympathetically — a veteran should describe every symptom fully rather than limiting the claim to the one condition they think they can "prove," and let the VA work through the whole record.

These doctrines compound. A combat veteran with split medical opinions whose VA exam was skipped has three separate doctrines working simultaneously: combat presumption, benefit of the doubt, and duty to assist. Each is an independent basis to challenge a denial.

So the practical moves are to invoke these by name. When the evidence is mixed, cite § 5107(b) and § 3.102 directly in the written submission, because that forces the adjudicator to address the doctrine. Check whether a C&P exam was even ordered, since a denial issued without one after the veteran submitted credible evidence is vulnerable on duty-to-assist grounds under § 5103A. Combat veterans should put any witness account on VA Form 21-10210 as a buddy statement, where it carries real weight under § 1154(b), rather than leaving it verbal. And describe every symptom, not just the named condition, because the sympathetic-reading rule makes the VA read the claim as broadly as the record supports; Ch. 9 — Landmark Court Cases That Shaped Veteran Rights has the cases that define that obligation, and Ch. 6 — 38 CFR Part 3: The Adjudication Rules covers the regulatory structure behind it.

Cited Sources

Verify all citations and statutory text against current primary sources before acting.

- 38 U.S.C. § 5107 — Claimant responsibility; benefit of the doubt. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5107&num=0&edition=prelim>
- 38 CFR § 3.102 — Reasonable doubt. <https://www.ecfr.gov/current/title-38/section-3.102>
- 38 U.S.C. § 1154 — Consideration to be accorded time, place, and circumstances of service (combat presumption at § 1154(b)). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1154&num=0&edition=prelim>
- 38 U.S.C. § 5103 — Notice to claimants of required information and evidence (duty to notify / VCAA). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5103&num=0&edition=prelim>

- 38 U.S.C. § 5103A — Duty to assist claimants. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5103A&num=0&edition=prelim>
- 38 CFR § 3.304(b) — Presumption of soundness. <https://www.ecfr.gov/current/title-38/section-3.304>
- 38 CFR § 3.306 — Presumption of aggravation. <https://www.ecfr.gov/current/title-38/section-3.306>
- VA Form 21-10210 — Lay/Witness Statement. <https://www.va.gov/find-forms/about-form-21-10210/>

Ch. 8 — The Acts That Built and Expanded Benefits

BLUF: Congress has rewritten the VA benefits rulebook multiple times since 1991. Each major law fixed a specific problem: Vietnam veterans left out of herbicide presumptions, a broken appeals system, offshore Navy veterans denied coverage, and post-9/11 veterans exposed to burn pits and toxic smoke. A veteran who was denied a claim years ago may now qualify under a newer law. The covered-condition lists change. Veterans should check VA.gov at the time of filing — not rely on memory or old paperwork.

The Ground Truth

VA disability law did not arrive complete. Congress built it over decades, responding to failures: veterans sick from herbicides who could not prove the link, claimants trapped in backlogs for years, sailors who never set foot in Vietnam told they did not qualify, and a generation of post-9/11 veterans breathing toxic smoke with no path to compensation.

Six laws stand out as the load-bearing ones. Each changed what a veteran can claim, who can claim it, or how claims get decided.

Agent Orange Act of 1991. Before this law, a Vietnam veteran with a disease linked to herbicide exposure had to prove, individually and with medical evidence, that Agent Orange caused the condition. That was nearly impossible. The herbicides had been sprayed across Vietnam by the U.S. military, the records were incomplete, and years had passed. Congress stepped in. The Agent Orange Act of 1991 (Public Law 102-4) directed the VA to work with the National Academy of Sciences to regularly review the science on herbicide-related diseases. Where the science showed a link, the VA was required to establish presumptive service connection — meaning a Vietnam veteran who served in a covered location and later developed a covered disease would be presumed to have gotten it from service. No proof of direct exposure required. The covered-disease list has grown since 1991 as the science has evolved. Veterans should verify the current list at VA.gov at the time of filing.

Veterans Claims Assistance Act of 2000 (VCAA). Before this law, the VA had no binding legal obligation to help a veteran build a claim. The VCAA changed that. Enacted November 9, 2000, as Public Law 106-475, it codified two duties into 38 U.S.C. § 5103 and § 5103A: the duty to notify and the duty to assist. Duty to notify means the VA must tell a claimant what evidence is needed to substantiate the claim. Duty to assist means the VA must actively help gather it, pulling service records, ordering medical exams when warranted, and identifying relevant federal files. Before the VCAA, a claim could be denied simply because the veteran did not know what to submit. The law made the VA a partner in claim development, not just a gatekeeper.

Veterans Appeals Improvement and Modernization Act of 2017 (AMA). Signed August 23, 2017, as Public Law 115-55, this law scrapped the old appeals system and replaced it with three clear options (called *lanes*) for contesting a VA decision. The old system funneled almost everything through a single path that could take years or even decades. The AMA went into effect on February 19, 2019, and applies to decisions issued on or after that date. Veterans can now choose a Supplemental Claim lane (new evidence), a Higher-Level Review lane (fresh eyes at the VA, no new evidence), or a Board of Veterans' Appeals lane (a formal appeal to the BVA, with sub-options for a hearing). The full mechanics of the three lanes are in Ch. 27 — The Appeals Process Under the AMA.

Blue Water Navy Vietnam Veterans Act of 2019. From the start, the VA interpreted the Agent Orange Act's coverage narrowly: a veteran had to have served *in* the Republic of Vietnam or on its inland waterways. Navy veterans who served on ships in the open ocean off Vietnam's coast, never setting foot on shore, were excluded. The Blue Water Navy Vietnam Veterans Act of 2019 (Public Law 116-23, signed June 25, 2019) ended that exclusion. Qualifying offshore Navy veterans are now treated as having served in a covered location for Agent Orange presumption purposes. Any veteran denied Agent Orange presumption specifically because of offshore service before 2019 has grounds to revisit that denial.

Honoring our PACT Act of 2022. Signed August 10, 2022, as Public Law 117-168, the PACT Act is the largest toxic-exposure expansion in VA history. Its full name is the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act. It covers three groups. Post-9/11 veterans exposed to burn pits in Afghanistan, Iraq, and other covered locations now have presumptive conditions, including respiratory diseases and cancers. Gulf War veterans received additional presumptive coverage. Vietnam-era veterans got two new Agent Orange presumptive conditions added to the existing list. The PACT Act also added new presumptive exposure locations for Agent Orange and radiation and extended VA healthcare eligibility for veterans in those eras. The law added more than 20 presumptive conditions in all. That list continues to evolve as VA implements the law. Veterans should verify current covered conditions at VA.gov, because the list from memory or a prior denial may be outdated. The PACT Act is covered in depth in Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure.

Camp Lejeune Justice Act of 2022. Signed the same day as the PACT Act, the Camp Lejeune Justice Act is a separate statute addressing Marines and family members exposed to contaminated drinking water at Camp Lejeune, North Carolina, from the 1950s through the 1980s. Before this law, veterans could file VA disability claims under existing presumptive rules for Camp Lejeune water contamination, but a legal bar had prevented civil lawsuits in federal court for those injuries. The Camp Lejeune Justice Act opened a separate federal civil action path (a lawsuit against the government) for those harmed by the water whose conditions are not already covered through VA claims. It is not a VA disability claim. It is a separate legal remedy. The details of the Camp Lejeune claim path are in Ch. 23 — Agent Orange, Gulf War Illness & Camp Lejeune.

The Rule, Briefly

The Agent Orange presumption is 38 U.S.C. § 1116, added by Pub. L. 102-4 in 1991: a covered disease in a veteran with covered service is treated as incurred in service "notwithstanding that there is no record of evidence of such disease during the period of such service," and that last clause is the whole engine, because the disease can surface decades later and still count without the veteran proving the link. The duty to assist is § 5103A, added by the VCAA (Pub. L. 106-475) in 2000, under which the Secretary "shall make reasonable efforts" to help obtain the evidence — mandatory, not discretionary, so the VA can't deny for lack of evidence without first trying to help gather it. And the PACT Act, Pub. L. 117-168 in 2022, amended Title 38 to add more than 20 presumptive conditions, expand the covered exposure locations, and extend health care, the largest such expansion in VA history. The text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

A prior denial is not always the end of the road. Vietnam-era veterans denied because they could not prove Agent Orange caused a disease should look at what the presumptions cover now. Navy veterans denied because of offshore service should look at what the Blue Water Navy Act changed. Veterans and survivors

who walked away from old decisions should revisit them against current law.

Burn pit veterans should file if eligible. The PACT Act created presumptive conditions for post-9/11 veterans who served in covered locations. A veteran who was previously denied, or who never filed, should check current eligibility at VA.gov. That covered-condition list is not fixed; it will continue to evolve as VA implements the law. Any list in a book, article, or prior decision may already be outdated.

A few specific situations worth flagging:

Offshore Navy Vietnam veterans denied Agent Orange presumption before 2019 solely because they served offshore have grounds to reopen those claims under the Blue Water Navy Act.

If a veteran believes the VA failed to notify them of what evidence was needed, or failed to help obtain records, those are VCAA arguments that can be raised in an appeal.

The AMA applies to decisions dated February 19, 2019, and later. Veterans with older decisions are on the "legacy" appeals path, a different track. The three AMA lanes (Supplemental Claim, Higher-Level Review, Board Appeal) apply to decisions in the new system. See Ch. 27 — The Appeals Process Under the AMA for both paths.

Camp Lejeune claims are not limited to veterans. Family members who lived at Camp Lejeune during the covered period and developed qualifying conditions may also be eligible. The VA disability path and the Camp Lejeune Justice Act civil action path are separate; a veteran can potentially pursue both depending on the circumstances. See Ch. 23 — Agent Orange, Gulf War Illness & Camp Lejeune.

So the practical moves are about timing and old denials. Check the current PACT Act and Agent Orange covered-condition lists at VA.gov before filing, because any list in a book, an old handout, or a prior decision may be outdated, and the authoritative source at the moment of filing is va.gov/resources/the-pact-act-and-your-va-benefits/. Review every old denial against current law: if a claim was turned down before 2019 over offshore Navy service, or before 2022 because a burn-pit condition lacked presumptive coverage, it may be reopened under the Blue Water Navy Act or the PACT Act by filing a Supplemental Claim with the new legal basis (Ch. 27 — The Appeals Process Under the AMA has the correct lane). And a veteran financially supporting a dependent parent should file to add them now, because the dependent-parent add-on under § 1115 requires a VA filing and doesn't backdate to when the support began.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- Agent Orange Act of 1991 — Public Law 102-4, Feb. 6, 1991. Codified primarily at 38 U.S.C. § 1116. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1116&num=0&edition=prelim>
- Veterans Claims Assistance Act of 2000 — Public Law 106-475, Nov. 9, 2000. Codified at 38 U.S.C. §§ 5103, 5103A. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5103A&num=0&edition=prelim>
- Veterans Appeals Improvement and Modernization Act of 2017 — Public Law 115-55, Aug. 23, 2017; effective Feb. 19, 2019. <https://www.congress.gov/bill/115th-congress/senate-bill/423>
- Blue Water Navy Vietnam Veterans Act of 2019 — Public Law 116-23, June 25, 2019. <https://www.congress.gov/bill/116th-congress/house-bill/299>

- Honoring our PACT Act of 2022 — Public Law 117-168, Aug. 10, 2022. Full text: <https://www.congress.gov/bill/117th-congress/senate-bill/3373> (law number and signing date confirmed against govinfo.gov)
- VA.gov — The PACT Act and your VA benefits — Primary VA summary of PACT Act effects, eligibility, and current presumptive conditions. <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/>
- Camp Lejeune Justice Act of 2022 — Enacted as part of Public Law 117-168 (PACT Act). VA Camp Lejeune water contamination information: <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/camp-lejeune-water-contamination/>
- 38 U.S.C. § 1116 — Presumptions of service connection for herbicide agents. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1116&num=0&edition=prelim>
- 38 U.S.C. § 5103A — Duty to assist claimants. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5103A&num=0&edition=prelim>

Ch. 9 — Landmark Court Cases That Shaped Veteran Rights

BLUF: Veterans do not get their rights from the VA. They get them from the courts. A series of decisions by the U.S. Court of Appeals for Veterans Claims, the Federal Circuit, and the U.S. Supreme Court forced the VA to prove nexus three ways, accept pain as a disability, honor lay testimony, and credit medical reasoning over credentials. Knowing these cases tells a veteran exactly where the VA's legal guardrails are, and when the VA has crossed them.

The Ground Truth

The VA claims system did not always look the way it does today. For most of the twentieth century, veterans had almost no way to appeal a VA decision to an independent court. Congress changed that in 1988 with the Veterans' Judicial Review Act, which created the U.S. Court of Appeals for Veterans Claims (CAVC). That one law opened the door for veterans to challenge VA decisions before a federal judge, and the case law that followed rewrote the rules of the game.

The court ladder has three rungs.

CAVC is the trial-level appellate court for VA decisions. A veteran who loses at the Board of Veterans' Appeals can appeal here. CAVC judges are appointed by the President and confirmed by the Senate. Their decisions bind the VA on every claim in the country.

The U.S. Court of Appeals for the Federal Circuit is the next rung up. Either side can appeal a CAVC decision there. Its decisions bind both the CAVC and the VA.

The U.S. Supreme Court is the final word. Supreme Court veterans-law decisions are rare but absolute. *George v. McDonough* (2022) is the most recent major one.

What follows is a plain-English guide to the cases that matter most. For each one, the chapter explains what the court held and what that holding means for a veteran filing or appealing a claim today.

By the Case Law

Caluza v. Brown — The Three-Part Test for Service Connection

Caluza v. Brown, 7 Vet. App. 498 (CAVC 1995), defined the three elements a veteran must establish to win service connection for a disability:

1. A current disability (a present medical condition).
2. An in-service incurrence or aggravation (something that happened or got worse during service).
3. A nexus: a medical or legal link connecting the current disability to the in-service event.

These three elements are the blueprint for every service-connection claim. If the VA denies a claim, the denial has to identify which element is missing. A veteran who knows the three-part test knows exactly what gap the VA found and what evidence fills it. *See also Ch. 15 — The Elements of Service Connection, which covers these elements in full.*

DeLuca v. Brown and Correia v. McDonald — Testing Painful Motion

DeLuca v. Brown, 8 Vet. App. 202 (CAVC 1995), held that when rating a joint disability, the VA must test range of motion through pain, not just the maximum range achieved before pain starts. A veteran who can move a knee to 80 degrees but experiences significant pain starting at 30 degrees is not the same as a veteran with a fully painless 80-degree range. The rating has to reflect that difference.

Correia v. McDonald, 28 Vet. App. 158 (CAVC 2016), extended the rule: range-of-motion testing must be done on both active motion (the veteran moves the joint themselves) and passive motion (the examiner moves it). An exam that tests only one or neither is legally inadequate.

If a Compensation and Pension (C&P) exam for a joint condition did not test painful motion, or used only one type of motion testing, the exam can be challenged. An inadequate exam is grounds to request a new one or to appeal on the basis that the rating rests on an insufficient evidentiary foundation.

Saunders v. Wilkie — Pain Alone Can Be a Disability

Saunders v. Wilkie, 886 F.3d 1356 (Fed. Cir. 2018), settled a long-running dispute. Does a veteran need a formal *diagnosis* to have a service-connected *disability*? The CAVC had said yes, holding that pain alone is not a disability for VA compensation purposes. The Federal Circuit reversed, ruling that the CAVC erred as a matter of law. Pain alone, without an underlying diagnosis, can constitute a disability if that pain causes functional impairment.

The VA had long taken the position that without a diagnosed condition, there was nothing to compensate. *Saunders* rejected that. The statute talks about *disability*, not *disease*. If pain prevents a veteran from doing things a healthy person could do, that is a disability under the law.

A veteran whose provider cannot pin a diagnosis on chronic pain, or whose pain condition does not yet have a recognized name, is not automatically out. The claim gets built around the functional impairment the pain causes. Evidence of what the veteran cannot do (lift, walk, concentrate, sleep) is the foundation.

Clemons v. Shinseki — The Claim Is About the Symptoms, Not the Diagnosis

Clemons v. Shinseki, 23 Vet. App. 1 (CAVC 2009), held that when a veteran files a claim for a mental health condition, the claim covers all mental health conditions that reasonably fit the described symptoms, not only the specific diagnosis the veteran named on the form.

A veteran who files for "depression" is not locked out of benefits for PTSD if the underlying facts show PTSD. The VA must consider what the symptoms actually are, not just what label the veteran used. Describe symptoms in full. If the VA denies by narrowly reading the stated diagnosis, that denial can be challenged. The claim is as broad as the symptoms it describes.

Jandreau v. Nicholson and Buchanan v. Nicholson — Lay Testimony Is Real Evidence

Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007), established that a veteran's own lay statements (personal observations about symptoms, pain, and in-service events) are competent and credible evidence. The VA cannot dismiss lay testimony simply because it is not in the medical records.

Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006), reinforced this: the absence of a contemporaneous service medical record does not automatically defeat a veteran's lay testimony. Many conditions were never documented in service records. That alone is not a reason to disbelieve the veteran. *See also Ch. 18 — Evidence That Wins Claims.*

A veteran's statement that a condition started in service, or that pain has been continuous since discharge, is evidence the VA must weigh. If the VA ignores or dismisses lay testimony without explanation, that is legal error. Written buddy statements and personal declarations carry real legal weight.

Nieves-Rodriguez v. Peake — A Medical Opinion Is Only as Good as Its Reasoning

Nieves-Rodriguez v. Peake, 22 Vet. App. 295 (CAVC 2008), held that the value of a medical opinion depends on its reasoning, not the title of the person who wrote it. A one-line conclusion from a highly credentialed specialist carries less weight than a thorough analysis from any qualified examiner who walks through the facts and explains the logic.

The flip side matters equally: an inadequate VA exam opinion, one that says "not related to service" with no reasoning, can be challenged on the same grounds. Conclusions without analysis are not competent medical opinions.

When a veteran submits an independent medical opinion (IMO) from a private provider, the quality of that opinion matters more than the provider's rank or specialty. An IMO that identifies the relevant medical literature, applies it to the veteran's specific history, and explains the reasoning is the strongest possible evidence. A C&P opinion that reaches a conclusion without that process can be attacked at appeal.

Walker v. Shinseki — Continuity of Symptomatology and the Chronic Disease List

Walker v. Shinseki, 708 F.3d 1331 (Fed. Cir. 2013), clarified when a veteran can use "continuity of symptomatology" to establish service connection. Under 38 C.F.R. § 3.303(b), a veteran who can show continuous symptoms from service to the present can establish service connection without direct medical evidence of an in-service event. But *Walker* held that this pathway applies only to the specific chronic diseases listed in 38 C.F.R. § 3.309(a): conditions like arthritis, diabetes, and hypertension. For conditions not on that list, a veteran must establish service connection through the standard three-part *Caluza* test.

If the veteran's condition is on the § 3.309(a) chronic-disease list, continuity of symptomatology is a valid and powerful route to service connection, no documented in-service event required. If the condition is not on the list, that shortcut does not apply. Knowing which list applies shapes the entire evidentiary strategy.

George v. McDonough — "Wrong Interpretation" Is Not Clear and Unmistakable Error

George v. McDonough, 596 U.S. 740 (2022), was the Supreme Court's most recent major veterans-law decision. The case addressed Clear and Unmistakable Error (CUE), the doctrine that allows a veteran to reopen a final VA decision if the original decision contained an obvious legal or factual error.

The veteran in *George* argued that when the Supreme Court later changes how a regulation is interpreted, all prior decisions applying the old interpretation contain CUE and should be reopened. The Supreme Court disagreed. A change in how a regulation is interpreted, even a later-held-correct interpretation, is not CUE in a prior final decision. CUE requires an error that was *obvious at the time* the original decision was made, not one revealed only by later legal development.

CUE is a powerful tool but a narrow one. A final rating decision can be reopened through CUE only if there was a clear factual or regulatory error at the time, not simply because the law has since moved in a direction more favorable to veterans. Veterans and advocates should not count on CUE as a backdoor to undo final decisions whenever courts hand down favorable rulings later.

What This Means in Practice

Know the *Caluza* three-part test. Every service-connection denial is missing at least one of the three elements. Identifying which one tells a veteran exactly what evidence to gather.

For joint conditions, demand a complete exam. Under *DeLuca* and *Correia*, a C&P exam for any joint must test painful motion and both active and passive range of motion. An exam that skips either step is legally inadequate and can be challenged on appeal.

Chronic pain without a diagnosis is still claimable. Under *Saunders*, functional impairment from pain, documented through daily-activity evidence and provider notes, is the basis for a valid claim.

Describe symptoms, not just diagnosis names. Under *Clemons*, a claim covers the symptoms described, not just the label used. Be thorough about how a condition actually affects daily life.

Write it down. Under *Jandreau* and *Buchanan*, lay statements are real evidence. Submit personal statements, buddy letters, and declarations describing in-service events and continuous symptoms, especially when records are missing or incomplete.

A well-reasoned independent medical opinion beats a thin C&P opinion. Under *Nieves-Rodriguez*, the analysis matters more than credentials. A private nexus letter that works through the facts and cites the relevant literature is one of the most powerful tools available.

Check the § 3.309(a) chronic-disease list before choosing a strategy. If the condition is on the list, continuity of symptomatology (*Walker*) is available. If not, the *Caluza* three-part build is the path.

CUE is not a reset button. Under *George*, a subsequent favorable court ruling does not automatically reopen every prior final decision. CUE requires an obvious error at the time, not a later shift in the law.

So put these cases to work. Match every denial to the missing *Caluza* element — figure out which of the three (current disability, in-service event, or nexus) the VA found lacking, because that gap is the exact evidence needed on appeal. Challenge any joint C&P exam that skipped painful-motion testing, since under *DeLuca* and *Correia* a joint exam has to test both active and passive range of motion through the point of pain, and a report that doesn't document it is legally inadequate, grounds to demand a new one (Ch. 19 — The C&P Exam: What to Expect and How to Prepare). Submit a private nexus letter with full written reasoning, because under *Nieves-Rodriguez* a well-reasoned independent opinion outweighs a one-line C&P conclusion when it cites the relevant literature and applies it to the veteran's specific history (Ch. 18 — Evidence That Wins Claims). And check whether the condition is on the § 3.309(a) chronic-disease list: if it is, continuity of symptomatology under *Walker* is available even without a documented in-service event, and if it isn't, the standard *Caluza* three-part case is what to build.

Cited Sources

Verify all citations and figures against current primary sources before acting. Every case below was verified against the CourtListener database on 2026-07-16: case name, reporter citation, deciding court, and filing date each confirmed against the docket record.

- *Caluza v. Brown*, 7 Vet. App. 498 (U.S. Court of Appeals for Veterans Claims, decided April 12, 1995). <https://www.courtlistener.com/opinion/6730847/caluzavbrown/>
- *DeLuca v. Brown*, 8 Vet. App. 202 (U.S. Court of Appeals for Veterans Claims, decided September 22, 1995). <https://www.courtlistener.com/opinion/6731095/delucavbrown/>

- *Correia v. McDonald*, 28 Vet. App. 158 (U.S. Court of Appeals for Veterans Claims, decided July 5, 2016). <https://www.courtlistener.com/opinion/8205716/correia-v-mcdonald/>
- *Jandreau v. Nicholson*, 492 F.3d 1372 (U.S. Court of Appeals for the Federal Circuit, decided July 3, 2007). <https://www.courtlistener.com/opinion/210539/jandreau-v-nicholson/>
- *Buchanan v. Nicholson*, 451 F.3d 1331 (U.S. Court of Appeals for the Federal Circuit, decided June 14, 2006). <https://www.courtlistener.com/opinion/794714/donald-buchanan-claimant-appellant-v-r-james-nicholson-secretary-of/>
- *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (U.S. Court of Appeals for Veterans Claims, decided December 1, 2008). <https://www.courtlistener.com/opinion/817246/angel-s-nieves-rodriguez-v-james-b-peake/>
- *Clemons v. Shinseki*, 23 Vet. App. 1 (U.S. Court of Appeals for Veterans Claims, decided February 17, 2009). <https://www.courtlistener.com/opinion/817263/william-n-clemons-v-eric-k-shinseki/>
- *Saunders v. Wilkie*, 886 F.3d 1356 (U.S. Court of Appeals for the Federal Circuit, decided April 3, 2018; docket 2017-1466). <https://www.courtlistener.com/opinion/4483241/saunders-v-wilkie/>
- *Walker v. Shinseki*, 708 F.3d 1331 (U.S. Court of Appeals for the Federal Circuit, decided February 21, 2013). <https://www.courtlistener.com/opinion/821026/walker-v-shinseki/>
- *George v. McDonough*, 596 U.S. 740 (U.S. Supreme Court, 2022). <https://supreme.justia.com/cases/federal/us/596/740/> · <https://www.courtlistener.com/opinion/6477906/george-v-mcdonough/>
- 38 CFR § 3.303 — Principles relating to service connection. <https://www.ecfr.gov/current/title-38/section-3.303>
- 38 CFR § 3.309 — Disease subject to presumptive service connection (the chronic-disease list). <https://www.ecfr.gov/current/title-38/section-3.309>

Ch. 10 — How to Read the Regs Directly and Track Updates

BLUF: The rules that govern VA disability claims are public, free, and searchable online. A veteran who can navigate eCFR, VA.gov, and the Federal Register does not have to take anyone's word for what the law says. This chapter shows exactly where the regulations live, how to find a specific rule, and how to know when the rules change — because they do change, and a veteran who relies on an outdated screenshot can walk into a claim with the wrong facts.

The Ground Truth

Every rating decision the VA makes has to rest on a written rule. Those rules are not secret. They are published by the federal government in plain sight, free of charge, on websites anyone can reach. The problem is not access: it is knowing where to look and what to look for.

The regulatory universe for VA disability claims has four main sources.

First is Title 38 of the Code of Federal Regulations (38 CFR), the actual binding rules the VA must follow when it rates a claim. Second is VA.gov, the VA's own plain-language guides to the benefit system and the official forms. Third is the VA Adjudication Procedures Manual (M21-1), the internal instructions VA raters use; it is not binding law, but it shows how the VA interprets its own rules. Fourth is the Federal Register, where new rules and proposed changes are published before they become final.

Each one serves a different purpose. A self-sufficient veteran knows which one to reach for and when.

eCFR — Where the Law Actually Lives

The Electronic Code of Federal Regulations (eCFR) at [ecfr.gov](https://www.ecfr.gov) is the authoritative, continuously updated digital text of the federal regulations. When a rule changes, the eCFR is updated, often the same day or within days of the effective date.

For VA disability, the two most important parts of Title 38 are Part 3 and Part 4. Part 3 covers adjudication: eligibility, service connection, ratings, and claims procedures. If a veteran wants to understand the legal standard for a particular type of claim, Part 3 is the starting point. Part 4 is the Schedule for Rating Disabilities (also called the VASRD), the master list of every ratable condition organized by body system, with diagnostic codes and rating criteria. If a veteran needs to know exactly what percentage a condition should carry, Part 4 is the answer.

How to navigate eCFR to a specific section:

1. Go to [ecfr.gov](https://www.ecfr.gov).
2. Select Title 38 (Pensions, Bonuses, and Veterans' Relief) from the title list.
3. Select Chapter I (Department of Veterans Affairs), then the Part: either Part 3 or Part 4.
4. Within a Part, each rule has a section number (e.g., § 3.303 for direct service connection, § 3.340 for total disability). Jump straight to a section using the search box.
5. To find a Diagnostic Code (DC), go to Part 4, then the subpart for the body system. Musculoskeletal conditions are in Subpart B; knee diagnostic codes start in the 5000s. Each DC lists the rating criteria verbatim.

The page header on every eCFR section shows the effective date and often the history: when the section last changed and which Federal Register notice made the change. That date matters. It tells a veteran whether the criteria they are reading are the same ones that applied when their rating was decided.

VA.gov — Plain Language and Official Forms

VA.gov is the VA's public-facing portal. It is not the law (the CFR is), but it serves two practical purposes.

First, it translates the legal framework into plain English. A veteran who has never read a regulation can use VA.gov to understand what compensation is, what the filing process looks like, and what evidence is generally needed. The disability section at va.gov/disability is a reasonable starting point for any first-time claimant.

Second, VA.gov hosts the official forms. The forms a veteran needs to file or appeal — VA Form 21-526EZ (application for compensation), VA Form 10-10EZ (health care enrollment), VA Form 20-0995 (supplemental claim), and others — are available for download on VA.gov. Using an outdated form pulled from a third-party site is a common and avoidable mistake. The official version is the one on VA.gov.

VA.gov is not the place to find the exact legal standard for a rating decision. For that, a veteran goes to eCFR.

M21-1 — How the VA Interprets Its Own Rules

The M21-1 Adjudication Procedures Manual is the internal guidebook VA raters use to apply the regulations. It is not a regulation. It cannot override the CFR or the statute. The Board of Veterans' Appeals and the federal courts have made clear that M21-1 is guidance only, not binding law.

But M21-1 is useful. It shows how the VA thinks about certain situations, what evidence raters are trained to look for, and what shortcuts or policies the agency applies in practice. For a veteran who wants to understand why a rater reached a particular decision, M21-1 often explains the reasoning.

The M21-1 is publicly accessible. The VA posts it on its benefits knowledge base at the benefits.va.gov domain. Chapter 4 of this volume covers service connection standards; the relationship between M21-1 guidance and the binding CFR language comes up there in more detail.

Federal Register — Where Changes Are Announced

When the VA wants to change a regulation, federal law requires it to go through a public process. The VA publishes a Proposed Rule in the Federal Register at federalregister.gov. Anyone — veterans, VSOs, advocacy groups, the general public — can submit comments during the comment period, usually 60 days. The VA reviews the comments and publishes a Final Rule. The Final Rule has an effective date, and on that date the eCFR is updated.

This matters for veterans because the VASRD (38 CFR Part 4) is actively being rewritten. The VA is updating the rating criteria body system by body system in what is called the VASRD Modernization Project. Body systems already updated include musculoskeletal, mental disorders, the ear, the eye, and the genitourinary system, among others. More are pending.

When criteria change, the old criteria do not automatically apply to open claims. The new criteria may be more favorable, less favorable, or simply different. A veteran who has been relying on criteria they read two years ago needs to verify those criteria are still current.

The govinfo.gov site maintained by the Government Publishing Office archives the Federal Register and the full bound volumes of the CFR. It is the right tool when a veteran needs to establish what the rules said on a specific date in the past.

The Habit: Check the Effective Date, Never Trust a Screenshot

One practice separates a self-sufficient veteran from one who gets bad information. Before relying on any regulatory text — from an online forum, a VSO's handout, a YouTube video, or even a prior chapter of this manual — pull up the current section on eCFR, note the effective date shown on the page, and confirm that the criteria match what was described.

Screenshots age. PDFs get saved and shared for years after they go stale. A diagnostic code that carried one set of criteria in 2020 may carry different criteria today. The eCFR reflects the current text. The eCFR is always the answer.

The Rule, Briefly

- Why the regs are public — 44 U.S.C. § 1510: every agency rule with general applicability and legal effect must be codified and published. The eCFR is the living, continuously updated version — a veteran reading 38 CFR Part 4 on eCFR is reading the exact legal text that governs their claim.
- How changes happen — 5 U.S.C. § 553 (the APA's notice-and-comment rule): proposed rules must first be published in the Federal Register, which is why VASRD changes appear there first — and why veterans and VSOs have a legal right to comment before they take effect.

The verbatim text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

eCFR is the primary tool. Before citing any regulation, veterans and their representatives should pull the current text from [ecfr.gov](https://www.ecfr.gov) and note the effective date on the page. If the date has changed since they last checked, re-read the section.

Finding a diagnostic code takes three steps: Title 38 → Part 4 → the body-system subpart → the DC number. Most VA conditions have a four- or five-digit code. Knowing that code makes it possible to navigate directly to the exact rating criteria.

Use each tool for what it does. VA.gov for forms; CFR for law. Never download a form from a third-party site. Never cite VA.gov as the legal source for a rating standard.

M21-1 is a window into VA reasoning, not the rulebook. If a rater's decision seems to track M21-1 guidance that conflicts with the CFR, the CFR wins. This distinction matters on appeal.

Veterans with rated musculoskeletal, mental health, or genitourinary conditions should verify whether their conditions were updated under the VASRD Modernization Project and, if so, what changed and when. The effective date on eCFR will show it.

Federal Register comment periods are an action opportunity. When a proposed rule affects a veteran's condition, the comment period is a chance to submit feedback on the record. VSOs typically monitor these and submit comments on behalf of the veteran community. Signing up for Federal Register notifications at [federalregister.gov/my/following/topics](https://www.federalregister.gov/my/following/topics) lets a veteran track proposed changes in real time.

If a veteran needs to know what the rating criteria said on the date of a rating decision years in the past, [govinfo.gov](https://www.govinfo.gov) archives the annual bound CFR volumes. That is the tool for legacy-criteria arguments.

In practice that comes down to a few habits. Look up the exact CFR section for the condition on eCFR today — go to [ecfr.gov](https://www.ecfr.gov), Title 38, Part 4, find the diagnostic code, and note the effective date on the page, which shows whether the criteria a rater applied are still current law. Download every VA form straight from [va.gov/find-forms/](https://www.va.gov/find-forms/) at the time of filing, because third-party copies go stale and submitting an outdated version is an avoidable cause of delay. Set a free Federal Register alert at [federalregister.gov](https://www.federalregister.gov) for any Part 4 body system covering the rated conditions, since the VASRD Modernization Project is actively rewriting criteria and a change can affect pending and future claims. And when arguing against a rating decision, check that the rater applied the CFR and not just M21-1 guidance — the manual is internal procedure only, so where it conflicts with the CFR text the CFR controls and that conflict is a ground for appeal. The one habit under all of this: check the effective date, and never trust a screenshot.

Cited Sources

Verify all citations and URLs against current primary sources before acting.

- eCFR — 38 CFR Title 38 (full title): <https://www.ecfr.gov/current/title-38>
- eCFR — 38 CFR Part 3 (Adjudication): <https://www.ecfr.gov/current/title-38/chapter-I/part-3>
- eCFR — 38 CFR Part 4 (Schedule for Rating Disabilities): <https://www.ecfr.gov/current/title-38/chapter-I/part-4>
- VA.gov — VA Disability Compensation (overview and forms): <https://www.va.gov/disability/>
- VA.gov — VA Forms search: <https://www.va.gov/find-forms/>
- VA Benefits Knowledge Base (M21-1 access point): https://benefits.va.gov/warms/M21_1.asp (VA reorganizes this page periodically; if the link moves, search "M21-1")
- Federal Register (proposed and final rules): <https://www.federalregister.gov/>
- GovInfo — CFR archive (historical bound volumes): <https://www.govinfo.gov/app/collection/CFR>
- The rating schedule itself (38 CFR Part 4, always current): <https://www.ecfr.gov/current/title-38/chapter-I/part-4>
- 44 U.S.C. § 1510 — Code of Federal Regulations: <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title44-section1510&num=0&edition=prelim>
- 5 U.S.C. § 553 — Rulemaking (notice-and-comment): <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title5-section553&num=0&edition=prelim>

Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%

BLUF: The VA does not add ratings together. It uses the "whole person" method — each new disability chews into what efficiency remains after the last one, not into 100%. A veteran with a 50% rating and a 30% rating ends up at 70%, not 80%. Understanding this math is the difference between being surprised by the VA's decision and knowing exactly what to expect before the letter arrives.

The Ground Truth

Most veterans learn their combined rating the hard way: by expecting 80% and getting 70%. The math feels wrong. It is not wrong. It just does not work the way most people expect.

Here is the core idea. The VA thinks of a person as a whole: 100% efficient, fully capable. Every disability chips into that efficiency. Each new disability chips into what is left, not into the original 100%.

Think of it like this. A veteran has a knee injury rated at 50%. That knee has taken away half of the veteran's functional capacity. Fifty percent gone. Fifty percent still there.

Now the veteran also has a back condition rated at 30%. But that back condition does not operate on a fresh, healthy person. It operates on the 50% that survived the knee injury. Thirty percent of 50 is 15. So the back condition takes away 15 more points of efficiency.

Total efficiency lost: $50 + 15 = 65\%$. Total efficiency remaining: 35%.

The VA's combined value is 65%. That gets rounded to the nearest 10. The final combined rating is 70%.

The veteran expected 80. The VA calculated 70. Both sides used 50 and 30. The math was different, and the regulation was right.

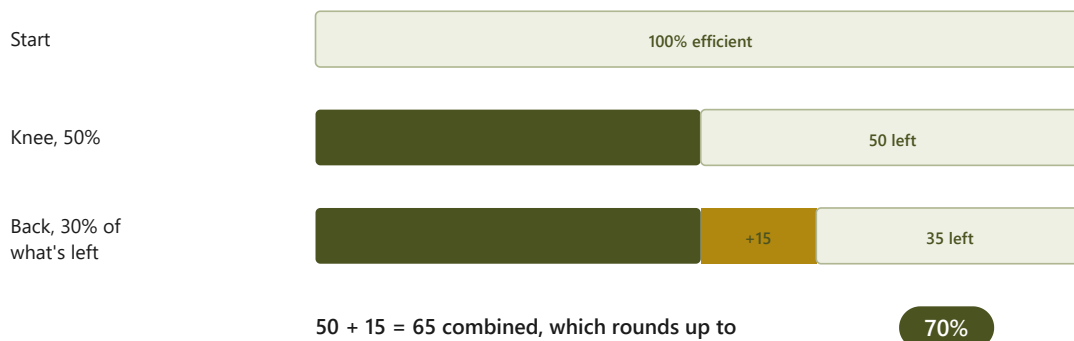


Figure 11-1. Ratings combine, they don't add. Each new rating chips into the efficiency that's left, not the original 100%, so 50% and 30% land at 70%, not 80%.

The Step-by-Step Worked Example

A concrete example is easier to follow than the concept. Here is the same scenario in table form:

Table 11-1. VA Math Worked Example: Combining 50% and 30%.

Step	Action	Disability	Efficiency Remaining
Start	Veteran begins at 100% efficiency	0% disabled	100%

Step	Action	Disability	Efficiency Remaining
Rating 1	50% rating applied to 100% efficiency: $50\% \times 100 = 50$ points lost	50% disabled	50% left
Rating 2	30% rating applied to the remaining 50%: $30\% \times 50 = 15$ points lost	$50 + 15 = 65\%$ disabled	35% left
Round	65 rounds to nearest 10: 65 ends in 5, VA rounds up	Final: 70%	—

Why 80 felt right: $50 + 30 = 80$. Simple addition. Logical.

Why 70 is correct: the back condition acts on 50 remaining efficiency, not on 100. Thirty percent of 50 is 15, not 30. The method prevents the sum of parts from exceeding the whole — a person cannot be more than 100% disabled.

The Order of Ratings Matters

The regulation requires disabilities to be arranged from highest to lowest before combining. The most severe condition goes first. This is not optional. It matters most when the bilateral factor is involved. Two ratings for the same body's paired limbs get a slight bonus before they enter the combining sequence. That bonus (the bilateral factor) is covered in full in Ch. 13 — The Bilateral Factor. For now: always list highest to lowest.

With only two ratings, this does not change the outcome. With three or more ratings, the order shifts the math slightly each step. The VA's Table I (the Combined Ratings Table) does all of this arithmetic automatically. Veterans who want to check the VA's work can use the table or one of the VA's own online calculators.

Three Ratings: The Method Scales

The same logic applies when a veteran has three or more ratings. Each one acts on the efficiency left after all previous ratings have been applied.

Example with three ratings — 50%, 30%, and 10%:

1. Start: 100% efficient.
2. Apply 50%: 50% of 100 = 50 lost. 50 efficiency remains.
3. Apply 30%: 30% of 50 = 15 lost. 35 efficiency remains. Running total: 65% disabled.
4. Apply 10%: 10% of 35 = 3.5 lost. Running total: 68.5% disabled.
5. Round 68.5 to nearest 10: ends between 60 and 70 — 68.5 is closer to 70. Final: 70%.

Four conditions is the same process. Five conditions is the same process. The table handles it all.

The Rule, Briefly

- The whole-person method — 38 CFR § 4.25: the combined ratings table works on the *efficiency* the veteran has left, not on adding scores. A 60% disability leaves 40% efficiency; a further 30% takes 30% of that remaining 40 (12 points), leaving 28% efficient — so 72% disabled. Each rating bites into what's left, never into the original whole.
- Order and rounding — § 4.25(a): arrange disabilities from most to least severe, combine through the table, then round to the nearest multiple of 10 — values ending in 5 round *up*. The regulation's own example is $50\% + 30\% =$ a combined value of 65, converted to 70. So $65 \rightarrow 70$, $75 \rightarrow 80$, $45 \rightarrow 50$. The "surprise" is the prescribed arithmetic, not a mistake.

The verbatim text of these sections (including Table I) is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

Calculate before the decision arrives. The whole-person method is predictable. A veteran can run the math (or use the VA's combined ratings calculator) and know what combined value the VA should reach. If the VA's result differs significantly, that is worth questioning.

More ratings do not add up the way more money does. Each additional rating brings less marginal gain than the one before it. A 10% rating on top of a 90% combined value adds only 10% of the remaining 10% efficiency, which is 1 point and changes nothing after rounding. The math rewards early high ratings more than it rewards piling on low ones.

The rounding rule can work for or against a veteran. A combined value of 55 rounds up to 60. A combined value of 64 rounds down to 60. Veterans near a round number should be aware of this before requesting or releasing any additional conditions.

The table does the work. Table I in § 4.25 produces the combined value directly from two ratings at a time. Veterans do not need to do the arithmetic by hand, but understanding the method prevents being blindsided by a result that looks wrong.

Order matters for the bilateral factor. When a veteran has conditions affecting both arms, both legs, or paired muscles, those ratings get a 10% bonus added (not combined) before they enter the sequence. This changes the input to the combining math. The full treatment is in Ch. 13 — The Bilateral Factor.

The combined rating drives the compensation rate. Once the final combined rating is established, the VA looks up the corresponding monthly benefit for the veteran's dependency status. What that rate is and how it changes with dependents is covered in Ch. 12 — Compensation Rate Tables and Dependent Add-Ons. This chapter teaches the math; that chapter teaches what the math is worth.

If a reader is not clear on what a 50% rating represents by itself, what conditions earn it and how the VA assigns it, that is Ch. 3 — How VA Disability Ratings Work (0–100%).

So the practical move is to run the math before the decision lands, using the VA's official combined-ratings calculator at VA.gov to compute the value a veteran should get; if the VA's result differs afterward, raise that discrepancy right away. A veteran can check the VA's arithmetic against Table I in § 4.25 (the table is at [ecfr.gov/current/title-38/section-4.25](https://eCFR.gov/current/title-38/section-4.25)), and any figure that can't be traced to a step in that table is worth questioning in writing. Confirm too that the ratings were arranged highest-to-lowest before the combining sequence, because the regulation requires it and the wrong order produces a lower final number, especially when the bilateral factor is in play (Ch. 13 — The Bilateral Factor). And know the rounding rule before requesting any new rating: a combined value of 55 rounds up to 60 while 64 rounds down to 60, so a veteran sitting near a round number should know where they stand before adding or releasing conditions. What the combined rating actually pays is in Ch. 12 — Compensation Rate Tables and Dependent Add-Ons, and what a single rating means is Ch. 3 — How VA Disability Ratings Work (0–100%).

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 CFR § 4.25 — Combined ratings table (the whole-person method, Table I, rounding rule). <https://www.ecfr.gov/current/title-38/section-4.25>
- 38 CFR § 4.26 — Bilateral factor (10% addition for paired-limb / paired-muscle disabilities; applied before combining). <https://www.ecfr.gov/current/title-38/section-4.26>
- VA.gov — *VA disability ratings* (overview of how ratings are assigned and combined). <https://www.va.gov/disability/about-disability-ratings/>
- VA.gov — *VA combined ratings calculator* (official tool). <https://www.va.gov/disability/about-disability-ratings/>

Ch. 12 — Compensation Rate Tables and Dependent Add-Ons

BLUF: Once a veteran has a combined disability rating (see Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%), that percentage maps directly to a monthly dollar amount in a federal rate table. At 0%, there is no cash payment — but the rating still matters. At 10% and 20%, the veteran receives a flat single-veteran rate. At 30% and above, the law adds a second lever: a veteran can add dependents — a spouse, children, and dependent parents — and each one increases the monthly payment. Those base amounts are set in statute and adjusted every year by a cost-of-living adjustment (COLA). The current-year table lives at VA.gov. Veterans should go there — not rely on any number in this chapter — for the dollar figure that will actually hit their account.

The Ground Truth

The combined rating from Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80% is not the finish line. It is the key that unlocks a row in a federal rate table. That table translates a percentage into a monthly cash amount. Every veteran in the same rating bracket, with the same dependent situation, gets the same number. The VA does not negotiate it. The math is set by federal law.

Three zones in the rate table.

The first zone is 0%. A 0% rating means the VA has confirmed the condition is service-connected, but does not consider it disabling enough to pay cash. That sounds like a loss, but it is not worthless. The 0% rating establishes the service-connection record, which matters for future increases and for VA healthcare eligibility. There is no monthly check at this level.

The second zone is 10% and 20%. These two ratings have a flat single-veteran rate: one number, no add-ons for family. A veteran rated 10% gets the same amount whether single or married, with kids or without. Dependents do not factor in at these two levels.

The third zone starts at 30% and runs to 100%. This is where the table opens up. The basic rate still rises with each step: 30%, 40%, 50%, all the way to 100%. But now the table has columns, not just rows. Each column represents a different dependent situation: no dependents, spouse only, spouse and one child, spouse and two children, and so on. The monthly amount changes based on which column applies to the veteran's household.

How dependents add to the payment.

Under 38 U.S.C. § 1115, a veteran rated at 30% or above is entitled to additional compensation for dependents. The law covers three categories.

Spouse: a veteran with a spouse gets more per month than the same-rated veteran without one. **Children:** biological, adopted, and stepchildren under 18 count, as do unmarried children between 18 and 23 who are enrolled in a qualifying school program; each additional child beyond the first adds a flat amount. **Dependent parents:** a parent who depends on the veteran for financial support can be added, and each qualifying parent adds to the payment.

There is one more add-on inside the spouse category: Aid and Attendance. If a veteran's spouse requires the regular aid of another person due to disability, blindness, or nursing-home care, the law authorizes an additional monthly amount on top of the spousal add-on. This is not the same as the veteran's own Aid and Attendance (an SMC-level benefit covered in Ch. 31 — Special Monthly Compensation (SMC)). This is specifically for a spouse who needs that level of care.

The rate goes up every year, automatically.

The dollar amounts in § 1114 are written into statute, but they don't sit frozen. Congress passes a separate bill each year, the Veterans' Compensation Cost-of-Living Adjustment Act, that raises the § 1114 and § 1115 amounts by the same percentage as the Social Security cost-of-living adjustment (COLA). It's worth being precise here, because it's widely misreported: for disability compensation this is not automatic. It takes an act of Congress every year, which is why the House Veterans' Affairs Committee itself calls it a bill Congress "must pass each year." In practice it passes and is pegged to the Social Security percentage, so the numbers on VA.gov keep drifting away from the base figures printed in the statute. (Two related benefits, VA pension and parents' dependency and indemnity compensation, are adjusted automatically under § 5312, but disability compensation is not.)

Guard & Reserve note: These monthly amounts assume the veteran is not also drawing military pay. A rated Guard or Reserve member who still drills cannot collect VA compensation and military pay for the same day, so the full monthly figure is reduced by the days waived to take drill, training, or active-duty pay. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

How to read the VA.gov rate table.

The VA publishes the current-year table at va.gov/disability/compensation-rates/veteran-rates/. Reading it takes about thirty seconds once a veteran knows the method. Find the row that matches the veteran's dependent situation (no dependents, spouse only, spouse plus one child, etc.). Find the column that matches the veteran's combined disability rating (30%, 40%, 50%, etc.). The cell where that row and column meet is the basic monthly rate. If there is more than one child, or the veteran's spouse receives Aid and Attendance, add the applicable amounts from the Added Amounts table printed below the main grid.

That is the full-month gross payment. It arrives tax-free, on the first business day of each month, directly deposited to the veteran's account on file with the VA.

Why the jump matters: the rate table is not a straight line.

The dollar amounts do not climb evenly. A step up at the low end adds a little money. A step up near the top adds a lot. The curve gets steeper as the rating rises.

Use the statute's own nominal (pre-COLA) base figures, purely to show the shape, not the current amounts: 10% sits at \$123 a month and 20% at \$243, so that step adds roughly \$120. But total (100%) sits at \$2,673. The climb from the 80s and 90s up to 100% is worth several times more than a step at the bottom of the scale. The money is back-loaded toward the high end.

Two lessons fall out of that shape. Pushing a borderline rating up one level near the top is often worth far more than it looks; the marginal dollars are biggest there. A secondary condition (see Ch. 25 — Secondary Conditions: The Underused Multiplier) that nudges a 90% combined rating to 100% can be worth more than several low ratings combined. And reaching 100%, or being paid at the 100% rate through TDIU (see Ch. 14 — TDIU: Paid at 100% Without a 100% Rating), is a large jump that also unlocks the dependent columns and the benefits cascade in Ch. 30 — What a 100% P&T Rating Unlocks.

Those figures are nominal, pre-COLA amounts shown only to illustrate the shape of the curve. The current-year dollars are higher and live at VA.gov. Never quote the statute figures as a current payment.

The 0% zone still has a practical use.

A 0% service-connected rating establishes a legal record that the condition is connected to service. If that condition worsens over time, the veteran does not have to re-prove service connection, only increased severity. At 0%, a veteran may also qualify for free VA healthcare for that specific condition, depending on their Priority Group. The 0% rating is not a dead end; it is a foundation.

Brief preview: SMC-K add-ons.

At any rating level, including 0%, a veteran who has suffered specific anatomical losses or the loss of use of certain body parts may qualify for Special Monthly Compensation, level K (SMC-K). SMC-K is an add-on, not a replacement. It is added on top of whatever the basic rate is. A veteran can receive up to three separate SMC-K awards simultaneously. The full treatment of SMC, including the higher levels (SMC-L through SMC-S), is in Ch. 31 — Special Monthly Compensation (SMC). This chapter just flags that the base rate table is not the ceiling for every veteran.

The Rule, Briefly

- The rate structure — 38 U.S.C. § 1114: the law sets a monthly rate for each step from 10% through total (100%), and separately authorizes the SMC-K add-on for specific anatomical losses. The dollar figures written into the statute are *nominal base amounts*, not the current check — the annual COLA is applied on top, so always pull the current-year number from VA.gov, never from the statute text.
- Dependent add-ons start at 30% — 38 U.S.C. § 1115: a veteran rated "not less than 30 percent" gets additional compensation for a spouse, children, and dependent parents (with an extra layer if the spouse independently needs aid and attendance). The 30% floor is hard and written into federal law — a veteran at 20% gets no dependent add-on. These amounts are also nominal/pre-COLA; verify the current year at VA.gov.
- COLA — the § 1114 and § 1115 dollar amounts are raised each year by a standalone *Veterans' Compensation Cost-of-Living Adjustment Act* (e.g., Pub. L. 119-42 for the December 1, 2025 increase), which sets the raise equal to the Social Security COLA under 42 U.S.C. § 415(i). This is annual legislation, not an automatic adjustment. The automatic-COLA statute, 38 U.S.C. § 5312, applies to VA pension and parents' DIC — not § 1114 disability compensation.

The verbatim text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

The rating percentage is not the payment amount. A 70% rating does not mean the veteran gets 70% of some salary. It maps to a specific row in a federal table. Veterans should look up that row at VA.gov every year because the COLA adjusts it.

At 10% and 20%, family size does not matter. A veteran with five dependents and a 20% rating gets the exact same check as a veteran who is single with a 20% rating. Dependents only add value at 30% and above.

Filing to add dependents is a separate step. Getting to 30% does not automatically trigger the dependent add-ons. The veteran must file VA Form 21-686c to add a spouse or child, and VA Form 21-674 to add a school-enrolled child over 18. The VA will not pay the add-on retroactively unless it was aware of the dependent. File promptly.

A 0% rating is worth keeping. Veterans sometimes see 0% as a rejection and move on. It is not a rejection. The 0% rating holds the service-connection record, preserves the ability to file for an increase later, and can unlock VA healthcare access for that condition.

Re-check the table after every COLA. Adjustments take effect December 1 each year, reflected in the January payment. Veterans who have not looked at VA.gov since they first filed may be surprised by how much the table has moved over several years.

Dependent add-ons are not automatic when the family situation changes. A veteran who gets married, has a child, or takes on financial support for a parent must notify the VA. Add-ons do not backdate to the life event; they start from the date of the VA's awareness. Notify quickly.

TDIU pays at the 100% rate for all purposes. A veteran who cannot work due to service-connected disabilities and is granted Total Disability based on Individual Unemployability (TDIU) receives compensation at the 100% rate, including the 100% dependent columns. That is covered in full in Ch. 14 — TDIU: Paid at 100% Without a 100% Rating.

SMC-K can be stacked at any rating. If a veteran qualifies for SMC-K, for the anatomical loss or loss of use of a creative organ, hand, foot, or similar, that flat add-on goes on top of the base rate at whatever rating applies, including ratings below 30%. Full SMC treatment is in Ch. 31 — Special Monthly Compensation (SMC).

So a few things are worth doing. Pull the current-year rate table at va.gov/disability/compensation-rates/veteran-rates/ and find the row matching the veteran's dependent situation, because COLA adjusts the amount every December 1 and any figure from memory or a prior year is probably wrong; re-check it after each annual adjustment, since a veteran who hasn't looked since filing may be underestimating what they're owed. A veteran rated 30% or higher should file VA Form 21-686c to add a spouse or dependent child (and 21-674 for a school-enrolled child over 18), and do it promptly, because the add-ons under § 1115 start from the date the VA receives the form, not from the life event, so every month of delay is a month of add-on that doesn't come back. And a 0% rating shouldn't be written off: it saves a veteran from having to re-prove service connection if the condition worsens, and it can open VA health-care access for that condition.

Cited Sources

Verify all citations and figures against current primary sources before acting. Dollar amounts in the statute text are nominal base figures; always confirm the current-year COLA-adjusted rate at VA.gov before publishing any specific figure.

- 38 U.S.C. § 1114 — Rates of wartime disability compensation (rate structure; subsections (a)–(j) cover 10%–100%; subsection (k) covers SMC-K anatomical losses). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1114&num=0&edition=prelim>
- 38 U.S.C. § 1115 — Additional compensation for dependents (30% threshold; spouse, child, parent add-ons; Aid and Attendance for spouse). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1115&num=0&edition=prelim>
- Veterans' Compensation Cost-of-Living Adjustment Act (annual) — sets the § 1114 / § 1115 increase equal to the Social Security COLA; the increase is NOT automatic and requires this act each year. Most recent: Pub. L. 119-42 (signed Nov. 25, 2025; effective Dec. 1, 2025). <https://www.congress.gov/119/plaws/publ42/PLAW-119publ42.htm>

- 38 U.S.C. § 5312 — automatic COLA authority for VA *pension* (§§ 1521, 1541, 1542) and *parents' DIC* (§ 1315) ONLY; does not cover § 1114 disability compensation. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5312&num=0&edition=prelim>
- VA.gov — *Current Veterans disability compensation rates* (the official, COLA-adjusted current-year rate table — the authoritative source for any dollar figure). <https://www.va.gov/disability/compensation-rates/veteran-rates/>
- VA.gov — *Special monthly compensation rates* (SMC-K and SMC-L through SMC-S rates). <https://www.va.gov/disability/compensation-rates/special-monthly-compensation-rates/>
- VA Form 21-686c — Declaration of Status of Dependents (required to add a spouse or child). <https://www.va.gov/find-forms/about-form-21-686c/>
- VA Form 21-674 — Request for Approval of School Attendance (required for dependent child over 18 in school). <https://www.va.gov/find-forms/about-form-21-674/>

Cross-references: Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80% (how the percentage is determined) · Ch. 14 — TDIU: Paid at 100% Without a 100% Rating (pays at the 100% rate) · Ch. 31 — Special Monthly Compensation (SMC) (SMC-K through SMC-S, Aid and Attendance for the veteran).

Ch. 13 — The Bilateral Factor

BLUF: When a veteran has service-connected disabilities on both sides of the body (both knees, both shoulders, both hands, or any paired skeletal muscles) federal regulations require the VA to apply an extra boost called the bilateral factor. The rule is 38 CFR § 4.26. It adds 10 percent of the combined bilateral value before those disabilities are folded into the overall combined rating. Many veterans, and some VA raters, miss it. A missed bilateral factor means a lower rating and less money on the table.

The Ground Truth

Most veterans know the VA combines ratings rather than adds them. A 50% rating and a 30% rating do not produce 80%. The math works on what is *left* of the body after each disability is counted. That system is the combined ratings table, covered in detail in Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%.

The bilateral factor is a separate rule that sits on top of that math. It exists because the VA recognized something any combat veteran already knows: losing function on both sides of the body is not twice as bad as losing it on one side. It is worse. When both knees are bad, the veteran cannot favor one leg to compensate. When both shoulders are damaged, every lift, every reach, every overhead task is affected. The combined ratings table alone does not capture that extra burden. The bilateral factor is the regulation's correction for that gap.

Here is the plain-English version of how it works.

Step 1: Identify which disabilities qualify. Any service-connected condition affecting both arms, both legs, or paired skeletal muscles (both rotator cuffs, both hip flexors, both tibialis anterior muscles) qualifies. The VA counts the whole upper extremity as one "arm" and the whole lower extremity as one "leg," so a right-thigh condition paired with a left-foot condition still triggers the factor. The key question: do the disabilities affect the use of paired extremities?

Step 2: Combine the bilateral disabilities using the standard combined ratings table. Treat that combined number as a sub-total.

Step 3: Add 10 percent of that sub-total. This is the bilateral factor. It is added directly, not run through the combined-ratings table. The regulation uses the word "added" specifically to make this clear.

Step 4: Treat the result (combined bilateral value plus the bilateral factor) as a single disability. Rank it against all other service-connected disabilities by severity. Then combine everything else using the standard table.

Step 5: Convert to the nearest 10 percent. The result is the final combined rating.

A Walked Example

Suppose a veteran has two service-connected knee conditions: right knee rated at 20% and left knee rated at 10%. One other condition, a back condition, is rated at 30%. Here is the order of operations.

The bilateral pair comes first.

Combine the two knees: 20% combined with 10% = 28%, which rounds in the process but stays as 28 for the next step.

Apply the bilateral factor: 10% of 28 = 2.8, rounded to 3. Add it: 28 + 3 = 31%.

That 31% becomes a single disability entry. Now rank all disabilities by severity: 31 (bilateral knees) and 30 (back).

Combine 31 and 30 using the standard table: 31% combined with 30% means 30% is applied to the 69% that remains after the first disability. $31 + (30\% \text{ of } 69) = 31 + 20.7 = 51.7\%$, rounded to 52%, which converts to 50% as the final combined rating.

Without the bilateral factor, the order would be: 30 (back), 20 (right knee), 10 (left knee). The combined result of that sequence is lower. The bilateral factor produces a better outcome for the veteran, and it is not optional. The regulation requires it.

Note: the illustration above uses simplified rounding to show the concept. The VA's actual calculation uses the precise values from the combined ratings table at 38 CFR § 4.25. The underlying logic holds.

Why the Order of Operations Matters

The bilateral factor must be applied before combining with other disabilities. Applying it in the wrong order, or skipping it and combining all disabilities together, produces a lower final number. This is not a gray area. The regulation states the bilateral factor "will be applied to such bilateral disabilities before other combinations are carried out." Bilateral pair first, factor applied, then combine with everything else.

Cross-reference: Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80% covers the full combined-ratings table and the general order of operations. This chapter covers only the bilateral factor layer that sits on top of that system.

The Rule, Briefly

38 CFR § 4.26 sets the bilateral factor. Three things make it money in the veteran's favor:

- Added, *not* combined. When partial disabilities affect both arms, both legs, or paired skeletal muscles, the right- and left-side ratings combine as usual, then 10% of that value is added directly (not run through the reducing combined-ratings table). The example in the reg: 60/20/10/10 (the two 10s bilateral) → the bilateral pair becomes 21, order is 60/21/20, combining to 74 → rounded to 70.
- Order is mandatory. The bilateral group is processed and the factor applied *before* other combinations. A rater who runs everything through the table first and tacks the factor on at the end is doing it wrong.
- "Arms" and "legs" are broad. Upper or lower extremity as a whole — the right thigh and the left foot are a bilateral pair; the right hand and left shoulder are too. Any two compensable conditions on paired extremities count (one narrow carve-out in paragraph (d); have a VSO check a (d) denial).

The verbatim text of § 4.26 is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

Any bilateral pair should trigger a check. If a veteran's file shows service-connected conditions on both sides (both knees, both shoulders, both elbows, both ankles, or any paired skeletal muscles) the bilateral factor is required. Veterans should verify that their rating decision reflects it.

The decision letter shows the math. A VA combined ratings decision will list the disabilities and the order of combination. Veterans can check whether the bilateral factor appears as a separate line item in that sequence. If it does not appear and both sides are rated, that is a flag worth raising.

VA raters can miss it. This is documented enough that veterans' advocates list it routinely as a common rating error. It is not malice; it is the kind of thing that gets overlooked on a busy caseload. But it is the veteran's rating and the veteran's money, so verification matters.

A missed bilateral factor is a basis for a rating increase. If the bilateral factor was not applied in a prior decision and it should have been, that error can be raised in a supplemental claim, a higher-level review, or a board appeal. The path depends on where the decision is in the appeals timeline. Ch. 27 — The Appeals Process Under the AMA covers those routes.

The factor applies to compensable disabilities only. A 0% rating (service-connected but not compensable) does not trigger the bilateral factor on its own. Both conditions in the pair need to carry a rating above 0% for the factor to kick in.

Both conditions must be service-connected. A civilian knee injury on one side and a service-connected knee condition on the other do not form a bilateral pair for this purpose.

Veterans with four affected extremities should get a precise review. The regulation provides a specific procedure when all four extremities are involved (§ 4.26(b)). That scenario is uncommon but not rare among veterans with extensive orthopedic histories. The calculation sequence differs; a VSO or accredited claims agent should verify the math in those cases.

So the move is to check the rating decision for the bilateral-factor step. For a veteran with service-connected conditions on both sides — both knees, both shoulders, both ankles, any paired skeletal muscles — the factor must show up as a separate step in the combination sequence, and its absence is a potential rating error worth appealing. Verify that both conditions are service-connected and carry a compensable rating, because a 0% doesn't trigger the factor and both sides have to be above 0% for § 4.26 to apply (if one side is at 0%, filing for an increase there may unlock it). Confirm the bilateral pair was combined first, the 10% added, and only then ranked among the veteran's other conditions, since a rater who lumped everything together and skipped that step produced a lower final rating (Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80% has the full sequence). And if the factor was missed in a prior decision, that's a basis for a Supplemental Claim or Higher-Level Review, with the right lane depending on the decision date (Ch. 27 — The Appeals Process Under the AMA). For the paragraph (d) exception or a four-extremity case, have a VSO or accredited rep verify the math.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 CFR § 4.26 — Bilateral factor. <https://www.ecfr.gov/current/title-38/section-4.26>
- 38 CFR § 4.25 — Combined ratings table (the underlying math system; referenced for order-of-operations context). <https://www.ecfr.gov/current/title-38/section-4.25>
- Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80% (this volume) — Full explanation of the combined ratings table and general disability combination sequence.
- Ch. 27 — The Appeals Process Under the AMA (this volume) — Supplemental claims, higher-level reviews, and Board of Veterans' Appeals routes for contesting a rating decision.

Ch. 14 — TDIU: Paid at 100% Without a 100% Rating

BLUF: TDIU pays the full 100% compensation rate even when the combined schedular rating is below 100% — the test isn't a perfect rating on paper, it's whether service-connected disabilities keep the veteran from holding a steady, livable job. It's one of the most valuable and most under-claimed benefits in the system. Two roads in: the schedular thresholds (60% on one condition, or 40%+ with 70% combined), or the extraschedular backstop for veterans who can't work but fall short of the numbers. This chapter is the eligibility test, the evidence that wins it, and the forms.

Myth vs Fact

Plenty of veterans never file for TDIU because of something they heard secondhand. These five misreadings cost people the most.

Myth: I have to be rated 100% to be paid at 100%. That is the whole reason TDIU exists. If service-connected disabilities keep a veteran from holding down steady, gainful work, the VA can pay the veteran at the full 100% rate while the veteran's combined rating on paper stays at 70%, or lower through the extraschedular route. The number on the decision letter and the number on the check are two different things.

Myth: if I work at all, I'm out. The test is substantially gainful work, not any work. Odd jobs, a few protected hours, or a position someone keeps open for a veteran in a sheltered or family setting count as marginal employment, and marginal employment does not disqualify a veteran. The VA says it in plain words: odd jobs don't count. Earnings under the federal poverty line for one person are marginal by definition.

Myth: the day I go back to work, I lose it. The law deliberately gives a veteran room to try. A return to work cannot be used to cut a veteran's rating unless the veteran actually holds substantially gainful employment for twelve straight months, and brief interruptions do not count as breaks. That twelve-month window exists so a work attempt that fails does not punish a veteran for making it.

Myth: the VA can pull it the moment an exam looks better. The bar is far higher. To reduce TDIU the VA must show the veteran's actual employability by clear and convincing evidence, not merely a brighter exam, and it has to issue a formal proposal and give the veteran a chance to respond before anything is cut.

Myth: TDIU is a watered-down, temporary 100%. It pays the same rate as a 100% schedular award, dependent add-ons included. And any rating carried continuously for twenty years is protected by law from reduction unless it was built on fraud. A long-standing TDIU award is one of the steadiest things in the entire system.

Check the Threshold: Two Roads In

The word "unemployability" is doing the work here. The question isn't whether a veteran happens to be employed today; it's whether the veteran's service-connected disabilities prevent the veteran from securing and keeping a substantially gainful job. There are two ways in. The standard route is schedular, under § 4.16(a): pull the combined rating, and a veteran clears the bar if a single service-connected condition is rated 60% or more, or if the veteran has two or more conditions with at least one rated 40% or more and a combined rating of 70% or more. Clear that and show the veteran can't hold gainful work, and the schedular path is open. The second way is the extraschedular backstop under § 4.16(b), for a veteran who can't meet

those numbers but still can't work because of service-connected disabilities; the rating board sends that case to the Director of Compensation Service. It's a higher bar that needs strong documentation, but it exists so no one is denied on a technicality of the numbers.

A veteran sitting just under the bar should run the math before writing it off, because a veteran at 50% who adds a 20% secondary can land in the 60–70% range (Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%, and secondaries in Ch. 25 — Secondary Conditions: The Underused Multiplier). The thresholds are the floor for the fast track, not the ceiling of the benefit.

Being Employed Isn't Automatically a Bar

TDIU turns on a veteran's capacity to work, not current status, and the dividing line is "substantially gainful employment," meaning work that brings in a livelihood. Anything below that line is marginal employment, and it does not disqualify a veteran. The VA gives two clear examples of marginal: gross annual income below the federal poverty threshold for one person, or a job a veteran only keeps because an employer gives the veteran special, sheltered, or protected accommodations a normal workplace wouldn't. Odd jobs, a few protected hours a week, a position a family member bends the rules to keep a veteran in — that's marginal, and it doesn't stop the TDIU clock. The VA weighs the whole picture: the disabilities, the veteran's education, and the veteran's work history, since a back injury ends physical labor for someone whose whole career was physical work in a way it might not for a sedentary professional.

Build Evidence of Work Capacity

This is where TDIU claims are won or lost, because the evidence has to address what a veteran can't *sustain*, not just what hurts; a symptom list alone won't carry it. What moves the claim is a treating provider's written opinion that the veteran cannot sustain full-time employment because of the service-connected conditions, backed by documentation of how often a condition flares and for how long (unpredictable, frequent flares are what break full-time work) and any test results showing concrete work-limiting impairments in lifting, standing, concentration, or attendance.

File It

The main form is VA Form 21-8940, the Veteran's Application for Increased Compensation Based on Unemployability, which covers the veteran's work history, education, and how the disabilities stop the veteran from working; get it from va.gov/find-forms/about-form-21-8940/ or file it with the veteran's disability claim. Alongside it, VA Form 21-4192 (a Request for Employment Information) goes to the veteran's last employer and is usually required; it's at va.gov/find-forms/about-form-21-4192/. The full eligibility overview, the marginal-employment definition, and the current required forms all live at va.gov/disability/eligibility/special-claims/unemployability/. A denial isn't final, so appeal and strengthen the work-capacity record if it comes to that (Ch. 27 — The Appeals Process Under the AMA). One thing to track: TDIU pays the 100% rate including dependent add-ons, but the veteran's underlying combined rating stays the same on paper, so keep both numbers in mind.

After TDIU Is Granted: The Rules and Protections

The award is not the finish line. Knowing the rules that kick in afterward is what keeps a win from turning into a headache later.

A veteran can still earn at the margins. Marginal and sheltered work stays fine after the grant, exactly as it was while the claim was pending. The line that matters is substantially gainful work. Take a real, gainful job and keep it, and the VA can move to reduce the benefit, but only once the veteran has sustained that work for twelve continuous months. An honest attempt that does not hold up is protected.

The VA may ask a veteran to confirm work status. Because the benefit turns on employment, the VA can send the veteran VA Form 21-4140, the Employment Questionnaire, to verify where the veteran stands. Under current practice it is request-based: a veteran completes it when the VA asks, not on a fixed annual mailing like the old days. If a request comes and a veteran lets it sit, that alone can put the benefit in jeopardy, so answer it.

A veteran who returns to gainful work should say so. The sensible move is to tell the VA rather than wait for the next questionnaire. Keeping the record straight protects the veteran and spares the veteran a dispute over payments down the line.

Reductions are hard, and they harden over time. The VA cannot trim TDIU on a thin exam; it needs clear and convincing evidence of real employability and has to follow the due-process steps first. Once a veteran's rating has stood for twenty years, it is locked against everything short of fraud.

Traps That Cost Veterans Money

- Assuming a veteran has to reach 100% combined. TDIU pays the 100% rate from a lower combined rating.
- Not filing due to still being employed. Marginal or sheltered work doesn't disqualify a veteran.
- Submitting a symptom list instead of a work-capacity opinion. The VA needs "can't sustain a job," not "has symptoms."
- Writing off eligibility near the bar without running the combined math or filing a secondary first.
- Treating a denial as the end. The extraschedular road and the appeal lanes both exist.

The Rule, Briefly

Schedular TDIU is 38 CFR § 4.16(a): a total rating may be assigned below the 100% schedular level when a veteran can't secure or follow a substantially gainful occupation because of service-connected disabilities, provided one disability is rated 60% or more, or one is 40% or more with a 70%+ combined rating.

Extraschedular TDIU is § 4.16(b): VA policy is that any veteran unemployable because of service-connected disabilities shall be rated totally disabled, so cases that miss the (a) numbers go to the Director of Compensation Service. Both are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. Pull the combined rating and check it against the § 4.16(a) bar (60% on one, or 40%+ with 70% combined).
2. If short of the threshold, run the combined math and look for a secondary to file first (Ch. 11, Ch. 25) — or prepare the extraschedular case.
3. Get a treating provider to put work-capacity limits in writing: flare frequency/duration, tasks the veteran can't perform.

4. File VA Form 21-8940 ([va.gov/find-forms/about-form-21-8940/](https://www.va.gov/find-forms/about-form-21-8940/)) and have the veteran's last employer complete 21-4192.
 5. Don't let current marginal/sheltered work stop a veteran from filing — it doesn't disqualify a veteran.
-

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. The federal poverty threshold changes annually; confirm the current figure. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 4.16 — Total disability ratings based on unemployability. <https://www.ecfr.gov/current/title-38/section-4.16>
- 38 CFR § 4.18 — Unemployability. <https://www.ecfr.gov/current/title-38/section-4.18>
- 38 CFR § 3.343 — Continuance of total disability ratings (reduce only on material improvement + actual employability shown by clear and convincing evidence; (c)(2) bars reduction for returning to work unless substantially gainful employment is held 12 consecutive months). <https://www.ecfr.gov/current/title-38/section-3.343>
- 38 CFR § 3.951 — Preservation of disability ratings ((b): a rating held continuously 20+ years is not reduced absent fraud). <https://www.ecfr.gov/current/title-38/section-3.951>
- VA.gov — Individual Unemployability (eligibility, marginal-employment definition, forms). <https://www.va.gov/disability/eligibility/special-claims/unemployability/>
- VA Form 21-8940 — Application for Increased Compensation Based on Unemployability. <https://www.va.gov/find-forms/about-form-21-8940/>
- VA Form 21-4192 — Request for Employment Information. <https://www.va.gov/find-forms/about-form-21-4192/>
- VA Form 21-4140 — Employment Questionnaire (request-based employment verification for veterans receiving Individual Unemployability; Aug-2024 revision). <https://www.va.gov/find-forms/about-form-21-4140/>
- Ch. 3 / Ch. 11 / Ch. 12 / Ch. 25 / Ch. 27 — cross-references named inline.

Ch. 15 — The Elements of Service Connection

BLUF: To win a direct service-connection claim, a veteran must prove three things: a current diagnosed disability, an in-service event or exposure that could have caused it, and a medical nexus linking the two. All three pieces must snap together. Missing any one of them, especially the nexus, will sink the claim. This chapter teaches what each element is, why each matters, and where to go when one is missing.

The Ground Truth

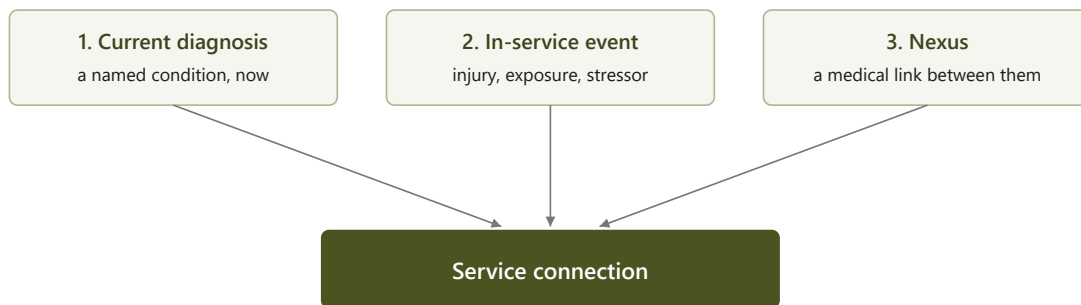


Figure 15-1. Direct service connection needs all three pieces at once. Miss any one, most often the nexus, and the claim fails (the three-part test from *Caluza v. Brown*).

Think of a direct service-connection claim as a three-piece puzzle. Every piece is required. Slide two into place and leave the third on the table, and the puzzle is not complete. The VA cannot grant what the law does not allow it to grant. A claim without all three elements is a denied claim.

Element 1: A current diagnosed disability. The veteran must have a condition that exists right now and has been diagnosed by a medical professional. A past injury that fully healed with no lasting effects does not qualify on its own. Pain that limits what a veteran can do, even without a named disease, can count as a disability if it causes functional loss. The Court of Appeals for Veterans Claims addressed this in *Saunders v. Wilkie* (2018), holding that pain causing functional impairment can be a disability even absent an underlying diagnosed condition. (See Ch. 9 — Landmark Court Cases That Shaped Veteran Rights for the full *Saunders* discussion.) The condition has to be real, present, and documented.

Element 2: An in-service event, injury, illness, or exposure. Something had to happen during military service. It could be a documented injury — a broken bone, a vehicle accident, a gunshot wound. It could be an illness contracted during deployment, or a long-term exposure: hearing loss from heavy equipment, respiratory illness from burn pit smoke, joint damage from years of rucking in rough terrain. The event does not have to be dramatic. A repetitive-stress injury from daily physical training qualifies just as much as a combat wound.

The source of evidence matters but is not limited to official records. Service treatment records (STRs) are the strongest proof because they were written at the time. If those records are incomplete or lost (records loss is a documented problem), a veteran can also rely on lay evidence: a personal statement describing what happened, or buddy statements from fellow service members who witnessed the event or conditions. The law specifically allows credible lay evidence for in-service events.

Guard & Reserve note: For a Guard or Reserve member, the in-service event has to fall inside a qualifying duty period, and the type of period controls what counts. A disease tied only to a drill weekend generally cannot satisfy this element, and the presumptions of soundness and aggravation usually do not apply. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Element 3: A medical nexus. This is the link between the current disability and the in-service event. A medical professional, usually a physician or qualified examiner, must state that the two are connected. The legal standard is "at least as likely as not," meaning a 50% or better probability. Not certainty. Just that a qualified medical professional reviewed the veteran's history and concluded service is at least as probable a cause as anything else.

The nexus is where most claims fail. A veteran can have clear proof of an in-service injury and a current diagnosis, but without a medical professional connecting those two facts in writing, the claim stalls. The C&P (Compensation and Pension) exam is the government's tool for generating nexus opinions. A negative C&P opinion is not the end of the road; a veteran can obtain an independent medical opinion (IMO) from a private provider. Both are covered in Ch. 18 — Evidence That Wins Claims and Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

The Three-Piece Rule in Plain English

The puzzle has three slots: Slot 1 is the diagnosis (the condition is real and current), Slot 2 is the in-service event (something happened during service), and Slot 3 is the nexus (a medical professional connected Slot 1 to Slot 2). All three must be filled. A veteran with a diagnosis and an in-service event but no nexus opinion is two-thirds of the way there and zero percent approved. The system does not reward partial puzzles.

Where Claims Break Down

Most denied claims fail at Slot 3. Two reasons come up again and again.

Some veterans assume the connection is "obvious" and never get a written nexus opinion. The VA does not assume anything on a veteran's behalf in a direct claim. The connection must be stated by a qualified medical source.

The other common failure: the C&P exam opinion comes back unfavorable. The examiner writes "less likely than not" or "no nexus established." That negative opinion goes into the record and should be challenged with a private IMO. A single bad C&P result is not the final word. The process for challenging it lives in Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

When Direct Service Connection Is Not the Right Path

Not every claim is a direct claim. Some conditions are *presumptively* service-connected: the law assumes the connection without requiring a nexus opinion if the veteran served in a qualifying time or place. Some conditions are *secondarily* service-connected, caused or worsened by an already-service-connected condition rather than by an in-service event directly.

Presumptive claims change which pieces a veteran must prove. Secondary claims change the source of the in-service event. Both are legitimate paths when the direct route is difficult or unavailable. Presumptive service connection is covered in Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation and Ch. 21 — Presumptive Conditions Explained. Secondary service connection is covered in Ch. 25 — Secondary Conditions: The Underused Multiplier. Knowing which path fits the facts is a strategic decision, one worth making before filing, not after a denial.

The Rule, Briefly

38 CFR § 3.303 is the foundation, and two subsections carry the weight. Under § 3.303(a), the VA's own regulation directs it to administer the law "under a broad and liberal interpretation consistent with the facts" — that's stated policy, not a loophole, so a veteran who documents all three elements is entitled to that reading on review of the *entire* record, including service records, unit history, and medical and lay evidence. Under § 3.303(d), a disease diagnosed *after* discharge can still be service-connected if the evidence shows it was incurred in service, which means the common myth that a condition must be diagnosed while the service member is still in uniform is wrong: a diagnosis years later doesn't bar the claim. The text of both subsections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

Caluza v. Brown (7 Vet. App. 498, 1995)

The Court of Appeals for Veterans Claims named the three elements in *Caluza v. Brown*. The court held that to establish direct service connection, a veteran must show: (1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service — the nexus.

Caluza is the case that locked these three elements into VA law. Every direct-service-connection claim filed since 1995 has been evaluated against this three-part framework.

What This Means in Practice

A veteran needs all three elements. Building a file with a diagnosis and service records but no nexus opinion is incomplete. A written medical opinion saying "at least as likely as not" must be in the record before the claim is ready.

"At least as likely as not" means 50/50, not certainty. A veteran does not need to prove beyond a reasonable doubt that service caused the condition. A tie goes to the veteran. That is the benefit of the doubt principle under 38 U.S.C. § 5107(b), and it applies when the evidence is in approximate balance.

Lay evidence is legitimate for Slot 2. If service treatment records are incomplete, a credible personal statement or buddy letter describing an in-service event can support the claim. Section 3.303(a) requires the VA to consider "all pertinent medical and lay evidence."

A negative C&P exam is not the last word. If the VA's examiner gives an unfavorable nexus opinion, a veteran can commission a private IMO from a qualified medical provider. The private opinion goes into the record, and the VA must weigh both. A well-reasoned private IMO with supporting medical literature often outweighs a perfunctory C&P result. See Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

Postservice diagnosis is not a barrier. Under § 3.303(d), a condition diagnosed after discharge can still be service-connected if the evidence links it to service. Chronic back injuries, hearing loss, and sleep apnea often develop or fully manifest only after separation.

Presumptive and secondary paths exist when direct connection is hard to prove. If the nexus is difficult to establish because records are lost, time has passed, or the connection is medically complex, a veteran should check whether a presumptive or secondary theory fits. Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation, Ch. 21 — Presumptive Conditions Explained, and Ch. 25 — Secondary Conditions: The Underused Multiplier cover those routes.

The C&P exam is an opportunity. Veterans should prepare a brief written summary of the in-service event and how the current condition affects daily life before attending. The examiner's opinion is shaped by what the veteran describes. Go in prepared.

Before filing, a veteran should audit each condition for all three elements: confirm there's a current diagnosis, identify the specific in-service event or exposure, and verify a written nexus opinion is actually in the record, because a two-of-three file is a losing file. Effort belongs on the weakest element — usually the nexus, where most claims fail — with a private medical opinion that uses "at least as likely as not" with documented reasoning before submitting. If a veteran's service treatment records are thin or lost, the in-service-event element should be filled with a specific personal statement and buddy statements, since § 3.303(a) requires the VA to weigh credible lay evidence. And if the direct nexus is genuinely hard to prove, check whether a presumptive or secondary theory fits before defaulting to the direct route (Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation, Ch. 21 — Presumptive Conditions Explained, and Ch. 25 — Secondary Conditions: The Underused Multiplier).

Cited Sources

Verify all citations and regulatory text against current primary sources before acting.

- 38 CFR § 3.303 — Principles relating to service connection. <https://www.ecfr.gov/current/title-38/section-3.303>
- 38 U.S.C. § 5107(b) — Benefit of the doubt standard. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5107&num=0&edition=prelim>
- *Caluza v. Brown*, 7 Vet. App. 498 (1995) — Three-element test for direct service connection.
- *Saunders v. Wilkie*, 886 F.3d 1356 (Fed. Cir. 2018) — Pain causing functional impairment qualifies as a disability even without an underlying diagnosed condition. (See Ch. 9 — Landmark Court Cases That Shaped Veteran Rights for full discussion.)
- VA.gov — *How to file a VA disability claim*. <https://www.va.gov/disability/how-to-file-claim/>
- VA.gov — *VA claim exam (C&P exam)*. <https://www.va.gov/disability/va-claim-exam/>

Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation

BLUF: Every VA disability claim travels one of four lanes: direct, secondary, presumptive, or aggravation. The lane is not cosmetic — it changes what a veteran must prove. Choosing the wrong lane and missing the easier path can mean losing a claim that should have won. This chapter maps all four lanes, explains the proof burden in each, and points to where each type gets its deep treatment later in the manual.

The Ground Truth

Think of service connection as a destination. Four roads get there. They all arrive at the same place: a condition legally tied to service and eligible for compensation. Each road starts from a different point and asks for different evidence along the way.

Lane 1: Direct service connection. The condition started in service or was caused by service. The link runs straight from service to the condition. This is the most common lane. It requires three elements: a current diagnosis, an in-service event or exposure, and a medical nexus bridging the two. Ch. 15 — The Elements of Service Connection covers those three elements in full.

Lane 2: Secondary service connection. A condition is connected to service indirectly, through a service-connected condition that caused it or made it worse. The link is condition-to-condition, not service-to-condition directly. A veteran does not have to prove the new condition started in service, only that an already-connected condition is responsible. This lane opens a second path when direct evidence falls short.

Lane 3: Presumptive service connection. The law does the work. For certain exposures and conditions, Congress has decided no nexus letter is required. If a veteran served in the right place at the right time and now has a listed condition, the law presumes the link. The veteran proves qualifying service and a current diagnosis. The rules governing which conditions qualify are in 38 C.F.R. § 3.309, with the procedures in §§ 3.307 and 3.308.

Guard & Reserve note: Presumptions generally require qualifying active service. A condition tied only to inactive duty training usually cannot ride a presumption, so the direct or secondary lane is often the realistic path for a Guard or Reserve member. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Lane 4: Aggravation of a preservice disability. Some veterans entered service with a condition already present. If service made that condition permanently worse beyond its natural course, the veteran is compensated for the increase. The whole condition is not service-connected, only the additional disability caused by service. The presumption of soundness, covered in Ch. 6 — 38 CFR Part 3: The Adjudication Rules and Ch. 7 — The Doctrines Working In Their Favor, is closely tied to this lane.

Lane selection matters because it changes what a veteran must prove. A veteran with a bad knee and knee-caused sleep apnea who files a direct claim for the sleep apnea may struggle: there may be no in-service event for the sleep apnea itself. A secondary claim connecting it to the service-connected knee can succeed where the direct lane fails. The evidence does not change. The lane does.

A Vietnam-era veteran with a listed cancer does not need a nexus letter at all. File a direct claim and a rater may demand evidence the law never required. Knowing the right lane prevents that mismatch.

The table below identifies the right lane by situation before any paperwork is gathered.

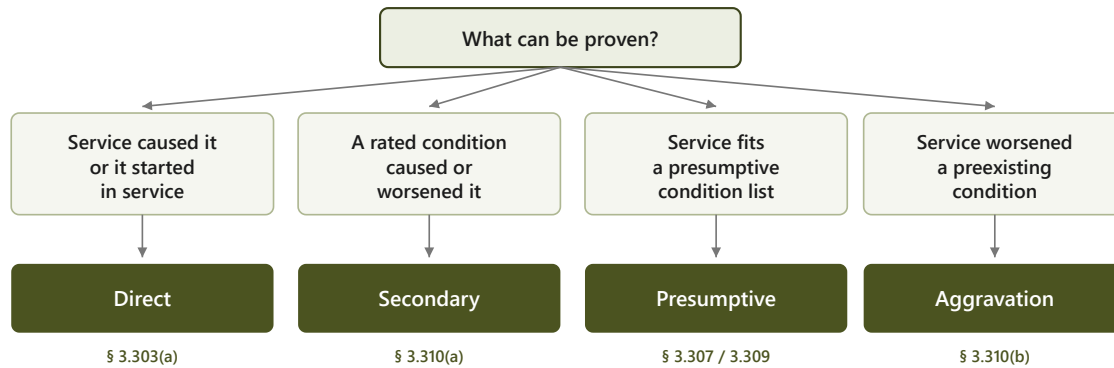


Figure 16-1. Four ways to win, sorted by what a veteran can prove. Pick the easiest winning lane before filing; a presumptive claim, where it fits, removes the nexus burden entirely.

Table 16-1. Claim-Lane Chooser: Matching Situation to Service-Connection Type.

Rule	If the situation is...	Claim lane	What the veteran must prove	Evidence / documents needed
1	The condition started in service or was caused by a service event or exposure	Direct (38 C.F.R. § 3.303(a))	(1) Current diagnosis; (2) in-service event or exposure; (3) medical nexus linking the two	Service treatment records showing the in-service event or exposure; current medical diagnosis; nexus letter from a qualified clinician
2	The condition was caused or worsened by an already service-connected condition	Secondary (38 C.F.R. § 3.310(a))	That an already-connected condition caused or is proximately responsible for the new condition; no in-service event required for the secondary condition	Existing rating decision confirming the anchor service-connected condition; medical nexus linking the anchor condition to the new condition
3	The veteran served in a qualifying theater or era and has a listed condition under § 3.309	Presumptive (38 C.F.R. §§ 3.307/3.309)	Qualifying active service in the right place at the right time; current diagnosis of a listed condition, no nexus letter required	DD-214 or service records confirming qualifying service; current diagnosis of a § 3.309-listed condition (check the current list — it grows)
4	The veteran had a condition before service and service made it permanently worse beyond its natural course	Aggravation (38 C.F.R. § 3.306(a)–(b))	An increase in disability during service; VA must then produce clear and unmistakable evidence the increase was only natural progression to rebut	Pre-service medical records establishing the baseline; service treatment records showing increased severity; medical opinion addressing natural versus service-caused progression

The Rule, Briefly

Each lane has a one-line rule behind it. Direct service connection (38 CFR § 3.303(a)) covers a condition incurred *in* service or aggravated by it — two ways in, differing only in which facts the evidence has to support. Secondary connection (§ 3.310(a)) covers a disability proximately due to a service-connected condition, which is then treated as *part of* the original rather than a lesser claim (deep dive: Ch. 25 — Secondary Conditions: The Underused Multiplier). A presumptive claim (§ 3.307(a)) treats a listed disease as incurred in service "even though there is no evidence of such disease during the period of service," so the law

bridges the gap and no nexus is needed (detail in Ch. 21 — Presumptive Conditions Explained through Ch. 23 — Agent Orange, Gulf War Illness & Camp Lejeune). And aggravation (§ 3.306(a)–(b)) means that once an increase in severity during service is shown, the VA has to produce *clear and unmistakable evidence* that it was only natural progression to rebut it — a high bar that sits on the VA, not the veteran. The text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

Know the lane before filing. Veterans and their representatives should identify which of the four types applies before submitting anything. Filing a direct claim for a condition that should be secondary, or missing a presumptive that removes the nexus requirement entirely, is a recoverable mistake, but it wastes time.

Secondary claims require an anchor. There must be a service-connected condition already in place that is causing or worsening the new one. Without that anchor, the path does not exist.

Presumptive claims are the most underused. Many veterans with Agent Orange, burn pit, or Camp Lejeune exposures still file direct claims and get asked for nexus letters that are not legally required. If a condition is listed under § 3.309 and the veteran has qualifying service, the nexus is presumed. That is a significant difference.

On aggravation: if a veteran had a bad knee before service and service made it worse, the VA pays for the additional disability, the part service caused. The VA is not responsible for where the condition started, only for how much further it went because of service.

Secondary aggravation counts too. Section 3.310(b) covers situations where a nonservice-connected condition is worsened (not caused) by a service-connected condition. That worsening alone is compensable. Veterans should not overlook this when causation is hard to establish but aggravation is not.

Multiple lanes can apply to the same veteran. One direct condition, one secondary condition flowing from it, one presumptive from their era of service, and an aggravated preservice condition can all be active at once. Each is governed by its own rules.

The presumption of soundness (see Ch. 6 — 38 CFR Part 3: The Adjudication Rules and Ch. 7 — The Doctrines Working In Their Favor) is the starting point for aggravation claims. When a veteran enters service with no noted defect, the law presumes they were sound. Overcoming that presumption requires the VA to show the condition pre-existed, and even then, the veteran may still win on aggravation.

So the work is to pick the lane before drafting anything: list every condition and match each to direct, secondary, presumptive, or aggravation, because the wrong lane demands the wrong evidence and risks a denial the right lane would have avoided. Check the presumptive lists before paying for a nexus letter, since a veteran with qualifying service and a listed condition under § 3.309 doesn't legally need one (Ch. 21 — Presumptive Conditions Explained and Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure). Build secondary claims on an existing anchor by asking, for each condition already service-connected, what downstream problems it may have caused or worsened, because § 3.310 can multiply total compensation without any new in-service event (Ch. 25 — Secondary Conditions: The Underused Multiplier). And on an aggravation claim, lean on the presumption of soundness: if a pre-service condition worsened during service, the burden is on the VA to produce clear and unmistakable evidence that the increase was only natural progression, not on the veteran.

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 CFR § 3.303 — Principles relating to service connection (direct). <https://www.ecfr.gov/current/title-38/section-3.303>
- 38 CFR § 3.306 — Aggravation of preservice disability. <https://www.ecfr.gov/current/title-38/section-3.306>
- 38 CFR § 3.307 — Presumptive service connection (general procedures). <https://www.ecfr.gov/current/title-38/section-3.307>
- 38 CFR § 3.309 — Diseases subject to presumptive service connection (listed conditions). <https://www.ecfr.gov/current/title-38/section-3.309>
- 38 CFR § 3.310 — Disabilities proximately due to, or aggravated by, service-connected disease or injury (secondary). <https://www.ecfr.gov/current/title-38/section-3.310>
- 38 U.S.C. § 1153 — Aggravation (statutory authority underlying § 3.306). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1153&num=0&edition=prelim>

Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates

BLUF: There is one step that takes about five minutes and can protect a full year of back pay, and most veterans skip it because they're waiting until their evidence is "ready." That step is the Intent to File. File it today, then take the time needed to build the actual claim, and submit VA Form 21-526EZ before a year is up. This chapter lays out the exact pages, the buttons, and the phone number for each part, because "go to VA.gov" is useless advice on its own.

The Order of Operations

File the Intent to File first, today. It does nothing but stamp a date, but that date is what the VA eventually pays back to, so getting it on the record buys a veteran months. Then take however long is needed to pull the records and line up the evidence. The full claim, on VA Form 21-526EZ, has to be in within a year of that Intent to File, or the protected date is gone. The rest of this chapter walks each part.

File the Intent to File (Today)

The Intent to File, or ITF, tells the VA a claim is coming and freezes the veteran's effective date while the claim gets built. It covers disability compensation, pension, and DIC. A veteran doesn't need evidence, a doctor's letter, or any records to file it. Just identifying information.

There are three ways to file it, and all three set the same date, so use whichever is fastest.

Online is usually quickest: 1. Go to va.gov/supporting-forms-for-claims/intent-to-file-form-21-0966/. 2. Sign in with Login.gov or ID.me (either is free to set up for a veteran who doesn't already have one). 3. Choose Disability compensation as the benefit type. 4. Submit, then save or screenshot the confirmation and the date.

By phone, call 1-800-827-1000 (TTY: 711), Monday through Friday, 8:00 a.m. to 9:00 p.m. Eastern. Tell them the call is to file an intent to file for disability compensation, and write down the date of the call. That call date is the date now locked in.

By mail, download VA Form 21-0966 from va.gov/find-forms/about-form-21-0966/, fill it out, and mail it to the address printed inside the PDF. Keep a copy and proof of mailing.

However it gets filed, from that date the effective date is protected for a year. Even if nothing else happens today, this is the one thing to do.

Build the Claim While the Clock Runs

The whole point of the ITF is that it buys a veteran time, so use it. Before sitting down with the main form, pull the DD-214 and write out every condition being claimed, the minor ones and anything secondary included. Note where treatment happened, VA and private, with rough dates so the VA can request those records, and gather whatever private medical records are already on hand. For any condition that isn't presumptive, a nexus letter tying it to service is needed too.

What evidence actually moves a claim, and how to get a nexus letter that holds up, is the whole of Ch. 18 — Evidence That Wins Claims. It's also worth mapping out any secondary conditions before filing rather than after; that's Ch. 25 — Secondary Conditions: The Underused Multiplier.

Submit VA Form 21-526EZ (Before the One-Year Mark)

VA Form 21-526EZ is the actual disability claim. A veteran can file it personally or have someone else file it on their behalf.

To file it personally online: 1. Go to va.gov/disability/file-disability-claim-form-21-526ez/ and sign in. 2. The form walks through it in order: the conditions being claimed, service history and discharge, where treatment happened, and whether evidence is being attached or the VA already has it. 3. Upload the records when it asks, submit, and save the confirmation number.

To file it through a VSO, which is free and the better move for most people: 1. Find an accredited rep at va.gov/get-help-from-accredited-representative/find-rep/. 2. Appoint that rep at va.gov/get-help-from-accredited-representative/appoint-rep/introduction/, which files VA Form 21-22, the appointment form. 3. The rep helps the veteran put the 21-526EZ together and looks it over for gaps before the VA ever sees it, at no charge.

The hard part is the deadline. The completed 21-526EZ has to reach the VA within one year of the ITF. If it doesn't, the ITF dies, and while a new one can be filed, the months in between are no longer protected. Don't run it to the wire. Treat the eleven-month mark as the real deadline.

For a veteran who wants the claim handled faster by certifying it as a Fully Developed Claim, that tradeoff is covered in Ch. 20 — Fully Developed Claim vs. Standard Claim.

Where the Money Actually Comes From

The effective date is the day the VA starts counting back pay, and it's the number that decides how much gets collected. The date the VA finally grants the claim doesn't matter to the money. So if the VA takes eighteen months to decide and then grants it, all eighteen months get paid in one retroactive check, counted from the effective date.

The rule itself is short: the effective date is the date the VA received the claim or the ITF, or the date the condition actually became disabling, whichever of those is *later*. Because the ITF counts as a date of receipt, filing it early is what pulls the whole thing back in a veteran's favor.

There's one break for the recently separated. For a veteran who files within a year of leaving active duty, the effective date can reach all the way back to the day after separation, even if the claim itself lands months later. Anyone still in their first year out should file right away to catch it.

Here's how it plays out. Say a veteran files an ITF on January 1, the evidence takes nine months to assemble, the 21-526EZ gets submitted on September 30, and the VA grants it in December. The effective date is still January 1. That's nine months of back pay earned with one five-minute step back in January.

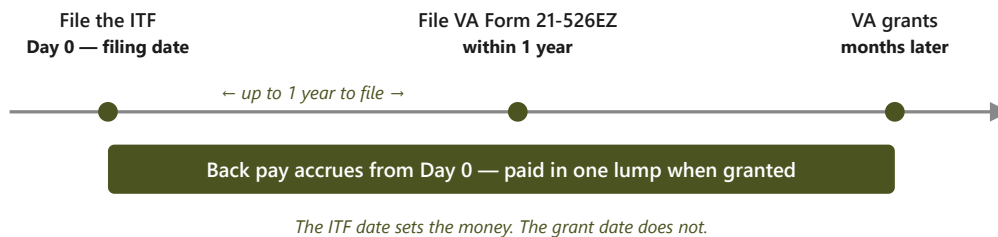


Figure 17-1. The Intent to File stamps Day 0. A veteran has up to a year to file the full claim, and whenever the VA finally grants it, back pay is paid all the way back to that ITF date.

Traps That Cost Veterans Money

- Waiting until the evidence is "ready" to file anything. The ITF exists precisely so a veteran doesn't have to wait. Get the date on the record, then build.
- Letting the one-year window quietly run out. Nobody calls to remind a veteran, and the date dies on its own. Put the eleven-month mark on a calendar.
- Assuming back pay runs from the decision. It runs from the effective date through the entire wait, which is why protecting that date early matters even if the claim drags on or goes to appeal.
- Skipping the ITF because the plan is to file the whole thing online "soon." Soon has a way of slipping. The ITF is five minutes of insurance on that date.
- Paying a company to file forms that are free. A VSO does the same work at no cost (Ch. 36 — VSOs, Attorneys, and Claim Sharks).

The Rule, Briefly

The authority, stated once so it can be checked directly: the Intent to File and its one-year window come from 38 CFR § 3.155(b), which lets an ITF, whether the online form, VA Form 21-0966, or an oral statement, hold the effective date as long as the complete claim follows within the year. The effective date itself is set by 38 CFR § 3.400 and 38 U.S.C. § 5110: it's the date of receipt or the date the condition became disabling, whichever is later, or the day after separation for a veteran who files within a year of discharge. Both sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. File the Intent to File today: online at va.gov/supporting-forms-for-claims/intent-to-file-form-21-0966/, by phone at 1-800-827-1000 (M–F, 8:00 a.m.–9:00 p.m. ET), or by mail on VA Form 21-0966. Save the confirmation and the date.
2. Put the eleven-month mark from that date on the calendar as the real deadline for the full claim.
3. Start pulling the claim together: the DD-214, a list of conditions, where treatment happened, and a nexus letter for anything that isn't presumptive (Ch. 18).
4. File VA Form 21-526EZ at va.gov/disability/file-disability-claim-form-21-526ez/, or have a VSO file it for free, before the year is up.
5. A veteran who got out within the last year should file now so the effective date reaches back to the day after separation.

Cited Sources

Verify all citations, form numbers, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.155 — How to file a claim; Intent to File and the one-year rule. <https://www.ecfr.gov/current/title-38/section-3.155>
- 38 CFR § 3.400 — Effective dates, general rule. <https://www.ecfr.gov/current/title-38/section-3.400>

- 38 U.S.C. § 5110 — Statutory authority for effective dates. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5110&num=0&edition=prelim>
- VA.gov — Your intent to file a VA claim (online ITF form, phone, mail). <https://www.va.gov/resources/your-intent-to-file-a-va-claim/>
- VA.gov — File for disability benefits (21-526EZ). <https://www.va.gov/disability/file-disability-claim-form-21-526ez/>
- VA.gov — Get help from an accredited representative or VSO (find and appoint). <https://www.va.gov/get-help-from-accredited-representative/>

Ch. 18 — Evidence That Wins Claims

BLUF: Think of a claim as a scale the VA has to weigh. It grants when the evidence tips to "at least as likely as not" that a veteran's condition is connected to service, and a dead-even 50/50 goes to the veteran. The VA will pull some of the veteran's records, but it won't build the veteran's case. The smart way to work is to figure out which of the three parts of the claim is weakest and put the evidence there. Five tools cover almost everything: service records, current medical records, a nexus letter, lay statements, and a DBQ. This chapter is how to get each one.

The Standard to Aim At

A veteran doesn't have to prove the case beyond doubt. The evidence has to get to "at least as likely as not," which is a 50 percent probability or better. If the evidence for and against ends up roughly even, the tie goes to the veteran. That's the benefit of the doubt under 38 CFR § 3.102, and it runs through the whole system. A veteran isn't trying to win in a landslide, just to get over that halfway line.

Find the Weak Leg

Every service-connection claim rests on three things (Ch. 15 covers them in full):

1. An in-service event, meaning something actually happened in service, whether an injury, an exposure, or a stressor.
2. A current diagnosis, meaning a provider has put a name to the condition today.
3. A nexus, meaning a medical link between the two.

Most claims that fail, fail on the nexus. Before chasing paper, decide which of the three is thinnest for the veteran's situation, because that's where everything below should be aimed. Piling more proof onto a leg the VA already accepts won't change the outcome. The evidence that moves a claim is the evidence aimed at the gap. (Details on the three legs: Ch. 15 — The Elements of Service Connection.)

Pull the Records

A veteran's service records cover the in-service event. Service treatment records hold the sick calls, exams, and separation physical; service personnel records hold deployment orders, the veteran's MOS, and line-of-duty findings that put the veteran where the injury or exposure happened. Request them at va.gov/records/get-military-service-records/, which also covers the DD-214. For older records held at the National Personnel Records Center, go through the National Archives at archives.gov/veterans. Be aware that a 1973 fire at the NPRC destroyed a lot of Army and Air Force records, and if the veteran's records were among them, the lay statements in Step 4 carry more weight to fill the hole.

A veteran's current medical records cover the diagnosis. VA records attach to the claim automatically once they're identified, and a veteran can review or download them at va.gov/health-care/review-medical-records/. Private records are on the veteran to submit, or the veteran can authorize the VA to request them. Private treatment records are worth chasing because the provider who treated the veteran is also the person who can write the nexus letter, which the next section covers.

Don't sit back and wait to see what the VA digs up. Its duty to assist under 38 U.S.C. § 5103A is a floor, not a ceiling, so request what's available and turn in whatever's already on hand.

Guard & Reserve note: the proof of *which duty period* a condition falls in usually lives in unit files, the NGB Form 23, and the line-of-duty determination. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Get the Nexus Letter (Usually the Make-or-Break)

The nexus letter is a written opinion from a licensed provider connecting a veteran's condition to service, and it's where most claims are won or lost. Three things decide whether it carries weight.

The first is the wording. The opinion has to say the condition is "at least as likely as not" caused or aggravated by service. Softer phrasing like "possibly related" or "may have contributed" doesn't meet the legal standard and gets little weight, no matter how sympathetic the doctor is.

The second is the reasoning behind it, which counts for more than the title of the person who wrote it. The Court of Appeals for Veterans Claims said as much in *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (CAVC 2008): an opinion's weight comes from the review of the file and the medical logic that walks from the facts to the conclusion, not from the provider's credentials. A thorough opinion from a family doctor will outweigh a one-line note from a specialist.

The third is the file review. The letter should say plainly that the provider went through the service treatment records, the personnel records, and the current records, and then it should lay out the reasoning step by step.

To get one, start with the provider already treating the veteran, and brief them before the appointment, because most doctors have no idea that "at least as likely as not" is the phrase that matters or that the reasoning is what gets weighed. If the treating provider won't write it, a private Independent Medical Examiner will, for a fee. A veteran can't write the medical opinion on their own, but can hand the doctor a structure to follow, and there's one ready in Appendix A5 — Templates & Sample Language.

Write the Lay and Buddy Statements

Lay evidence is first-hand testimony from someone without medical training, whether that's the veteran, someone the veteran served with, or a spouse. The VA treats it as legally competent evidence, not a nice-to-have. The Federal Circuit confirmed in *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007), that a layperson can establish things they actually observed, like what happened and what symptoms have continued, and in *Buchanan v. Nicholson*, 451 F.3d 1331 (Fed. Cir. 2006), that the VA can't brush it aside just because there's no record from the time.

These statements do two jobs. A buddy who saw the injury can corroborate an in-service event the treatment records never captured. And when the VA points to the years that passed before a veteran was diagnosed, a statement describing the symptoms across that gap ("he's limped since he got home") helps close it.

Write a personal statement and at least one buddy statement on VA Form 21-10210, the Lay/Witness Statement. Be specific about dates, places, what happened, what symptoms were seen, and how they affected the veteran's work and daily life. There are templates for both in Appendix A5 — Templates & Sample Language.

Get a DBQ If One Fits the Condition

A Disability Benefits Questionnaire is a form a provider fills out that maps a veteran's condition directly onto the rating criteria in 38 CFR Part 4, telling the rater how severe it is in the schedule's own language, which is what drives the veteran's percentage. Paired with a nexus letter it's a strong combination, since one proves the connection and the other proves the severity.

Not every condition has a DBQ the public can download, and the available set has changed over the years. Check what's currently offered at va.gov/find-forms (search "DBQ"), and have a private provider or IME complete the one that fits. If the VA schedules a Compensation and Pension exam instead, the examiner fills out the equivalent. That exam, and what to do if it comes back against the veteran, is Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

Traps That Cost Veterans Money

- Turning in every record a veteran owns without aiming at the weak leg. A denial almost always names the one element that was missing, so answer that one rather than burying it.
- Accepting a nexus letter that says "could be related." That wording fails the standard. Send it back and ask for "at least as likely as not," with reasoning.
- Skipping a personal statement out of the assumption that the VA only wants medical records. Lay evidence is competent on its own, and it's often the only proof available of an undocumented event.
- Waiting on the VA's duty to assist to surface records. Request them directly; a record nobody finds can't help the claim.

The Rule, Briefly

Competent evidence is defined in 38 CFR § 3.159(a): medical evidence comes from a qualified professional or recognized literature, lay evidence from anyone with direct personal knowledge of what they saw, and neither outranks the other within its lane, so the rater has to weigh both. Benefit of the doubt is § 3.102: when the evidence sits in approximate balance, the VA resolves it in the veteran's favor. And the key cases are *Nieves-Rodriguez* (reasoning over credentials) and *Jandreau* with *Buchanan* (lay evidence is competent and can't be dismissed just for lack of a record). Full citations and primary-source links are in Appendix A1 — Master Citation Index and Ch. 9 — Landmark Court Cases That Shaped Veteran Rights.

Do This Now

1. Decide which leg of the claim is weakest before gathering anything.
2. Request the veteran's military records at va.gov/records/get-military-service-records/ and review the veteran's VA medical records at va.gov/health-care/review-medical-records/.
3. Line up the nexus letter: brief the provider on "at least as likely as not" and the reasoning, using the structure in Appendix A5, and price a private IME if the treating provider won't write it.
4. Write a personal statement and one buddy statement on VA Form 21-10210 (templates in Appendix A5).
5. Check va.gov/find-forms for a DBQ that fits the veteran's condition and have a provider complete it.

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.159 — Competent medical and lay evidence; VA duty to assist. <https://www.ecfr.gov/current/title-38/section-3.159>
- 38 CFR § 3.102 — Benefit of the doubt. <https://www.ecfr.gov/current/title-38/section-3.102>
- 38 U.S.C. § 5103A — Duty to assist. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5103A&num=0&edition=prelim>

- *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (CAVC 2008) — opinion weight comes from reasoning, not credentials. <https://www.courtlistener.com/opinion/2613282/nieves-rodriquez-v-peake/>
- *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007) — lay evidence competent for observable facts. <https://www.courtlistener.com/opinion/955920/jandreau-v-nicholson/>
- *Buchanan v. Nicholson*, 451 F.3d 1331 (Fed. Cir. 2006) — VA cannot dismiss lay testimony for lack of records. <https://www.courtlistener.com/opinion/949839/buchanan-v-nicholson/>
- VA.gov — Evidence needed for your disability claim. <https://www.va.gov/disability/how-to-file-claim/evidence-needed/>
- VA.gov — Get your military service records (including DD214). <https://www.va.gov/records/get-military-service-records/>
- VA.gov — Review your VA medical records. <https://www.va.gov/health-care/review-medical-records/>
- National Archives — Veterans' service records. <https://www.archives.gov/veterans>

Ch. 19 — The C&P Exam: What to Expect and How to Prepare

BLUF: The Compensation and Pension exam is a single appointment with one examiner who writes an opinion the rater leans on, and that one snapshot can shape a veteran's rating and every appeal that follows. It isn't treatment, and the examiner isn't there to help the veteran. Three things are in a veteran's control and they move the outcome: showing up (a missed exam can sink the claim), describing the worst day instead of a good one, and making sure a joint exam measures the veteran's full range of motion. This chapter covers what to do before, during, and after.

How This Goes

A veteran doesn't schedule the exam; the VA does, and it contacts the veteran. When the letter comes, confirm it and keep the contact info current to actually get it. Before the exam, write down the worst version of each condition to avoid underselling it in the room. During the exam, describe that worst version honestly and, for joints, make sure both kinds of motion get measured. And if the result comes back bad, it isn't final. The rest of the chapter takes those one at a time.

Get the Letter and Confirm

A veteran can't start the scheduling. The veteran's VA medical center or a VA contractor kicks it off by mailing a letter with the date and time, and they may also call or email. Two habits keep that letter from getting lost. Keep the address, phone, and email current at va.gov/profile, because a claim stalls in a hurry when the exam letter goes to an old address. And confirm as soon as the letter shows up by calling the number printed on it (or just confirm on the call if the VA reaches the veteran by phone). While confirming, a veteran can also ask for help with transportation, any accommodation needed, or a male or female provider for a reproductive, breast, rectal, mental health, or military sexual trauma exam.

There's also a chance no exam will be needed at all. If a veteran's file already has enough medical evidence, the VA can use what it calls the Acceptable Clinical Evidence (ACE) process and review the records instead of bringing the veteran in, sometimes asking for a little more along the way. Strong evidence up front, the kind Ch. 18 — Evidence That Wins Claims walks a veteran through building, is what makes that possible. Skipping the exam that way is a good outcome, not a step missed.

Prep the Worst Day, in Writing

The exam captures one day. Whatever shape a veteran is in when the examiner sees them becomes the record that rides along through the rating and any appeal. The mistake that costs the most is downplaying symptoms, and it usually isn't weakness, it's training. We're all conditioned to push through pain and look squared away, and the exam room is the one place that habit takes money out of a veteran's pocket.

So before the appointment, write a page on each condition being claimed. Cover how it started and how it's changed since service. Cover how bad it gets on a bad day, not how it feels on an average one. If a bad day means the veteran can't get out of bed, can't make it to the mailbox, or can't sleep more than three hours, that's what belongs on the page. Note how often the bad days hit, whether that's daily, weekly, or in flares. And spell out what the condition keeps the veteran from doing at work and at home: the days missed, the tasks that can't be managed, the things given up.

Take that page in and walk the examiner through it. Keep it honest and don't inflate it, because examiners are trained to spot exaggeration and overstating the case costs credibility. A veteran is after the complete picture, not the brave face normally worn.

Work the Exam

Describe the worst presentation, the way it was written down. For symptoms that come and go, talk in terms of how often and how bad they get at their worst, not how a veteran happens to feel that particular morning.

For joints, the spine, and limbs, pay attention to how the examiner measures the veteran's range of motion, because the rating criteria for joints turn on degrees. The exam should capture how far the veteran can move the joint on their own, how far the examiner can move it for them, and where the pain starts. If the examiner only checks the first and skips the assisted motion, or doesn't note where the pain kicks in, say so right there. An exam that misses that can be challenged as inadequate, and the cases behind that argument, *Correia* and *DeLuca*, are in Ch. 9 — Landmark Court Cases That Shaped Veteran Rights.

Tie every condition back to work, too. The examiner is supposed to address how it affects the veteran's ability to hold or look for a job, so spell out the absences, the tasks that can't be done, and the limitations carried home. A veteran is allowed to take notes and bring someone along, though the examiner can limit how much that person takes part. Having a witness helps if the written report later doesn't square with what was actually said.

After the Exam: Fix a Bad Result

The examiner's opinion goes straight to the rater, and it usually answers two questions: whether the condition is at least as likely as not connected to service, and how severe it is. The rater doesn't have to follow it, but a negative opinion on the connection is hard to beat without a competing one. Either way, a bad exam is not the end of the road.

If the opinion is unfavorable, a private medical opinion can answer it. A qualified physician can review the veteran's file and write an opinion on the same questions with real reasoning and medical literature behind it, and that goes into the record to compete for the rater's attention. How to get one is in Ch. 18 — Evidence That Wins Claims. And if the exam itself was incomplete or sloppy, the rating board is required to send a report back when it lacks the detail to support a rating, which triggers a fresh exam. A veteran or their VSO can point that out and ask for the re-do.

Rescheduling (and What Happens After a Missed Exam)

If a veteran misses a C&P exam without contacting anyone, the VA can decide the claim on whatever's already in the file or deny it outright for failing to cooperate, and in most cases that's the end of it. So when the date won't work, don't just skip it. Reschedule at least 48 hours ahead by calling the number on the appointment letter; it routes to the veteran's VA medical center or whichever contractor has the exam, currently Loyal Source, OptumServe, Leidos QTC, or Veterans Evaluation Services, named on the letter and in the caller ID. With a contractor, a veteran only gets to reschedule once, and the new date has to land within five days of the original. If those five days won't work, tell the contractor and then call the VA to start it over once available. Bear in mind that any reschedule can push the claim back, so move the date only when genuinely necessary.

Traps That Cost Veterans Money

- Walking in and minimizing symptoms out of old habit. The good-day version becomes the permanent record, so describe the bad days.
- Letting a joint exam measure only the motion a veteran can do alone. Skipping the assisted motion or the onset of pain can leave the rating short, so flag it in the room.
- Treating a negative opinion as the final word. It's evidence the rater weighs, and a solid private opinion can outweigh it.
- Missing the exam without calling. Silence reads as refusing to cooperate and can take the whole claim down.
- Letting the exam letter go to an old address. Fix the contact info at va.gov/profile before filing.

The Rule, Briefly

When an exam gets ordered is set by 38 CFR § 3.326(a): the VA authorizes one only when the medical evidence with the claim isn't enough to rate it. Inadequate reports go back under § 4.2 — if a report doesn't support the diagnosis or lacks detail, the rating board has to return it, and it has to read every exam "in the light of the whole recorded history," so one weak exam doesn't erase a consistent record. And the range-of-motion requirement comes from *Correia v. McDonald* and *DeLuca v. Brown*, which make joint exams account for both kinds of motion and for pain and functional loss. Full citations and primary-source links are in Ch. 9 — Landmark Court Cases That Shaped Veteran Rights and Appendix A1 — Master Citation Index.

Do This Now

1. Update the address, phone, and email at va.gov/profile so the exam letter reaches the veteran.
2. The day the letter arrives, call the number on it to confirm, and ask for any accommodation or provider preference then.
3. Write a page on each claimed condition: the worst day, how often it hits, what it stops the veteran from doing. Bring it.
4. At a joint exam, make sure both kinds of motion and pain-on-motion get measured, and speak up if one is skipped.
5. If the result comes back unfavorable, line up a private medical opinion (Ch. 18) or push to have an inadequate exam returned.

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.326 — Examinations; when a VA exam is authorized. <https://www.ecfr.gov/current/title-38/section-3.326>
- 38 CFR § 4.2 — Interpretation of examination reports; inadequate reports must be returned. <https://www.ecfr.gov/current/title-38/section-4.2>
- VA.gov — VA claim exam (C&P exam) (scheduling, ACE, reschedule rules, contractors). <https://www.va.gov/resources/va-claim-exam/>
- VA.gov — Profile (update address, phone, email). <https://www.va.gov/profile>

- Ch. 9 — Landmark Court Cases That Shaped Veteran Rights — *Correia v. McDonald*, 28 Vet. App. 158 (2016) and *DeLuca v. Brown*, 8 Vet. App. 202 (1995): active/passive motion and pain on motion.
- Ch. 18 — Evidence That Wins Claims — rebutting an unfavorable exam with a private medical opinion.
- Ch. 35 — Top Mistakes That Tank Claims — consequences of missing a scheduled exam.

Ch. 20 — Fully Developed Claim vs. Standard Claim

BLUF: Every disability claim runs on one of two tracks. On the standard track the VA's legal duty to assist does a lot of the record-chasing for a veteran, which is slower but takes work off the veteran's plate. On the Fully Developed Claim track a veteran hands over all private evidence up front and certifies it's complete, and the VA can move faster because there's nothing left to develop. A veteran should go FDC when the evidence is genuinely in hand, and go standard when records are scattered or the nexus letter isn't done. The part most veterans don't realize is that trying FDC costs nothing: if it turns out a veteran isn't ready, the VA quietly drops the claim to standard and nothing is lost. This chapter is how to decide.

How to Decide

It comes down to one question: is a veteran's *private* evidence actually complete? Take an inventory first, match the situation to the table, and file. Both tracks use the same form, so the only real difference is whether a veteran certifies that nothing's outstanding.

Take Inventory First

List what's on hand and what's still outstanding:

- Private medical records: doctor reports, X-rays, lab results, treatment notes from non-VA facilities.
- A nexus letter, if the condition isn't presumptive (Ch. 18 — Evidence That Wins Claims).
- Any DBQ a provider has completed.
- Buddy or lay statements a veteran plans to use.
- Military records already in hand.

There's one thing a veteran never has to chase in either track: the federal records are always the VA's job. Service treatment records, personnel records, military pay records, and VA medical records all get pulled by the VA whether a veteran files FDC or standard. What FDC asks for is the veteran's private evidence, plus a certification that there's no other private evidence still out there.

Pick the Lane

Match the inventory to a row below. If everything private is in hand and the nexus is documented, FDC is faster. If anything's still outstanding, standard keeps the VA's duty to assist working in the veteran's favor.

Table 20-1. FDC vs. Standard lane selector.

If the situation is...	File this lane	Why (the tradeoff)	What to submit
All private records in hand, nexus documented, nothing outstanding	FDC	VA goes straight to rating; no development delay	21-526EZ + all private records, nexus letter, DBQs (VA still pulls federal records)
Private records in hand, but the nexus letter / IMO is still outstanding	Standard	Certifying complete without the nexus weakens the claim; duty to assist makes the VA order a C&P if evidence is thin	21-526EZ + records in hand; identify the outstanding evidence so the VA opens development
Service records scattered, partly lost, or fire-damaged (1973 NPRC fire)	Standard	The duty to assist requires the VA to make reasonable efforts to obtain federal records	21-526EZ + records in hand; written note on which records are missing and where

If the situation is...	File this lane	Why (the tradeoff)	What to submit
Buddy/lay statements not collected yet	Standard	Lay statements are private evidence; FDC removes the VA's help in developing them	21-526EZ + records in hand; name the potential lay witnesses
The veteran filed FDC but the VA needs more non-federal evidence	Standard (automatic)	The claim exits FDC and processes as standard — no penalty, no faster denial, no lost benefits	No action needed; duty to assist activates; effective date unchanged
Records seem complete but it is unclear everything private is in hand	Standard	When in doubt, standard keeps full duty-to-assist protection with no downside	21-526EZ + all available evidence (Ch. 18 for the inventory)

The effective date is the same whichever track a veteran picks; it's set by the Intent to File or claim date, not by the lane (Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates).

File It

Both tracks start with VA Form 21-526EZ at va.gov/disability/file-disability-claim-form-21-526ez/. For FDC a veteran also submits all private evidence with the claim, certifies that nothing private is outstanding, and then attends any C&P exam the VA schedules. The FDC requirements and evidence checklist are at va.gov/disability/how-to-file-claim/evidence-needed/fully-developed-claims/, and the side-by-side comparison is at va.gov/disability/how-to-file-claim/evidence-needed/.

Why FDC Is Low-Risk

Here's the part most veterans miss, and it's straight from VA.gov: if the VA decides it needs more non-federal records to decide the claim, it simply takes the claim out of the FDC program and runs it as a standard claim. A veteran doesn't lose benefits, the claim isn't denied any faster, and it doesn't get less attention. It just changes lanes, and the standard duty to assist takes over.

So the worst that happens when a veteran tries FDC is ending up in standard processing, which is where the claim would have started anyway. The certification isn't a trap either: if new evidence turns up after a decision, a Supplemental Claim is the route (Ch. 27 — The Appeals Process Under the AMA). For a veteran who is reasonably prepared, FDC is worth taking.

Traps That Cost Veterans Money

- Certifying FDC when the nexus letter or buddy statements still aren't done. That gives up the VA's help developing the exact thing still missing.
- Avoiding FDC because the certification feels like locking a veteran in. It doesn't lock anyone into anything; an unready FDC just drops to standard.
- Assuming FDC changes the effective date. It doesn't, because the ITF or claim date sets that.
- Trying to track down federal records personally for an FDC. That's the VA's job in both lanes, so a veteran's effort is better spent on the private evidence instead.

The Rule, Briefly

A claim has to be filed in the first place under 38 CFR § 3.151 — benefits aren't automatic, and both tracks begin with the prescribed form. The duty to assist then comes from 38 U.S.C. § 5103A and 38 CFR § 3.159(c): the VA has to make reasonable efforts to help obtain the evidence that substantiates the claim, which is the

standard lane's strength and stays a check even on an FDC (FDC itself is a VA policy program, not a separate statute). Both sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. List every piece of private evidence on hand, and everything still outstanding.
 2. If anything private is missing, file standard; if it's all in hand with a documented nexus, file FDC.
 3. File the 21-526EZ at va.gov/disability/file-disability-claim-form-21-526ez/, and for FDC attach all private records and certify it's complete.
 4. Don't chase federal records personally; the VA pulls those in both lanes.
 5. If an FDC drops to standard, there's nothing extra to do; the duty to assist takes over and the effective date holds.
-

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.151 — Claims for disability benefits; general filing requirement. <https://www.ecfr.gov/current/title-38/section-3.151>
- 38 U.S.C. § 5103A — Duty to assist claimants. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5103A&num=0&edition=prelim>
- 38 CFR § 3.159 — VA assistance in developing claims (duty to assist). <https://www.ecfr.gov/current/title-38/section-3.159>
- VA.gov — Fully Developed Claims program (requirements, checklist, lane-drop "no risk" language). <https://www.va.gov/disability/how-to-file-claim/evidence-needed/fully-developed-claims/>
- VA.gov — How to file a VA disability claim. <https://www.va.gov/disability/how-to-file-claim/>
- VA.gov — Evidence needed for your disability claim. <https://www.va.gov/disability/how-to-file-claim/evidence-needed/>
- VA Form 21-526EZ (both lanes). <https://www.va.gov/disability/file-disability-claim-form-21-526ez/>
- Ch. 7 / Ch. 17 / Ch. 18 / Ch. 27 — cross-references named inline.

Ch. 21 — Presumptive Conditions Explained

BLUF: Most claims make the veteran prove a nexus — the medical link between service and the condition, which is where claims die. A presumptive claim deletes that step: the law supplies the link. Prove qualifying service, prove a diagnosis on the list, and service connection is presumed — no nexus letter, no causation fight with a VA examiner. The lists keep growing (the PACT Act added dozens in 2022), so a condition denied years ago may be presumptive today. Many veterans are sitting on a qualifying condition and don't know it. This chapter is how to find it and file it the easy way.

The Equation

A direct claim requires proving three things: a current diagnosis, an in-service event, and a nexus tying them together. The nexus is the killer — it costs money, a C&P examiner can disagree, and years of distance invite skepticism. A presumptive claim removes it entirely:

Qualifying service + a condition on the list (38 CFR § 3.309) = presumed service connection.

The condition doesn't have to appear anywhere in the veteran's service records — § 3.307 says so expressly; it can emerge years later and still be presumed. The presumption is *rebuttable* (the VA can present affirmative evidence the condition predated service or clearly came from elsewhere), but the bar for that is high and the default favors the veteran.

Guard & Reserve note: The 90-day active-service trigger and the one-year chronic-disease presumption generally do not reach Guard or Reserve training service; presumptions usually attach only to active duty or a covered activation, not drill time alone. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Find the Right Bucket

Four main categories cover almost everything; match the veteran's service to one. The chronic-disease bucket (§ 3.309(a), the "one-year rule") covers a listed condition — arthritis, hypertension and cardiovascular-renal disease, diabetes, and many others — that appears to at least 10% within a year of separation from wartime service or active service after January 1, 1947, with no nexus needed. The toxic, exposure-based bucket is the biggest by veteran count: Agent Orange, ionizing radiation, burn pits under the PACT Act, Gulf War illness, and Camp Lejeune water, where the trigger is documented or presumed *presence* in a designated place rather than a time window, so service in Vietnam, in Korea near the DMZ between April 1968 and August 1971, in the Southwest Asia theater during or after the Gulf War, or at Camp Lejeune between August 1953 and December 1987 all open presumptive pathways (deep treatment in Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure and Ch. 23 — Agent Orange, Gulf War Illness & Camp Lejeune). The former-POW bucket (§ 3.309(c)) counts listed conditions that manifest to 10% at *any* time after discharge, with no deadline, so something that surfaced decades after release still qualifies. And the tropical-disease bucket (§ 3.309(b)) runs on a one-year rule like chronic diseases, plus a trigger when accepted medical treatises put the incubation period during service.

Check the Current List, and Refile Old Denials

The single most important practical point is that the lists are not fixed. Congress expands them by statute, the VA by regulation, and the PACT Act of 2022 was the largest single expansion in decades. So before building any nexus case, check the current § 3.309 list at va.gov/disability/eligibility/hazardous-materials-exposure/ and in the regulation itself rather than relying on memory or a static document. And for a veteran who was denied years ago because no presumption existed and one exists now, refile — a prior denial isn't permanent once the law changes, so open a Supplemental Claim on a change-in-law basis (Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation; Ch. 27 — The Appeals Process Under the AMA).

File It Presumptive (No Nexus Letter)

The whole package is proof of qualifying service + a current diagnosis of a listed condition. Do not spend money on a nexus letter — it's unnecessary and only adds delay. File the claim on the 21-526EZ at va.gov/disability/file-disability-claim-form-21-526ez/, and state plainly that the condition is presumptive for the veteran's service. The evidence the VA needs for presumptive claims is at va.gov/disability/how-to-file-claim/evidence-needed/; former-POW specifics at va.gov/disability/eligibility/former-pows/.

Traps That Cost Veterans Money

- Paying for a nexus letter on a condition that's already presumptive — wasted money and delay.
- Assuming a condition doesn't qualify without checking the current list — the PACT Act added many after 2022.
- Treating an old denial as final after the law changed — refile it.
- Filing in the wrong bucket (e.g., chronic-disease rules for an exposure condition) — match the category.
- For Guard/Reserve, assuming a presumption attaches to drill time — usually it doesn't (Ch. 2A).

The Rule, Briefly

The general presumptive rule is 38 CFR § 3.307: a listed disease is treated as incurred in service under the stated conditions even with no evidence of it during service, and the presumption is rebuttable. The disease lists themselves are in § 3.309, organized by category — chronic (a), tropical (b), POW (c), and exposure-based (d) through (f). The congressional authority is 38 U.S.C. § 1112 generally and § 1116 for herbicides/Agent Orange. These sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. Identify which bucket the veteran's service fits (chronic / exposure / POW / tropical).
2. Check the current § 3.309 list at va.gov/disability/eligibility/hazardous-materials-exposure/ — don't rely on memory.
3. If a condition qualifies, file it presumptive on va.gov/disability/file-disability-claim-form-21-526ez/ with proof of service + diagnosis — no nexus letter.
4. For a veteran denied before a presumption existed, refile as a Supplemental Claim on a change-in-law basis (Ch. 27).

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. The § 3.309 lists are amended often — confirm the current list before relying on it. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.307 — Presumptive service connection; general rules, qualifying service, rebuttal. <https://www.ecfr.gov/current/title-38/section-3.307>
- 38 CFR § 3.309 — Diseases subject to presumptive service connection (full lists by category). <https://www.ecfr.gov/current/title-38/section-3.309>
- 38 U.S.C. § 1112 — Authority for presumptive service connection. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1112&num=0&edition=prelim>
- 38 U.S.C. § 1116 — Herbicide-agent (Agent Orange) presumptions. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1116&num=0&edition=prelim>
- VA.gov — Eligibility based on hazardous materials exposure (burn pits, Agent Orange, Gulf War, Camp Lejeune, radiation). <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/>
- VA.gov — Evidence needed for your disability claim. <https://www.va.gov/disability/how-to-file-claim/evidence-needed/>
- VA.gov — Benefits for former prisoners of war. <https://www.va.gov/disability/eligibility/former-pows/>
- VA Form 21-526EZ — file the claim. <https://www.va.gov/disability/file-disability-claim-form-21-526ez/>
- Ch. 16 / Ch. 22 / Ch. 23 / Ch. 27 / Ch. 2A — cross-references named inline.

Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure

BLUF: The PACT Act of 2022 is the largest toxic-exposure expansion in VA history. It made dozens of conditions presumptive — meaning eligible veterans no longer have to prove their illness came from burn pits, Agent Orange, radiation, or contaminated water. For a veteran who served in a covered place and time and has a covered condition, filing proof of service plus the diagnosis skips the nexus fight. The single most-missed move: if a veteran was denied for one of these conditions *before* the law, refile now — the ground for that denial is gone. The list is long, phased in, and still growing, so always confirm the current one at VA.gov before filing.

Who Is Covered?

Before 2022, a veteran sickened by burn-pit smoke, contaminated water, or radiation had to prove in writing that *their* illness came from *that* exposure. It's brutally hard, and many lost and walked away with nothing. The PACT Act (Pub. L. 117-168, signed August 10, 2022, named for SFC Heath Robinson, an Army National Guard veteran who died of burn-pit-linked cancer) made dozens of conditions presumptive, so the VA assumes service caused them.

The primary group is Gulf War era and post-9/11 veterans — service on or after August 2, 1990 in Southwest Asia or the Middle East, or post-9/11 in Iraq, Afghanistan, Kuwait, Saudi Arabia, and many other places where open burn pits were used. Vietnam-era veterans gained too, since the law added Agent Orange presumptive *locations* (Thailand, Laos, Cambodia, Guam, American Samoa, and others, each with specific date ranges) plus two new conditions, hypertension and MGUS; if a veteran was denied for not serving in-country, check whether the actual duty station is now covered. Radiation-exposed veterans saw additional presumptive locations added as well. And the law created a "toxic exposure risk activity" category, a documented service activity that can support a claim even outside a named location.

Guard & Reserve note: PACT presumptions key off qualifying active service, including covered activations (the law's namesake served in the Army National Guard). Confirm the exposure falls inside a qualifying active or activated period. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Check the Current Condition List

The PACT Act didn't drop one static list on a single day; conditions phased in across August 10, 2022, then October 1 of 2023, 2024, and 2025, and the list still grows, so treat VA.gov as the controlling source rather than this chapter. As an overview of the major categories confirmed presumptive for eligible Gulf War era and post-9/11 veterans — not the complete list — two groups carry most of it. The cancer list runs to eleven broad categories:

- Brain (including glioblastoma), gastrointestinal (any type), head (any type), neck (any type), kidney, lymphoma (any type), melanoma, pancreatic, reproductive (any type), and respiratory (any type) cancers. The categories are deliberately broad, so the specific type just has to fall under the heading.

The respiratory and airway group covers:

- Asthma diagnosed after service, chronic bronchitis, COPD, chronic rhinitis, chronic sinusitis, constrictive or obliterative bronchiolitis, emphysema, granulomatous disease, interstitial lung disease, pleuritis, pulmonary fibrosis, and sarcoidosis.

For Vietnam-era veterans the law also added hypertension and MGUS under Agent Orange. Confirm the complete, current list at va.gov/disability/eligibility/hazardous-materials-exposure/ and the cancer list at va.gov/resources/presumptive-cancers-related-to-burn-pit-exposure/; a condition not in this short overview may still be covered, so check the source.

Use the Free Toxic-Exposure Screening

For a veteran not sure what they were exposed to, every veteran enrolled in VA health care is entitled to a free toxic-exposure screening at a VA facility — a structured conversation (not an exam) where a navigator asks about burn pits, Gulf War exposures, Agent Orange, radiation, Camp Lejeune water, and other hazards, then points the veteran to the right benefits, registries, and care. Not enrolled? A veteran can enroll and request it; enrolled veterans get a follow-up at least every five years. It's not a claims decision, but it's a no-cost starting point. Telehealth scheduling: vethome.va.gov.

File It, and Refile Old Denials

For a covered condition with qualifying service, a veteran does not submit a nexus opinion — the law does the linking. File on the 21-526EZ at va.gov/disability/file-disability-claim-form-21-526ez/ with proof of service and the diagnosis, stating the condition is presumptive under the PACT Act.

The most-missed move: revisit old denials. A pre-PACT denial for "no service connection" is not the end — federal law lets a veteran file a Supplemental Claim when a change in law removes the basis for the denial, and the PACT Act is exactly that. File VA Form 20-0995 at va.gov/decision-reviews/supplemental-claim/ citing the PACT Act (Ch. 27 — The Appeals Process Under the AMA). The VA also runs some automatic reviews, but don't wait on one — file affirmatively.

Traps That Cost Veterans Money

- Paying for a nexus letter on a PACT-covered condition — the law already supplies the link.
- Trusting a printed condition list — it's phased-in and live; confirm at [VA.gov](https://va.gov).
- Leaving an old denial alone after the law changed — refile as a Supplemental Claim.
- Vietnam-era veterans assuming "not in-country = not covered" — the location list expanded.
- Waiting on the VA's automatic review instead of filing directly.

The Rule, Briefly

The burn-pit and toxin presumption is 38 U.S.C. § 1120: a listed disease in a covered veteran "shall be considered" incurred in or aggravated during active service — the same mandatory "shall" that runs through §§ 1110 and 1131. The companion is § 1119, which defines the "covered veteran" by toxic-exposure-risk activity and directs the VA to consult exposure tracking records, so service at a known location during a covered period is itself evidence. Both are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. Confirm the veteran's service fits a covered location and era (or a documented toxic-exposure activity) at va.gov/resources/the-pact-act-and-your-va-benefits/.
2. Check the current condition list at va.gov/disability/eligibility/hazardous-materials-exposure/ — not a printed copy.

3. If a veteran is unsure of the exposures, request the free toxic-exposure screening (vethome.va.gov or any VA facility).
 4. File a covered condition presumptive on the 21-526EZ — no nexus letter.
 5. Refile any pre-PACT denial for a now-covered condition with VA Form 20-0995 citing the PACT Act (Ch. 27).
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Cited Sources

Verify all citations, condition lists, location lists, and effective dates against current primary sources before acting. The PACT Act list is a live document at VA.gov — do not rely on any printed version as definitive.

- Pub. L. 117-168 — Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (signed Aug. 10, 2022).
- 38 U.S.C. § 1119 — Presumptions of toxic exposure; "covered veteran"; exposure tracking. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1119&num=0&edition=prelim>
- 38 U.S.C. § 1120 — Presumption of service connection for diseases associated with burn pits and other toxins. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1120&num=0&edition=prelim>
- VA.gov — The PACT Act and your VA benefits (eligibility, conditions, locations, screening). <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/>
- VA.gov — Presumptive cancers related to burn pit exposure. <https://www.va.gov/resources/presumptive-cancers-related-to-burn-pit-exposure/>
- VA.gov — Eligibility based on hazardous materials exposure (full condition + location lists). <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/>
- VA.gov — Supplemental Claim (refile a PACT denial; Form 20-0995). <https://www.va.gov/decision-reviews/supplemental-claim/>
- VET-HOME — telehealth toxic-exposure screening. <https://vethome.va.gov/>
- Ch. 21 / Ch. 23 / Ch. 27 / Ch. 2A — cross-references named inline.

Ch. 23 — Agent Orange, Gulf War Illness & Camp Lejeune

BLUF: Three separate toxic-exposure programs, three different sets of rules — lump them together and a veteran loses money. Agent Orange gives Vietnam-era veterans a presumptive condition list, no nexus needed. Gulf War Illness is the strangest and most underused path: certain chronic symptoms can qualify *even with no diagnosis*, just by appearing in a Gulf War veteran. Camp Lejeune adds a third — both a VA presumptive disability path and a separate federal lawsuit under the Camp Lejeune Justice Act. Figure out which lane applies before filing. This chapter sorts them.

Lane 1 — Agent Orange (Herbicide Presumptives)

Agent Orange was a dioxin-laden tactical herbicide, and exposed veterans developed serious diseases years later. The framework is simple: qualifying service in a covered location during the covered period, plus a condition on the VA's herbicide list, equals presumed service connection with no nexus letter. The covered locations started as Vietnam and the Korean DMZ and have expanded over time to include Blue Water Navy ships off Vietnam (formally added after 2019 and the PACT Act), parts of Thailand, certain other sites, and C-123 aircraft crews, and the list keeps growing. The covered conditions include certain cancers, ischemic heart disease, Parkinson's, Type 2 diabetes, and more, and that list changes too. Verify both at va.gov/disability/eligibility/hazardous-materials-exposure/agent-orange/ rather than trusting memory or this page, then file on the 21-526EZ showing qualifying service plus the diagnosis.

Guard & Reserve note: A Guard or Reserve member needs orders or records showing the qualifying period fell in the covered location and time; the presumption attaches to qualifying active/activated service, not drill time alone. See Ch. 2A — Guard & Reserve: ACDUTRA, INACDUTRA, and Proving Service Connection.

Lane 2 — Gulf War Illness (No Diagnosis Needed — Use This)

This is the most underused path in the whole system, because it breaks the usual rule. Normally a diagnosis and a nexus are required. Here, for certain chronic symptoms that medicine can't explain, the symptom itself is enough for a veteran who served in the right theater — no named diagnosis, no nexus. Congress built it because Gulf War veterans came home with real, debilitating problems doctors couldn't pin down: chronic fatigue, muscle and joint pain, cognitive trouble, skin rashes, gastrointestinal disorders, fibromyalgia.

Two categories qualify under § 1117 and § 3.317: an *undiagnosed illness*, meaning a condition that after full workup can't be tied to any known diagnosis, and a *medically unexplained chronic multisymptom illness* (MUCMI), the recognized clusters like chronic fatigue syndrome, fibromyalgia, and functional gastrointestinal disorders.

The qualifying theater is the Southwest Asia theater — Iraq, Kuwait, Saudi Arabia, the Iraq–Saudi neutral zone, Bahrain, Qatar, the UAE, Oman, and the surrounding waters/airspace. Afghanistan is not in this theater — Afghanistan and other post-9/11 service runs through the PACT Act burn-pit presumptions instead (Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure). The chronic disability must have appeared during that service or to 10%+ by December 31, 2026 (the PACT Act broadened the window — verify the current date at VA.gov).

The move: a Gulf War veteran with fibromyalgia, chronic fatigue, or IBS-type symptoms should file under this path without waiting for a diagnosis. Confirm eligibility and the theater list at va.gov/disability/eligibility/hazardous-materials-exposure/gulf-war-illness-southwest-asia/.

Lane 3 — Camp Lejeune (Two Separate Sub-Lanes)

Marine Corps Base Camp Lejeune had contaminated drinking water (TCE, PCE, benzene, vinyl chloride) from roughly 1953 to 1987, and anyone who lived or worked there at least 30 cumulative days between August 1, 1953 and December 31, 1987 was exposed. There are two distinct remedies, and both can be pursued. The first is VA disability compensation: 30-plus days on base in that window plus a listed condition (certain cancers and other serious diseases) is a presumed connection with no nexus letter, filed on the 21-526EZ, and dependents who lived there in the qualifying period have a separate VA *health-care* benefit (not disability compensation) under its own program; verify the condition list at va.gov/disability/eligibility/hazardous-materials-exposure/camp-lejeune-water-contamination/. The second is the Camp Lejeune Justice Act lawsuit, enacted as part of the PACT Act, which is a federal civil suit against the United States in the Eastern District of North Carolina — not a VA claim — for damages from the contaminated water, open to veterans, family members, and others, with its own deadlines and rules that shift as courts decide cases, so consult an attorney who handles Camp Lejeune claims. The two run in parallel: a VA rating doesn't block the lawsuit and the lawsuit doesn't block the VA claim, so an eligible veteran should pursue both.

Traps That Cost Veterans Money

- Filing under the wrong framework (e.g., Agent Orange rules for a Gulf War symptom) — match the lane.
- Gulf War veterans not filing because no doctor named the condition — the missing diagnosis is the qualifier.
- Assuming Afghanistan service is "Gulf War" — it's PACT-Act burn-pit territory (Ch. 22).
- Camp Lejeune veterans running only one sub-lane — the VA claim and the lawsuit are separate; do both.
- Trusting a printed condition/location list — all three were expanded by the PACT Act; verify at VA.gov.

The Rule, Briefly

Agent Orange runs on 38 U.S.C. § 1116: a listed disease in a veteran with covered service is treated as incurred in service, with no record of it during service required. Gulf War Illness is 38 U.S.C. § 1117 and 38 CFR § 3.317: compensation for a qualifying chronic disability (an undiagnosed illness or a MUCMI) in a Persian Gulf veteran that can't be attributed to a known diagnosis. And Camp Lejeune combines the VA presumptive path with the CLJA civil cause of action created by the PACT Act. These sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. Identify the applicable lane: Agent Orange (location/era), Gulf War Illness (Southwest Asia symptoms), or Camp Lejeune (1953–1987 water).
2. Verify the current condition/location list on that lane's va.gov page (linked in Cited Sources).
3. Gulf War: file fibromyalgia / chronic fatigue / IBS-type symptoms under § 3.317 without a diagnosis.
4. Camp Lejeune: file the VA claim and, separately, consult a CLJA attorney — run both.
5. For a veteran denied before the PACT Act, refile under the updated rules (Ch. 22, Ch. 27 — The Appeals Process Under the AMA).

Cited Sources

Verify all citations, condition lists, and effective dates against current primary sources before acting. These lists are living documents at VA.gov. VA.gov reorganizes pages; confirm a link if it moves.

- 38 U.S.C. § 1116 — Agent Orange / herbicide-agent presumptions. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1116&num=0&edition=prelim>
- 38 U.S.C. § 1117 — Compensation for disabilities in Persian Gulf War veterans (undiagnosed illness). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1117&num=0&edition=prelim>
- 38 CFR § 3.317 — Gulf War qualifying chronic disability / MUCMI; Southwest Asia theater. <https://www.ecfr.gov/current/title-38/section-3.317>
- 38 CFR § 3.307 — Presumptive service connection; herbicide framework. <https://www.ecfr.gov/current/title-38/section-3.307>
- PACT Act of 2022 (Pub. L. 117-168) — expanded Agent Orange locations, the Gulf War window, and created the CLJA.
- VA.gov — Agent Orange exposure (current conditions + locations). <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/agent-orange/>
- VA.gov — Gulf War illness (Southwest Asia) (eligibility, theater, conditions). <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/gulf-war-illness-southwest-asia/>
- VA.gov — Camp Lejeune water contamination (presumptive conditions; dependents' health program). <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/camp-lejeune-water-contamination/>
- Ch. 21 / Ch. 22 / Ch. 27 / Ch. 2A — cross-references named inline.

Ch. 24 — How Common Conditions Are Rated

BLUF: The rating schedule assigns a percentage to every ratable condition through a Diagnostic Code. The percentage comes from matching a veteran's documented symptoms to the criteria in the current regulations — not from the diagnosis label alone. This chapter walks through how the VA rates the six most commonly claimed conditions: mental health, tinnitus, sleep apnea, back injuries, migraines, and GERD. The mechanics are the same for all of them: find the code, read the criteria, match the evidence.

The Ground Truth

Chapter 5 of this manual introduced the VA Schedule for Rating Disabilities (VASRD) — the rulebook that turns a medical condition into a percentage. That chapter explained the structure. This chapter shows the structure working on real conditions.

Six conditions account for a large share of all VA disability claims. Every one of them has a Diagnostic Code (DC) — a numbered entry in the schedule — with written criteria for each rating tier. A veteran's job is to know those criteria and make sure the medical evidence documents the symptoms that satisfy them.

That is the whole system. Find the code. Read the criteria. Match the evidence.

Mental Health and PTSD — The General Rating Formula

Mental health conditions — PTSD, major depressive disorder, anxiety disorders — are almost all rated under a single framework: the General Rating Formula for Mental Disorders, found at 38 C.F.R. § 4.130. Individual Diagnostic Codes point to this formula. DC 9411 is PTSD. DC 9434 is major depressive disorder. The formula is the same regardless of which code applies.

The formula doesn't ask what the diagnosis is. It asks one question: how much does this condition disrupt the veteran's work and social life? That disruption is called occupational and social impairment. The rating tiers — 0, 10, 30, 50, 70, and 100 percent — each describe a level of that impairment.

The criteria run from least to most disabling:

- 0% — A condition is service-connected and documented, but currently produces no symptoms, or symptoms so mild they do not impair work or social functioning.
- 10% — Occupational and social impairment is mild, or there are transient (temporary) symptoms that decrease work efficiency and ability to perform occupational tasks only during periods of significant stress.
- 30% — Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, even though generally functioning satisfactorily, with routine behavior, self-care, and conversation normal.
- 50% — Occupational and social impairment with reduced reliability and productivity. Symptoms may include flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory; impaired judgment; disturbances of motivation and mood; inability to establish and maintain effective work and social relationships.

- 70% — Occupational and social impairment with deficiencies in most areas — work, school, family relations, judgment, thinking, or mood — due to symptoms such as suicidal ideation, obsessional rituals that interfere with routine activities, near-continuous panic or depression affecting the ability to function independently, impaired impulse control, neglect of personal appearance and hygiene, and inability to establish and maintain effective relationships.
- 100% — Total occupational and social impairment due to symptoms such as gross impairment in thought processes or communication, persistent delusions or hallucinations, persistent danger of hurting self or others, intermittent inability to perform activities of daily living (including maintaining minimal personal hygiene), and disorientation to time or place.

Each tier lists examples of symptoms. The examples are illustrative, not a checklist. A veteran does not need every symptom listed at a tier to qualify for that tier. The key question is whether the overall level of impairment matches the tier. That matching happens through the Compensation and Pension (C&P) examination and the veteran's treatment records. Strong, documented evidence of how the condition actually affects daily work and personal relationships is what moves the needle. See Ch. 18 — Evidence That Wins Claims for what that documentation looks like.

Worked Example: Rating a Common Condition

A veteran is service-connected for PTSD. The rater applies the General Rating Formula under § 4.130.

The veteran's treatment records and C&P exam document the following: the veteran has not missed work entirely, but productivity has dropped and the supervisor has noted unreliability. The veteran avoids social gatherings, has difficulty concentrating on complex tasks, and reports mood disturbances most days. There are no suicidal ideation notations in the file, and the veteran maintains basic hygiene and can follow routine conversations.

The rater works through the tiers. The 30% tier describes occasional decreases in work efficiency and intermittent inability to perform occupational tasks, with generally satisfactory functioning otherwise. The 50% tier describes reduced reliability and productivity, with symptoms that may include impaired memory, disturbances of motivation and mood, and inability to establish and maintain effective work and social relationships.

The veteran's picture — reduced reliability, mood disturbances, social avoidance, difficulty with complex tasks — more nearly approximates the 50% tier than the 30% tier. The rater assigns 50%.

The rating reflects occupational and social impairment, not the diagnosis label. Two veterans with identical PTSD diagnoses may receive different ratings based solely on how completely their documented symptoms fill out the tier criteria.

For building the evidence record that supports this analysis, see Ch. 18 — Evidence That Wins Claims and Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

Tinnitus — DC 6260

Tinnitus is ringing, buzzing, or hissing in one or both ears. It is one of the most commonly claimed VA conditions, especially for veterans who served in high-noise environments. It is rated under DC 6260 in 38 C.F.R. § 4.87.

The schedular maximum for tinnitus under DC 6260 is 10 percent, and the schedule assigns that single evaluation whether the sound is perceived in one ear, both ears, or in the head (§ 4.87, DC 6260, Note 2). A rating above 10 percent through the regular schedule is not available for tinnitus alone, but veterans with

tinnitus rated at 10% may still benefit significantly from combinations with hearing loss or other service-connected conditions, and a total rating under TDIU remains a separate path (see Ch. 14 — TDIU: Paid at 100% Without a 100% Rating).

Sleep Apnea — DC 6847

Sleep apnea is rated under DC 6847 in 38 C.F.R. § 4.97, and the tiers turn on treatment, not on how loud the snoring is. The current schedule:

- 100% — Chronic respiratory failure with carbon dioxide retention or cor pulmonale (right-sided heart failure caused by the apnea), or a required tracheostomy.
- 50% — Requires use of a breathing assistance device such as a CPAP machine.
- 30% — Persistent daytime hypersomnolence.
- 0% — Asymptomatic, but with a documented sleep disorder.

The 50% tier is the one most veterans land on, and the practical point is that the treatment record decides it: a prescribed CPAP, documented in the file, is direct evidence that breathing assistance is required. Veterans should make sure the prescription and its ongoing use appear in the records the VA will review. The VA has floated modernizing these criteria for years; the schedule above is the law in force, and any future change has to go through public rulemaking first.

Back and Musculoskeletal Conditions — § 4.71a

Back injuries — including lumbar strain, degenerative disc disease, and similar conditions — are rated under the musculoskeletal schedule at 38 C.F.R. § 4.71a. The primary driver for most back ratings is range of motion — how far the veteran can flex, extend, and bend the spine, measured in degrees.

Two supporting regulations shape almost every musculoskeletal rating:

- 38 C.F.R. § 4.59 says the VA must account for painful motion. A joint that causes pain on movement is rated at least at the minimum compensable rating for that joint, even if the measured range of motion is still within a normal range. Pain counts.
- The *Correia* and *DeLuca* principles (addressed in Ch. 9 — Landmark Court Cases That Shaped Veteran Rights) address functional loss — the idea that a veteran may be unable to use a joint effectively even when a snapshot range-of-motion measurement looks acceptable, because pain and weakness reduce function under real-world conditions.

The spine-specific Diagnostic Codes use forward flexion of the thoracolumbar spine as the primary measuring tool. The degree of limitation — for example, flexion limited to 60 degrees, or 30 degrees, or less — maps to the corresponding percentage tier. Veterans should ensure C&P examiners measure both active and passive range of motion, document the point at which pain begins, and address flare-up frequency and severity. Specifics must be verified at the current eCFR, as spine criteria have been updated through VASRD modernization.

Migraines — DC 8100

Migraines are rated under DC 8100 in 38 C.F.R. § 4.124a. The key term is prostrating — meaning an attack severe enough to require the veteran to lie down and stop normal activity. Frequency of prostrating attacks drives the percentage.

The verified criteria from § 4.124a:

- 50% — Very frequent, completely prostrating, and prolonged attacks productive of severe economic inadaptability.
- 30% — Characteristic prostrating attacks occurring on an average of once a month over the last several months.
- 10% — Characteristic prostrating attacks averaging one in two months over the last several months.
- 0% — Less frequent attacks.

Two things follow from these criteria. First, the medical record needs to show frequency. How often do prostrating attacks occur? If the treatment records only show occasional office visits without documenting attack frequency, the VA has nothing to rate. Veterans should tell their doctor how often these attacks happen and make sure it is in the notes. Second, the 50% tier adds an economic component: the attacks must produce severe economic inadaptability, meaning the condition significantly disrupts the veteran's ability to work and earn. Work history, missed days, and employer documentation can matter at the high end.

GERD — Now Has Its Own Code

For years, gastroesophageal reflux disease (GERD) had no dedicated Diagnostic Code, and the VA rated it by analogy, usually under the hiatal hernia code. That changed when the VA modernized the digestive system schedule. GERD now has its own code, DC 7206, in 38 C.F.R. § 4.114.

The new criteria rate GERD on its documented complications, keyed to esophageal stricture: recurrent or refractory strictures causing dysphagia (trouble swallowing), with symptoms such as aspiration, undernutrition, or substantial weight loss driving the higher tiers. Heartburn alone, controlled by medication, sits at the low end. The old analogy target, hiatal hernia (DC 7346), now cross-references the same stricture criteria (DC 7203). The practical lesson is unchanged: the rating follows what the medical record documents, so swallowing problems, weight loss, and treatment escalation need to be in the notes.

Ratings by analogy are still addressed in 38 C.F.R. § 4.20 for conditions that lack a code. The VA selects the code whose criteria most closely match the severity and nature of the veteran's condition.

The Criteria, At a Glance

Ratings aren't negotiated — they're assigned when a veteran's *documented symptoms match the written criteria*. So the move is to read the criteria for the condition and document the symptoms that hit the next tier up. Two high-value examples (the complete schedule for every condition is at eCFR 38 CFR Part 4; this is a reference, not the full text):

- Mental disorders — 38 CFR § 4.130 (General Rating Formula). Rated by *occupational and social impairment*, not symptom count. 100% = total occupational and social impairment. 70% = deficiencies in most areas (work, family, judgment, mood) — e.g. suicidal ideation, near-continuous panic or depression, impaired impulse control, inability to maintain effective relationships. The tier that's hit is about how much the condition impairs functioning, so document the functional impact, not just the diagnosis.
- Migraine — 38 CFR § 4.124a, DC 8100. 50% = very frequent completely prostrating, prolonged attacks productive of severe economic inadaptability; 30% = characteristic prostrating attacks averaging once a month; 10% = averaging one in two months; 0% = less frequent. The word that drives it is *prostrating* — document that the attack stops the veteran cold, and how often.

The verbatim criteria for these (and the full Part 4 schedule) are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

What This Means in Practice

The diagnosis is the starting line, not the finish line. Getting PTSD, sleep apnea, or migraines service-connected is step one. The percentage depends on how well the evidence matches the rating criteria. Two veterans with the same diagnosis can get very different ratings based on documented severity.

For mental health, document function, not just symptoms. The General Rating Formula is about work and relationships, not a symptom list. Treatment records that note "veteran reports anxiety" get a lower rating than records that document missed work, inability to maintain relationships, panic attacks at certain frequencies, and behavioral changes observed by a clinician or family member.

For tinnitus, the rating is what it is. DC 6260 caps at 10 percent schedularly. Veterans should make sure all related conditions — hearing loss, secondary headaches — are separately claimed and rated.

For sleep apnea, the CPAP prescription is evidence. If a doctor prescribed a breathing device, that fact belongs in the C&P exam and the claims file. If treatment has changed since the last rating, an increase may be warranted.

For back conditions, flare-ups belong in the record. Range-of-motion measurements taken on a good day underrate a fluctuating condition. Veterans should inform examiners how symptoms change under stress, exertion, and during flare-ups. Section 4.59 and functional loss arguments (see Ch. 9 — Landmark Court Cases That Shaped Veteran Rights) apply here.

For migraines, frequency is everything. Keep a headache log with dates, duration, and severity. Bring it to medical appointments. If the treatment record does not show monthly prostrating attacks, a 30% rating is not supported — even if the veteran actually has them.

For GERD, the analogous code is the thing to confirm. Because GERD is rated by analogy, it's worth knowing whether the VA picked the correct analogous code and criteria — and that detail sits on the rating code sheet, not the decision letter, so a veteran may have to request the code sheet from their Regional Office to see it. If the code sheet shows the wrong analogous DC, or the VA cannot say which one it used, that is worth questioning on appeal.

Sleep apnea and GERD criteria: verify both before this chapter is published. Both areas are under VASRD review. Criteria in effect on publication date govern the rating.

The pattern under all of it is the same: find the Diagnostic Code for each rated condition — get it from the rating code sheet if requested, or by matching the condition in 38 CFR Part 4 — look it up in the current eCFR to unlock the exact criteria, read the criteria one level above the current rating, and aim the treatment records and C&P testimony at closing that gap. Document against the criteria, not the diagnosis label — for mental health that means recording missed work and disrupted relationships, for migraines a dated headache log with frequency and duration, for back conditions the flare-up severity and functional limits reported at every appointment. And for sleep apnea and GERD specifically, verify the criteria against the live eCFR before filing or appealing, because both are under active VASRD modernization review and the criteria in effect on the decision date govern (Ch. 5 — The Rating Schedule (VASRD) and Diagnostic Codes for how the schedule is structured, Ch. 18 — Evidence That Wins Claims for the evidence).

Cited Sources

Verify all citations and figures against current primary sources before acting. CFR criteria are subject to VASRD modernization updates — the current eCFR is the controlling source.

- 38 CFR § 4.130 — Schedule of ratings: Mental disorders (General Rating Formula). <https://www.ecfr.gov/current/title-38/section-4.130>
- 38 CFR § 4.87 — Schedule of ratings: Ear (DC 6260, Tinnitus). <https://www.ecfr.gov/current/title-38/section-4.87>
- 38 CFR § 4.97 — Schedule of ratings: Respiratory system (DC 6847, Sleep Apnea Syndromes). <https://www.ecfr.gov/current/title-38/section-4.97>
- 38 CFR § 4.124a — Schedule of ratings: Neurological conditions and convulsive disorders (DC 8100, Migraine). <https://www.ecfr.gov/current/title-38/section-4.124a>
- 38 CFR § 4.114 — Schedule of ratings: Digestive system (analogous ratings for GERD). <https://www.ecfr.gov/current/title-38/section-4.114>
- 38 CFR § 4.71a — Schedule of ratings: Musculoskeletal system (back / spine). <https://www.ecfr.gov/current/title-38/section-4.71a>
- 38 CFR § 4.59 — Painful motion (musculoskeletal minimum ratings). <https://www.ecfr.gov/current/title-38/section-4.59>
- 38 CFR § 4.20 — Analogous ratings. <https://www.ecfr.gov/current/title-38/section-4.20>
- eCFR (live, authoritative) — <https://www.ecfr.gov/current/title-38/chapter-I/part-4>

Ch. 25 — Secondary Conditions: The Underused Multiplier

BLUF: A secondary condition is a new problem caused or worsened by a condition the VA has already rated, and it's one of the most winnable claims a veteran can file, because the proof only has to run from one condition to another instead of all the way back to a service event from twenty years ago. One rating becomes the foundation for the next, and each one adds points to the veteran's combined rating and can eventually open the door to TDIU. The catch is that the VA won't connect these for the veteran. A veteran has to map each rated condition to what it caused downstream, get a short nexus on each, and file. This chapter is that map.

Map the Body

Most people picture service connection as a single straight line: a service event leads to a condition, which leads to a rating. There's a second line that matters just as much, and it runs from a condition the VA has already rated to a new problem that grew out of it. That new problem is a secondary condition, and the law requires the VA to connect it, but only if the veteran actually files for it.

This is why secondaries are the underused multiplier. A veteran doesn't have to prove the new problem traces back to service, because the link only needs to reach the condition that's already rated, and connecting two current medical problems is far easier than reconstructing something that happened decades ago. So go through each rated condition and ask what else it has caused or made worse. A few chains come up over and over:

- A rated knee changes how a veteran walks, and favoring one leg loads the opposite hip and strains the lower back over time. It's well recognized in the orthopedic literature, and it's a common path from a knee rating to a hip or back rating.
- PTSD disrupts sleep, drives weight changes, and alters muscle tone at night, and the link between PTSD and sleep apnea is established enough that it's widely granted with a nexus opinion.
- The medications used for PTSD or chronic pain, like NSAIDs and some psychiatric drugs, irritate the stomach and cause reflux. If a rated condition is the reason a veteran is on those medications and the medications caused the GERD, that's a secondary.
- Service-connected Type 2 diabetes, which is common under the Agent Orange presumptions, damages nerves and kidneys over time, and diabetic neuropathy and kidney disease are textbook secondaries that the VA grants routinely.

These aren't the only ones. Any condition that flows medically from a rated condition is worth looking at. Sit down with a doctor, ideally a specialist, and walk each rated condition down its likely chain.

Decide: Causation or Aggravation

Both routes come from the same regulation, § 3.310, but a veteran proves them differently. Under causation (§ 3.310(a)), the rated condition proximately caused the new one. It has to be a direct, foreseeable cause, though not the only cause, just a real one, the way a rated knee causes a back problem. Under aggravation (§ 3.310(b)), a veteran had a condition already, from before service or developed on its own, that wasn't service-connected, and the rated condition made it worse beyond its natural course. There the VA pays for the extra disability the worsening added.

Aggravation comes with one extra burden. A veteran has to establish a baseline, meaning medical records that show how bad the condition was before the worsening started, or at least the earliest records from when it started. The VA takes the current severity, subtracts that baseline and anything that was just natural progression, and rates what's left. Without a documented before-state there's nothing to measure the increase against, so the claim fails. This is exactly why old medical records are worth digging up; pull the earliest ones available for that condition.

Get the Nexus

A secondary isn't automatic; it still needs a medical nexus tying the two conditions together. The good news is the burden is usually lighter, because a doctor can examine the veteran now, review the veteran's current records, and write an opinion on whether the rated condition caused or worsened the new one. That's a question about the present, something a clinician can actually observe, rather than a reconstruction of the past. How to get a nexus letter that holds up is in Ch. 18 — Evidence That Wins Claims.

File Each One

File each secondary as its own claim on VA Form 21-526EZ at va.gov/disability/file-disability-claim-form-21-526ez/, with the nexus attached. If a condition was denied before, the route is a Supplemental Claim with the new nexus as new-and-relevant evidence (Ch. 27 — The Appeals Process Under the AMA). When possible, file secondaries alongside the related primary claim, since they share medical evidence and one C&P exam may cover both. The claim types and how to open each are in Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation, and the eligibility overview is at va.gov/disability/eligibility/.

The reason it's worth the trouble is that every secondary gets its own rating, and ratings stack through the combined-ratings math (Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%) into a higher overall rating and a bigger monthly check. Enough stacked ratings can also clear the TDIU thresholds, which pays at the 100% rate without a 100% schedular rating (Ch. 14 — TDIU: Paid at 100% Without a 100% Rating).

Traps That Cost Veterans Money

- Waiting for the VA to notice a veteran's secondaries. It won't, and anything not filed stays unrated.
- Filing a secondary with no nexus. Without the medical link there's nothing bridging the two conditions.
- Filing an aggravation claim with no baseline records. The VA can't calculate the extra disability, and the claim fails.
- Treating a secondary as part of the primary's rating. It's a separate claim that earns its own rating.
- Stopping at one rating and never mapping the rest. That first rating is a foundation, and every downstream condition a veteran skips is money left behind.

The Rule, Briefly

Secondary service connection is 38 CFR § 3.310(a): a disability proximately due to a service-connected condition is itself service-connected and treated as part of the original. Aggravation is § 3.310(b): the worsening of a non-service-connected condition beyond its natural progress, caused by a service-connected condition, is compensated — but only after a medical baseline is established. Both are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. List every service-connected condition and, with a doctor, map each to what it may have caused or worsened.
 2. For each candidate, decide whether it's causation or aggravation, and for aggravation pull the earliest medical records to set the baseline.
 3. Get a short nexus opinion linking the two conditions (Ch. 18).
 4. File each secondary on va.gov/disability/file-disability-claim-form-21-526ez/ with the nexus attached, bundling with a related primary when possible.
 5. If a secondary was denied before, refile it as a Supplemental Claim with the nexus as new evidence (Ch. 27).
-

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.310 — Secondary service connection and aggravation. <https://www.ecfr.gov/current/title-38/section-3.310>
- 38 U.S.C. §§ 1110 / 1131 — Basic entitlement (authority behind § 3.310).
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1110&num=0&edition=prelim> · <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1131&num=0&edition=prelim>
- 38 CFR Part 4 — Schedule for Rating Disabilities (used for the § 3.310(b) baseline/current severity math).
<https://www.ecfr.gov/current/title-38/part-4>
- VA.gov — Disability eligibility (including secondary service connection).
<https://www.va.gov/disability/eligibility/>
- VA.gov — About VA disability ratings. <https://www.va.gov/disability/about-disability-ratings/>
- VA Form 21-526EZ — file the claim. <https://www.va.gov/disability/file-disability-claim-form-21-526ez/>
- Ch. 11 / Ch. 14 / Ch. 16 / Ch. 18 / Ch. 27 — cross-references named inline.

Ch. 26 — Reading the Rating Decision Letter

BLUF: The rating decision is a legal document that sets the rating, the monthly payment, and the back-pay start date — and it contains errors often enough that every veteran should audit it line by line. The move is not to check the headline number and file the rest in a drawer. It's to run a seven-point audit, find the money the VA left on the table, and read the "Reasons and Bases" section, which tells a veteran exactly which evidence gap to close if they appeal. The clock to act starts the day the letter is dated. This chapter is the audit.

Get the Whole Packet First

The decision comes in the mail, and a veteran can also pull it online, but there are two different documents in play, and a veteran may only receive one of them. The notification letter is what lands in the veteran's mailbox: the cover summary listing each condition granted or denied, the combined rating, the monthly payment, and the effective date. What it does not contain is the Diagnostic Code for each condition. That detail lives on a separate internal document, the rating code sheet, which the VA does not automatically send. The code sheet lists, for every condition, the name, the granted-or-denied outcome, the percentage, the Diagnostic Code that says which rating criteria were used (Ch. 5 — The Rating Schedule (VASRD) and Diagnostic Codes), and the effective date. If the packet did not include it — most don't — the veteran should request it from their VA Regional Office, in person or in writing through a FOIA/Privacy Act request. While waiting, pull what's available online: the rating at va.gov/disability/view-disability-rating/, claim status at va.gov/claim-or-appeal-status/, and the decision letter under va.gov/disability/after-you-file-claim/. Most veterans read only the cover and put the rest in a drawer, which is exactly where the errors hide, so read the whole thing — letter and code sheet — before reacting to any number.

Run the Seven-Point Audit

This is the heart of the chapter. A veteran should sit down with the packet and their own filing records side by side and work through these seven checks, because each one is a place the VA routinely costs veterans money:

1. Is every condition the veteran claimed actually addressed? The VA has to decide each one. If a veteran claimed five and the packet covers four, the missing one is a legal problem, so follow up rather than letting it vanish.
2. Is each effective date right? It should be the date the VA received the claim, or the veteran's Intent to File date, which can reach back up to a year, not the date of the decision. Check it against the veteran's own filing record; a six-month error at 70% is thousands in lost back pay (Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates).
3. Does each percentage match the Diagnostic Code? Find the DC first — from the code sheet, or by matching the condition in the current rating schedule — then read what the assigned level requires and read the level above it. If a veteran's symptoms already meet that higher level, they have grounds for an increase.
4. Is the combined-rating math right? It isn't addition; 40 and 20 don't make 60. The VA runs a whole-person formula and rounds to the nearest 10, and the arithmetic is wrong often enough that a veteran should re-run it every time (Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%).

5. Are the veteran's dependents reflected? A spouse, dependent children, or dependent parents raise the monthly payment above the single-veteran rate, but only if the VA has them on file, so the higher rate won't apply on its own (Ch. 12 — Compensation Rate Tables and Dependent Add-Ons).
6. Did anything come back at 0%? A noncompensable grant still establishes service connection, which is a win worth banking, since raising an already-connected condition later is far easier than connecting it from scratch.
7. Write down the decision date. The date on the notification letter starts the veteran's one-year clock to act, and it belongs on the audit no matter how the veteran feels about the result.

Read "Reasons and Bases"

Buried deeper in the packet is the most useful section for anyone who isn't fully satisfied. To grant service connection the VA has to find three things — a current diagnosis, an in-service event, and a nexus linking them (Ch. 15 — The Elements of Service Connection) — and when it denies or low-rates a claim, the Reasons and Bases section names which of the three it found missing. That tells the veteran which fight they're actually in. If it says there's no current diagnosis, get a current medical evaluation that names the condition. If it says there's no in-service event, it's a records problem, so go find the buddy statement, incident report, or service record that places it (Ch. 18 — Evidence That Wins Claims). And if it says the nexus wasn't established, a private medical opinion connecting the condition to service is needed. Read this before deciding anything, because a veteran who reads it is working from information and one who skips it is guessing at which evidence to add.

If the Veteran Disagrees, Pick the Lane

A decision is a starting line, not a sentence, and a partial grant lets a veteran collect on what was granted while fighting what was denied. If the audit turned up an error or a low rating and the veteran disagrees, the routes are a Supplemental Claim, a Higher-Level Review, or a Board appeal, all laid out in Ch. 27 — The Appeals Process Under the AMA (start at va.gov/decision-reviews/). If instead a condition has simply gotten worse since the decision, the veteran files for an increase (Ch. 28 — Increasing an Existing Rating). Either way, under the Appeals Modernization Act a veteran generally has one year from the date on the notification letter to choose a review lane and keep the effective date — miss it and the options aren't all lost, but the landscape shifts, which is why that date went on the audit in the first place.

Traps That Cost Veterans Money

- Reading the headline rating and filing the rest away. The errors live in the code sheet and the effective dates, not the cover number.
- Trusting the combined-rating math. Re-run it; rounding and formula mistakes are common.
- Skipping Reasons and Bases and then appealing blind, which means adding the wrong evidence because the veteran guessed which element was weak.
- Letting a missing condition slide. If the VA didn't decide it, it won't quietly resolve.
- Letting the one-year clock run out. The date is on the letter the day it arrives, so calendar it.

The Rule, Briefly

A veteran's right to a written decision comes from 38 CFR § 3.103(a) — every claimant is entitled to written notice of the decision, a hearing, and representation, and inadequate notice is itself a basis to challenge a decision. The effective-date rule is 38 CFR § 3.400 (date of receipt or the date entitlement arose, whichever is

later), which is what makes that line the most financially significant in the packet. And the one-year window to elect a review lane comes from 38 U.S.C. § 7105 under the AMA. Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.103 — Procedural due process; right to written notice of the decision.
<https://www.ecfr.gov/current/title-38/section-3.103>
- 38 CFR § 3.400 — Effective dates, general rule. <https://www.ecfr.gov/current/title-38/section-3.400>
- 38 CFR Part 4 — Schedule for Rating Disabilities (Diagnostic Codes and criteria).
<https://www.ecfr.gov/current/title-38/chapter-I/part-4>
- 38 U.S.C. § 7105 — Filing of review/appeal; AMA one-year window.
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section7105&num=0&edition=prelim>
- VA.gov — After you file your disability claim. <https://www.va.gov/disability/after-you-file-claim/>
- VA.gov — View your VA disability ratings. <https://www.va.gov/disability/view-disability-rating/>
- VA.gov — Check your claim or appeal status. <https://www.va.gov/claim-or-appeal-status/>
- VA.gov — Decision reviews and appeals. <https://www.va.gov/decision-reviews/>
- Rating code sheet — how to obtain it. The notification letter is a summary and does not list Diagnostic Codes; the DCs live on the VA's internal rating code sheet, which is not sent automatically. It is requested from the veteran's VA Regional Office in person or via a FOIA/Privacy Act request. VA FOIA/Privacy Act: <https://department.va.gov/foia/> · VA records: <https://www.va.gov/records/> · Background (veteran-law explainer): Cuddigan Law, <https://www.cuddiganlaw.com/blog/getting-your-va-rating-code-sheet-is-crucially-important.cfm>
- Ch. 5 / Ch. 11 / Ch. 12 / Ch. 15 / Ch. 17 / Ch. 18 / Ch. 27 / Ch. 28 — cross-references named inline.

Ch. 27 — The Appeals Process Under the AMA

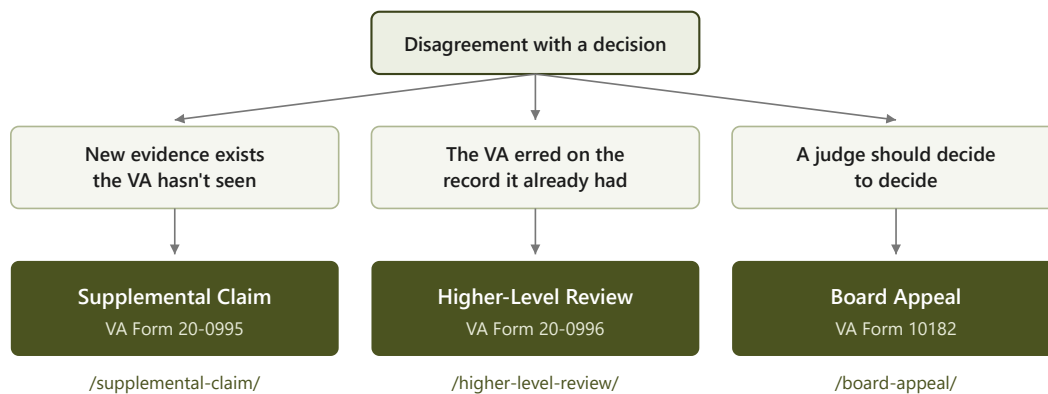
BLUF: A denial or a low rating is not the end. The Appeals Modernization Act gives three review lanes — Supplemental Claim, Higher-Level Review, and Board Appeal — and picking the right one for a veteran's situation is the whole game. Pick wrong and a veteran wastes months or loses effective-date protection; pick right and the veteran keeps the original back-pay date while the VA looks again. A veteran generally has one year from the decision to file. This chapter is the lane chooser and the exact page to file each one.

Docket the One-Year Clock First

After the VA mails a decision, a veteran generally has one year from the date on the notice to choose a lane and file, and getting inside that window does two things at once: it starts the review, and it protects the effective date of the veteran's original claim, which the rule calls being "continuously pursued." Move through the lanes on time and the back pay still counts from when the veteran first filed. Let the year lapse and the decision becomes final, which means starting over with a new claim, a new effective date, and the earlier back pay gone. So calendar that date on day one (the effective-date mechanics are in Ch. 26 — Reading the Rating Decision Letter).

Match the Lane to the Problem

There are three lanes for three different situations. A Supplemental Claim is for when a veteran has new evidence the original decision never saw — a nexus letter, new treatment records, buddy statements — and a regional-office reviewer looks again with that added. A Higher-Level Review is for when a veteran has no new evidence but believes the rater misread the file or applied the wrong rule; a senior adjudicator re-reviews the same record, and the veteran can request an informal phone conference to walk them through the errors. A Board Appeal puts it in front of a Veterans Law Judge, with three sub-options of its own: direct review (no new evidence, the fastest), evidence submission (send a brief or new evidence within 90 days of filing), or a hearing (appear before the judge, with evidence allowed within 90 days of the hearing). A veteran can also move between lanes, and going Lane 1 then Lane 3 is common. The diagram and Table 27-1 below match the veteran's exact situation to a lane.



File within one year of the decision to keep the effective date.
All three lanes start at va.gov/decision-reviews/

Figure 27-1. Pick the lane by what the veteran has: new evidence goes to a Supplemental Claim, a misread of the existing record goes to Higher-Level Review, and a judge's review goes to a

Board Appeal.

Table 27-1. Which lane fits your situation.

If the situation is...	Use this lane	New evidence?	What to file
A nexus letter, new records, or buddy statements are not in the original file	Supplemental Claim (Lane 1)	Yes — must be "new and relevant"	VA Form 20-0995 + the new evidence
The rater misread the evidence, applied the wrong reg, or made a clear error	Higher-Level Review (Lane 2)	No	VA Form 20-0996; list the specific errors for the informal conference
A judge's independent review of the existing record is wanted, fastest	Board Appeal — Direct Review (Lane 3)	No	VA Form 10182; select Direct Review docket
A written brief or new evidence should go to the judge	Board Appeal — Evidence Submission (Lane 3)	Yes — within 90 days of filing	VA Form 10182; submit within the 90-day window
Testimony before a Veterans Law Judge is wanted (in person, video, or at a VA facility)	Board Appeal — Hearing (Lane 3)	Yes — within 90 days of the hearing	VA Form 10182; request hearing docket
Higher-Level Review failed and new evidence now exists	Supplemental Claim → then Board if needed	Yes at Lane 1	VA Form 20-0995, then 10182
Higher-Level Review failed and there is no new evidence	Board Appeal (Lane 3)	Per sub-option	VA Form 10182

Two judgment calls worth getting right: new evidence belongs in Lane 1, not the Board — sending it straight to the Board is slower and can cost effective-date protection. And Lane 2 only helps if the file was already good — a senior reviewer reads the same record, so if the evidence was thin, Higher-Level Review won't fix it; that's a Supplemental Claim. Be honest about whether the VA misread the file or the file itself was the problem.

File the Lane

Each lane has its own page on VA.gov where a veteran files online or downloads the form. A Supplemental Claim goes through va.gov/decision-reviews/supplemental-claim/ on VA Form 20-0995; a Higher-Level Review through va.gov/decision-reviews/higher-level-review/ on VA Form 20-0996; and a Board Appeal through va.gov/decision-reviews/board-appeal/ on VA Form 10182, the Notice of Disagreement. Form numbers and versions change over time, but the lane page always links the current one. An accredited VSO will file any of these for free and knows the lanes cold, so use one before paying anybody (Ch. 36 — VSOs, Attorneys, and Claim Sharks).

Keep the Chain Timely (Where the Money Is)

Lane movement preserves the original effective date only when every filing is timely. Each decision — original, Higher-Level Review, Board — restarts a one-year clock; file the next step inside it and the effective date stays locked to the original claim. Let the window lapse at any step and effective-date protection is lost at that step. That protection is real back pay, often the largest dollar figure in the whole fight.

Claim Sharks Hunt Here

The appeals stage is where predatory operators target veterans. They charge fees to file forms that are free, promise outcomes no legitimate rep can guarantee, and sometimes file the wrong lane — which can cost a veteran the effective date. The only legitimate help is an accredited VSO, an accredited attorney, or a VA-accredited claims agent. How to tell them apart and find one is in Ch. 36 — VSOs, Attorneys, and Claim Sharks.

Traps That Cost Veterans Money

- Sending new evidence to the Board instead of filing a Supplemental Claim — slower, and it can drop effective-date protection.
- Filing Higher-Level Review when the real problem was missing evidence. A senior reviewer can't add what isn't there.
- Letting the one-year clock lapse at any step in the chain and silently losing the original effective date.
- Paying a claim shark to file a free form, or letting one pick the wrong lane.
- Using a stale form version. File from the lane's va.gov page so the current form is the one that gets submitted.

The Rule, Briefly

The three lanes and the one-year window come from 38 CFR § 3.2500: within a year of a decision a veteran may elect a Higher-Level Review or a Board appeal, and a veteran may file a Supplemental Claim at any time. The effective-date protection is in § 3.2500(h)(1) — continuously pursue the issue with timely filings and the effective date stays fixed to the original claim (receipt or entitlement, whichever is later). And the "new and relevant" standard for a Supplemental Claim is 38 CFR § 3.2501: the evidence has to be both new (not already in the record) and relevant (it tends to prove or disprove a fact at issue), after which the agency of original jurisdiction readjudicates. Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

Do This Now

1. Calendar the one-year deadline from the decision date the day the letter arrives.
2. Use Table 27-1 to match the veteran's situation to a lane — be honest about whether there's new evidence or just a misread file.
3. File at the lane's va.gov page: supplemental-claim, higher-level-review, or board-appeal under va.gov/decision-reviews/.
4. For a veteran chaining lanes, file each next step inside its own one-year window to keep the effective date.
5. Get an accredited VSO to file it free before paying anyone (Ch. 36).

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.2500 — Review of decisions; AMA lanes, one-year window, continuously pursued effective dates. <https://www.ecfr.gov/current/title-38/section-3.2500>

- 38 CFR § 3.2501 — Supplemental claims; new-and-relevant evidence standard.
<https://www.ecfr.gov/current/title-38/section-3.2501>
- 38 CFR § 3.156 — New evidence; § 3.156(d) links the supplemental-claim framework.
<https://www.ecfr.gov/current/title-38/section-3.156>
- 38 U.S.C. § 5104B — Higher-level review by the agency of original jurisdiction.
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5104B&num=0&edition=prelim>
- VA.gov — Decision reviews and appeals (overview + all three lanes). <https://www.va.gov/decision-reviews/>
- VA.gov — Supplemental Claim (file, Form 20-0995). <https://www.va.gov/decision-reviews/supplemental-claim/>
- VA.gov — Higher-Level Review (file, Form 20-0996). <https://www.va.gov/decision-reviews/higher-level-review/>
- VA.gov — Board Appeal (file, Form 10182). <https://www.va.gov/decision-reviews/board-appeal/>
- Ch. 26 — Reading the Rating Decision Letter (effective dates, the one-year window); Ch. 36 — VSOs, Attorneys, and Claim Sharks (accredited representation).

Ch. 28 — Increasing an Existing Rating

BLUF: When a service-connected condition gets worse, a veteran can file for a higher rating to match it — and the timing is worth money. Under 38 CFR § 3.400(o)(2), the effective date can reach back up to a year before filing, but only if a dated medical record pins when the condition worsened. The catch: filing triggers a re-exam, and a re-exam that finds improvement can lower the rating instead. So file when the condition is genuinely worse and the evidence proves it, document the worsening date early, and know which ratings are protected before disturbing them. This chapter is how.

The Three Gates Before Filing

A rating isn't carved in stone. Each Diagnostic Code has tiers (10, 30, 50, 70, 100%), and a condition sitting at 30% can move up if it's genuinely gotten worse. But a claim for increase is a new claim with a fresh burden of proof, not a renewal, so three things should all be true before filing. First, the veteran has to be clearly worse, not "about the same" — symptoms that used to be manageable now eat into daily function or work. Second, the evidence has to back that up, whether treatment records, a doctor's note, or a recent diagnosis showing the worse picture, because the VA won't take the veteran's word for it. And third, the worsening has to actually reach the next tier: if the veteran is at 30% and the evidence still only supports 30%, the claim fails, so read the criteria for the next level on the veteran's Diagnostic Code (Ch. 5 — The Rating Schedule (VASRD) and Diagnostic Codes) and confirm the veteran's symptoms meet it.

Document the Worsening Date (Where the Money Is)

Increase claims break the normal effective-date rule, and they break it in the veteran's favor. Normally the effective date is the day of filing, but for an increase § 3.400(o)(2) lets the VA reach back to the earliest date it's factually ascertainable that the condition worsened, as long as the claim is filed within a year of that date. So if the condition got worse in January but the claim isn't filed until November, the effective date can be January — ten extra months of back pay — *provided a dated record pins the worsening to January*. A doctor's visit that month noting the condition "has significantly worsened" is worth real money; an undocumented claim filed in November with nothing earlier defaults to the November date. That's why the smart move is the opposite of what most veterans do: see a doctor when the condition worsens, not just before filing, because that dated note is what the back pay flows from.

File It

Lock the clock the same day with an Intent to File on VA Form 21-0966 (online at va.gov, or the form from va.gov/find-forms/about-form-21-0966/), which freezes the earliest possible effective date while a veteran assembles evidence; the clock then runs from the ITF date or the factually-ascertainable date, whichever is later. Then file the increase itself on va.gov/disability/file-disability-claim-form-21-526ez/, marking it as a claim for increase on an existing service-connected condition, and attach the current evidence showing the worse level, including that dated record. A Supplemental Claim on VA Form 20-0995 also works for a veteran with new and relevant evidence (Ch. 27 — The Appeals Process Under the AMA). When to file and what counts as worsening is laid out at va.gov/disability/how-to-file-claim/when-to-file/.

The Re-Exam Cuts Both Ways

Filing for an increase almost always triggers a Compensation and Pension re-exam, and it isn't optional — skipping it risks a denial. That exam is a fresh snapshot of where the veteran is now, and if the examiner decides the veteran has actually improved, the rating can go *down*. So walk in prepared the way Ch. 19 — The C&P Exam: What to Expect and How to Prepare describes: describe the worst days honestly and bring current records.

Before filing, know whether the rating about to be disturbed is protected. A rating held five years or more gets heightened protection under § 3.344, where the VA has to show sustained material improvement before it can reduce, and a different examiner's opinion alone doesn't establish that; the protection survives an increase claim, but the re-exam is the opening the VA would need. A 100% rating is harder still: it can't be reduced without an exam showing material improvement under the ordinary conditions of life (§ 3.343), meaning improvement while working or seeking work, not from rest. A 100% or permanent-and-total rating carries the strongest protection there is, so think hard before disturbing one (Ch. 29 — Protected Ratings, with the reduction mechanics in Ch. 37 — Avoiding a Rating Reduction).

Two related routes are worth weighing instead of, or alongside, an increase. If the condition keeps a veteran from working, TDIU may apply, which pays at the 100% rate without a 100% schedular rating (Ch. 14 — TDIU: Paid at 100% Without a 100% Rating). And if the worsened condition has caused a new problem — a knee that changed a veteran's gait and wrecked a hip — that's a separate secondary claim, not part of the increase (Ch. 25 — Secondary Conditions: The Underused Multiplier).

Traps That Cost Veterans Money

- Filing with no dated record of when the condition worsened, which forfeits the one-year lookback and drops the effective date to the filing date.
- Filing when the condition is only "about the same," which hands the re-exam a chance to find improvement and cut the rating.
- Disturbing a stable 5+ year or 100%/P&T rating without strong evidence of worsening, inviting a reduction review.
- Skipping or no-showing the C&P re-exam, which is treated as a denial.
- Treating a new secondary condition as part of the increase instead of filing it separately.

The Rule, Briefly

The increase effective-date rule is 38 CFR § 3.400(o)(2): the earliest date it's factually ascertainable the disability increased, if the claim or ITF arrives within a year of that date, and otherwise the date of receipt. The stabilized-rating protection is § 3.344 — ratings continued five years or more aren't reduced on a single exam without evidence of sustained improvement — and the total-rating protection is § 3.343(a), which keeps a total rating from being reduced without an exam showing material improvement under the ordinary conditions of life. Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

Do This Now

1. Confirm all three gates honestly before filing — especially that the veteran's symptoms meet the next tier.
2. Get a dated medical record now that pins when the condition worsened (the § 3.400(o)(2) money date).

3. File an Intent to File (21-0966) today to lock the effective-date clock.
 4. File the increase on [va.gov/disability/file-disability-claim-form-21-526ez/](https://www.va.gov/disability/file-disability-claim-form-21-526ez/), marked as an increase, with current evidence attached.
 5. Before filing, check whether the rating is protected (5+ years or 100%/P&T) — Ch. 29 — and prep for the re-exam — Ch. 19.
-

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.400(o) — Effective dates; (o)(2) governs the one-year lookback for increase claims. <https://www.ecfr.gov/current/title-38/section-3.400>
- 38 CFR § 3.344 — Stabilization of disability evaluations; 5+ year reduction protection. <https://www.ecfr.gov/current/title-38/section-3.344>
- 38 CFR § 3.343 — Continuance of total disability ratings. <https://www.ecfr.gov/current/title-38/section-3.343>
- 38 U.S.C. § 5110(b)(3) — Statutory authority for the increase-claim effective date. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5110&num=0&edition=prelim>
- VA.gov — When to file (increased claim guidance). <https://www.va.gov/disability/how-to-file-claim/when-to-file/>
- VA.gov — File for disability (Form 21-526EZ). <https://www.va.gov/disability/file-disability-claim-form-21-526ez/>
- VA Form 21-0966 — Intent to File. <https://www.va.gov/find-forms/about-form-21-0966/>
- Ch. 5 / Ch. 14 / Ch. 19 / Ch. 25 / Ch. 27 / Ch. 29 / Ch. 37 — cross-references named inline.

Ch. 29 — Protected Ratings

The Rules That Lock In What a Veteran Has Earned

BLUF: Federal law builds a set of time-based shields around a veteran's disability rating. Once a service connection or rating has been in place long enough, the VA's ability to reduce or sever it shrinks dramatically. The 5-year rule requires proof of sustained improvement before any reduction. The 10-year rule makes service connection nearly permanent. The 20-year rule locks in the rating floor for life. Permanent & Total (P&T) status removes the threat of future re-exams entirely. Veterans who know these protections can defend them and avoid the trap of reopening a claim that didn't need to be touched.

Table 29-1 maps each time-based protection to its threshold, governing regulation, and what the VA must prove before a reduction can stand.

The longer a rating is held, the harder it is to touch →



Figure 29-1. Time-based protections stack and get stronger: at 5 years the VA must prove sustained improvement, at 10 it can't sever service connection, at 20 it can't drop below the floor, and a Permanent & Total rating ends re-exams.

Table 29-1. Rating and Service-Connection Protections by Time in Effect.

Rule	If the rating / service connection has been in effect...	Protection	What the VA must show to change it
1	5+ years (stabilized rating)	VA cannot reduce on a single exam; must review the entire medical-industrial record (38 CFR § 3.344(a)). Does not apply to ratings not yet stabilized or expected to improve (§ 3.344(c)).	Sustained improvement under ordinary conditions of life, supported by the complete examination record, not just one favorable exam.
2	10+ years (service connection)	VA cannot sever service connection entirely (38 CFR § 3.957; 38 U.S.C. § 1159). Rating percentage can still be reviewed; only the existence of service connection is locked. Protection extends to DIC and death-compensation claims.	Fraud, or clear proof from military records that the veteran never had the required service or qualifying character of discharge.

Rule	If the rating / service connection has been in effect...	Protection	What the VA must show to change it
3	20+ years (rating floor)	VA cannot reduce the rating below the lowest level continuously held during that 20-year period, ever (38 CFR § 3.951(b); 38 U.S.C. § 110). The 20-year clock runs from the effective date of the evaluation, not the claim-filed date.	Fraud only. No other basis survives. (the effective date is stated in the decision letter)
4	Permanent & Total (P&T); no time threshold; the VA must formally designate the condition permanent	No future scheduled reexaminations. The reexamination cycle ends entirely, not just the current rating period. Unlocks additional benefits (see Ch. 30 — What a 100% P&T Rating Unlocks).	Not applicable. The VA schedules no future exams once P&T is granted; a reduction would require a separate formal action.

The Ground Truth

Every VA rating starts out as provisional. The VA can reexamine a veteran, compare the new findings to the old ones, and lower the rating if the condition has improved. That is the default. But the law does not let that threat hang over a veteran forever. The longer a rating stays in place, the harder it becomes for the VA to reduce it.

There are four layers of protection, each one time-triggered, each one specific about what the VA must prove before a reduction can happen.

Layer 1 — The 5-Year Rule (Stabilized Rating)

A rating that has been in effect for five or more years is called a *stabilized* rating. At that point, the VA cannot reduce it based on a single exam. The regulation (38 CFR § 3.344) requires that the whole record — every exam, every treatment note, the full medical-industrial history — be reviewed. For conditions that tend to fluctuate or have good days and bad days (such as heart disease, asthma, or psychiatric conditions), a single improved examination is not enough. The VA must show that *sustained* improvement has taken place under *ordinary conditions of life* — meaning the veteran got better in real daily life, not just during a period of rest or hospitalization.

If the VA cannot show that, the reduction does not happen.

Note: the 5-year rule applies to ratings that have *stabilized*. It does not protect ratings for conditions that have *not* stabilized and are still expected to improve. For those, a reexamination showing improvement can still lead to a reduction.

Layer 2 — The 10-Year Rule (Service Connection Protection)

After service connection has been in place for ten or more years, the VA cannot sever it (strip the veteran of service connection entirely). The only two exceptions are fraud, or clear proof from military records that the veteran never had the required service or character of discharge.

This protection matters because it separates two things that often get confused: *service connection* and the *rating percentage*. The 10-year rule locks in service connection. The VA can still evaluate whether the condition has improved and potentially reduce the rating percentage. But it cannot declare that the condition was never service-connected in the first place. That door closes at ten years.

Layer 3 — The 20-Year Rule (Rating Floor)

If a disability has been continuously rated at or above a certain level for twenty or more years, the VA cannot reduce it below the lowest rating it has held during that period — ever. The only exception is fraud. This is the strongest rating protection in the CFR short of P&T. Once a rating hits its twentieth anniversary, the floor is permanent.

The 20-year rule also protects the continuity of the rating. The twenty-year clock starts from the *effective date* of the evaluation — confirm that date in the decision letters, because it is not always the same as the date the original claim was filed.

Layer 4 — Permanent & Total (P&T)

Some veterans reach a point where the VA declares their condition permanent. *Permanent* means the condition is not expected to improve. When a veteran is both *permanently* and *totally* disabled (rated at 100%, or granted Individual Unemployability at the 100% level with no expectation of improvement), the VA schedules no future reexaminations. There is no next exam to worry about.

P&T is the strongest position a rated veteran can hold. It ends the reexamination cycle entirely, not just the current rating's protection. P&T also unlocks a range of additional benefits (Chapter Thirty covers what P&T opens up).

A Separate Tool — CUE (Clear and Unmistakable Error)

CUE is not a time-based shield. It is a narrow legal doctrine that allows a veteran to challenge a *final* rating decision that was undebatably wrong on the law or the facts as they existed at the time the decision was made. The key word is *undebatable*. A difference of medical opinion is not CUE. A better legal argument that developed later is not CUE.

The Supreme Court addressed this directly in *George v. McDonough* (2022). In that case, veterans argued that a later change in how the law was interpreted should open old decisions to CUE challenges. The Court held that it does not. A subsequent change in legal interpretation is not CUE. A decision can only be CUE if it was plainly wrong under the law as it read at the time. (The legal and evidentiary standards for CUE are covered in Chapter Nine.)

The Trap: Reopening What Does Not Need to Be Touched

These protections only hold as long as the veteran does not disturb the underlying record. Filing for an increase on a stabilized or protected rating reopens the VA's authority to look at that condition again. The VA can find improvement even when the veteran only asked for an increase. This is a genuine risk with ratings at lower thresholds (such as 10% or 20%) where the condition is stable and the veteran's primary income driver is a different, higher-rated condition.

Before filing anything that touches an existing protected rating, veterans should weigh the upside against the risk of a reduction. This is particularly important when the existing rating has been in place long enough to carry 5-year or 20-year protections. Ch. 37 — Avoiding a Rating Reduction covers the mechanics of reduction decisions and how to respond to them. Ch. 28 — Increasing an Existing Rating covers the relationship between increase claims and rating stability.

The Rule, Briefly

Three regulations draw three bright lines, and each one gets harder to cross the longer a veteran holds a rating. The 5-year rule (38 CFR § 3.344(a), (c)) means a rating held at the same level for five or more years can't be reduced on a single exam: the VA has to review the entire record and show sustained, real-world improvement, not just one better result, and it can't base a cut on an exam less thorough than the one that set

the rating. That protection covers stabilized ratings rather than ones still expected to improve, so it works as a procedural floor instead of a blanket shield. The 10-year rule (38 CFR § 3.957, authority 38 U.S.C. § 1159) means that once service connection has been in effect for ten or more years, it can't be severed except on a showing of fraud or clear military-record proof the person lacked the required service or discharge. And the 20-year rule (38 CFR § 3.951(b), authority 38 U.S.C. § 110) means a disability continuously rated at or above a level for twenty or more years can't be reduced below that level except for fraud. Fraud is the only door that stays open past each line, and it's a high bar that's rarely met. The verbatim text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

Pull the decision letters, find the effective dates, and calculate the anniversaries — five years, ten years, twenty years. These protections activate automatically by law, but a veteran who doesn't know the dates can't invoke them when the VA comes knocking.

A protected rating can still be reviewed; the 5-year rule doesn't end reexaminations, it raises the evidentiary bar, so the VA has to look at the whole record instead of just the latest exam and show sustained improvement in ordinary daily life. The 10-year service-connection protection reaches survivors too, because the regulation explicitly covers Dependency and Indemnity Compensation (DIC) and death compensation, so a widow or dependent doesn't lose DIC just because service connection was old and the VA has a new opinion. The 20-year floor runs from the effective date of the evaluation rather than the claim date, which means two veterans can file the same day and hit their 20-year anniversary on different dates depending on when the ratings were granted; confirm those effective dates in the decision letters.

Filing for an increase on a protected rating carries real risk. When a veteran asks the VA to raise a rating, the VA schedules a new exam and looks at the condition fresh, and if that exam shows improvement the rating can drop even though the veteran only asked for more, so anyone with a stable, low-percentage rating inside a protection window should think hard before filing anything. Reaching Permanent & Total takes the reexamination threat off the table entirely, which is genuine financial security, so pursuing P&T where the medical record supports it is a legitimate and important goal. CUE stays a last resort: it requires proof the original decision was undebatably wrong under the law as it existed at the time, and a stronger argument, a better exam, or a later change in VA policy won't meet it, so a veteran who believes an old decision was wrong should ask a VA-accredited claims agent or attorney whether the facts actually clear the CUE standard.

Action Steps

The drill is short. Pull every rating decision letter and log the effective date for each service-connected condition, then calculate the 5-, 10-, and 20-year anniversaries now, before any re-exam notice lands, because these protections only help a veteran who knows to invoke them. Before filing anything that touches a stable, protected rating, talk to an accredited VSO or attorney, since filing for an increase reopens the VA's authority to examine and possibly reduce; weigh the upside against that risk first. If a re-exam notice does arrive on a protected rating, respond in writing right away and cite the protection that applies (§ 3.344, § 3.951, or § 3.957); don't ignore it, and don't attend without knowing which protection applies. Ch. 37 — Avoiding a Rating Reduction has the response mechanics, Ch. 28 — Increasing an Existing Rating covers how increase claims interact with rating stability, and Ch. 9 — Landmark Court Cases That Shaped Veteran Rights covers the CUE standard. And pursue P&T status where the medical record supports it, since it ends the re-examination cycle entirely and unlocks the cascade described in Ch. 30 — What a 100% P&T Rating Unlocks.

Cited Sources

Verify all citations and regulatory text against current primary sources before acting.

- 38 CFR § 3.344 — Stabilization of disability evaluations (5-year rule). <https://www.ecfr.gov/current/title-38/section-3.344>
- 38 CFR § 3.951 — Preservation of disability ratings (20-year rule). <https://www.ecfr.gov/current/title-38/section-3.951>
- 38 CFR § 3.952 — Protected ratings (1925 schedule protections). <https://www.ecfr.gov/current/title-38/section-3.952>
- 38 CFR § 3.957 — Service connection (10-year protection). <https://www.ecfr.gov/current/title-38/section-3.957>
- 38 U.S.C. § 110 — Preservation of ratings (statutory authority for § 3.951). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section110&num=0&edition=prelim>
- 38 U.S.C. § 1159 — Protection of service connection (statutory authority for § 3.957). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1159&num=0&edition=prelim>
- *George v. McDonough*, 596 U.S. 740 (2022) — A subsequent change in legal interpretation does not constitute Clear and Unmistakable Error; CUE requires the original decision to be undebatably wrong under the law as it existed at the time. <https://www.courtlistener.com/opinion/6477906/george-v-mcdonough/>
- VA.gov — *Permanent and Total disability rating*. <https://www.va.gov/disability/about-disability-ratings/>

Ch. 30 — What a 100% P&T Rating Unlocks

BLUF: A total, permanent rating pays a monthly check, and the check is the smallest part of it. The same rating opens health coverage for the family, school for the dependents, full dental care, a waived home-loan fee, and a faster Social Security decision. It also starts two clocks that most veterans never learn about, and one of them can pay a surviving spouse for life. None of it is automatic. Each piece takes its own application, and the VA sends no list.

The Play

1. Read the decision letter and find out whether the rating is total, permanent, or both. That answer decides which doors open.
2. Learn what the rating is already doing on its own: the reexamination rules and the two protection clocks.
3. Apply for the family benefits, since these are the largest and the VA will not start them.
4. Apply for the money already owed, which usually means fixing the dependent record.
5. Go outside the VA for the state property-tax exemption and for Social Security.
6. Stop paying for things the rating already covers.

Step 1 — Find out which findings the rating actually carries

The VA makes two separate findings, and veterans blur them together constantly.

Total means the impairment is severe enough that the average person could not hold a substantially gainful occupation. It is about severity. The rule says plainly that total disability may or may not be permanent.

Permanent is a second, different finding. It means the impairment is reasonably certain to continue for the rest of the veteran's life. It is a prediction about the future, not a measure of how bad things are today.

Both findings together are what people mean by P&T. This matters because several of the biggest benefits in this chapter require permanent and total, not a 100% rating alone.

The place to look is the rating decision letter. It states the permanent and total finding when the VA has made it. Veterans should keep that letter somewhere reachable, because nearly every program below asks for it.

Table 30-1. What each benefit actually requires.

Rule	If the situation is	Outcome	Evidence/documents needed	Do this next
1	Rated 100% schedular or TDIU, permanence not found	Health priority, dental, funding-fee waiver, dependent add-ons, SMC, Social Security expedite all still available	Rating decision letter	Work Steps 3–6; skip the P&T-only rows
2	Rated total and permanent (P&T)	Everything in Rule 1, plus CHAMPVA, Chapter 35 (DEA), and Space-A travel	Rating letter stating permanent and total	Work every step
3	Paid at the total rate through TDIU	Priority Group 1 applies by name; where the VA found the TDIU permanent, the P&T-only benefits open too	Rating letter	Read the letter for a permanence finding

Rule	If the situation is	Outcome	Evidence/documents needed	Do this next
4	Any compensable service-connected rating, 0% to 100%	Commissary, exchange, and MWR access	Service-connected rating	See the Traps section; this is not a 100% benefit
5	Family is eligible for TRICARE (e.g. a military retiree's family)	CHAMPVA is barred	—	Use TRICARE; do not file for CHAMPVA

Step 2 — Learn what the rating already does without an application

Two things are running in the background from the day the rating takes effect. Neither requires a form.

Reexaminations mostly stop. The rule lists the situations where the VA does not schedule a periodic future exam. Those include a disability established as static, findings that have not materially improved in five years or more, a disease that is permanent with no likelihood of improvement, and, notably, veterans over 55 years of age except in unusual circumstances. Most P&T veterans land in at least one of those.

Here is the honest limit, and veterans should hear it straight. The same regulation says these are general guidelines, and they do not take away the VA's authority to order a reexamination at any time. The practical effect is that routine exams stop. It is not a legal shield that makes an exam impossible.

A total rating is hard to cut. The rule says a total rating will not be reduced, absent clear error, without an examination showing material improvement. It goes further, and this is the part that protects veterans: the VA must consider whether the improvement holds up under the ordinary conditions of life, meaning while the veteran is working or actively seeking work. Feeling better during a stretch of rest is not material improvement.

Table 30-2. The two clocks that run in the background.

Rule	If the situation is	Outcome	Effective date
1	A rating has been continuously at or above a given evaluation for 20 years or more	It cannot be reduced below that evaluation, except on a showing that the rating was based on fraud	Counted from the evaluation's effective date
2	A veteran was continuously rated totally disabling for 10 years or more immediately before death	Survivors may receive Dependency and Indemnity Compensation even though the death was not caused by the service-connected condition	Counted to the date of death
3	A veteran was continuously rated totally disabling for 5 years or more from discharge, then died	Same survivor outcome as Rule 2	Counted from release from active duty
4	A former prisoner of war was continuously rated totally disabling for 1 year or more before death	Same survivor outcome as Rule 2	Counted to the date of death

Rule 2 deserves a plain restatement, because it is the most valuable thing in this chapter and almost nobody talks about it. A veteran holds a total rating for ten years. The veteran later dies of something completely unrelated to the service-connected condition. The surviving spouse may still be paid. The catch is in the same statute: the spouse must have been married to the veteran for at least one year before the death, or have had a child with the veteran.

That makes the effective date of a total rating more than a back-pay question. It is the start of a clock that can pay a spouse for life, and it is a reason to pin the earliest correct effective date (see Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates).

Step 3 — Apply for the family benefits

These are the largest, and both are P&T-only.

Health coverage for the family (CHAMPVA). The statute lets the VA provide medical care to the spouse or child of a veteran with a total disability, permanent in nature, from a service-connected condition. It is not the veteran's own care; the veteran uses VA health care. The VA shares the cost of the family's care.

Check one thing first. A family eligible for TRICARE cannot use CHAMPVA. The VA states it directly: eligible for or enrolled in TRICARE means no CHAMPVA. Military retirees' families are the common case, and this is where a lot of published advice sends veterans to file a form they cannot use.

The application is VA Form 10-10d. It goes in online, by mail, or by fax. Mail goes to the VHA Office of Community Care, CHAMPVA Eligibility, PO Box 137, Spring City, PA 19475. Guides that still name a Denver office are out of date, and mail sent there is mail that does not arrive. <https://www.va.gov/health-care/family-caregiver-benefits/champva/>

School for the dependents (Chapter 35 / DEA). The statute makes a child or spouse an eligible person when the veteran has a total disability permanent in nature from a service-connected disability. The statute ties that disability to a period of qualifying service, so unusual service histories need a closer read.

Chapter 35 can pay for college, vocational training, apprenticeships, and on-the-job training. The monthly amount depends on the training type and on full-time or part-time attendance.

Two things veterans get wrong here. The dependent is the applicant, not the veteran. And Chapter 35 is a separate entitlement from the veteran's own GI Bill, so using one does not spend the other. The form is VA Form 22-5490, filed online or mailed to the regional processing office for the state where the school is. After approval, the dependent must verify enrollment each term or the payments stop.

<https://www.va.gov/education/survivor-dependent-benefits/dependents-education-assistance/>

Step 4 — Fix the dependent record and collect the money already owed

Once a veteran is rated 30% or higher, the VA pays more for qualifying dependents: a spouse, dependent children, and a dependent parent. At the total rate those additions are large, and they are the most commonly forfeited money in this chapter.

Using the rates effective December 1, 2025: a veteran at 100% with no dependents receives \$3,938.58 a month. The same veteran with a spouse, one child, and a dependent parent receives \$4,495.23. That is a difference of \$556.65 every month, or \$6,679.80 a year, between two veterans with identical ratings for identical conditions. The only difference is whether the VA knows who lives in the house.

Veterans lose this by marrying, having a child, or taking in a dependent parent and never reporting it. The fix is VA Form 21-686c. <https://www.va.gov/view-change-dependents/>

Compensation above 100%. A total rating is not the top of the scale. Special Monthly Compensation pays above the 100% rate for specific severe situations, such as loss of use of a limb, blindness, or needing the regular aid and attendance of another person. It runs on its own ladder of letters, each with its own rate. SMC is not automatic and it is the benefit most often missed, so any veteran with an amputation, serious vision

loss, or aid-and-attendance needs should have a VSO run the SMC criteria against the file (see Ch. 31 — Special Monthly Compensation (SMC)). <https://www.va.gov/disability/compensation-rates/special-monthly-compensation-rates/>

Step 5 — Go outside the VA

The state property-tax exemption. This can be worth more per year than everything else in this chapter, and the VA has no part in it. These are state programs written by state legislatures. The required rating, the exempted amount, the filing deadline, and whether the state recognizes TDIU all differ from state to state. There is no national figure, and any source that quotes one is describing some other veteran's state.

To find it: search for the home state's department of veterans affairs, or the state's revenue or taxation agency, and look for the veteran property-tax exemption. Those two offices own it, and either one will route a veteran to the right place. The application needs the rating letter showing the permanent and total finding plus the state's own form. The deadline is a state deadline, and missing it usually costs a full year (see Ch. 33 — State-Level Veteran Benefits).

A faster Social Security decision. Social Security expedites disability claims filed by veterans with a VA rating of 100% P&T. The rating does not decide the claim. Social Security says so directly: a 100% P&T rating does not guarantee Social Security disability benefits, because the programs use different criteria. Social Security requires a severe impairment expected to last at least a year or to result in death, severe enough that the person could not perform any substantial work. Receiving VA compensation does not reduce Social Security benefits.

The expedite is not automatic, and this is the step nobody publishes. The veteran must apply, and must self-identify. Social Security's instruction is to identify as a "veteran rated 100% P&T" when applying, and when applying online, to enter "Veteran 100% P&T" in the Remarks section of the application. The veteran also provides the VA notification letter verifying the rating. Without that, the claim is processed as an ordinary claim. <https://www.ssa.gov/pubs/EN-05-10565.pdf>

Step 6 — Stop paying for what the rating already covers

Full dental care. Veterans whose service-connected disabilities are rated 100% by schedular evaluation, or who are entitled to the 100% rate by reason of individual unemployability, may be authorized any needed dental treatment. That is Class IV dental, and it is close to unknown among veterans who reach a total rating. Note the wording carefully: this one turns on 100% or TDIU, and does not require permanence. <https://www.va.gov/health-care/about-va-health-benefits/dental-care/>

The front of the health care line. Veterans rated 50% or greater, and veterans found unemployable, are placed in Priority Group 1, the highest tier, with the shortest waits and the lowest copayments for service-connected care. Priority Group 1 is not enrollment. A veteran who is not already in the VA health care system still has to apply (see Ch. 34 — VA Healthcare Enrollment & Priority Groups). <https://www.va.gov/health-care/apply/application/introduction>

The home-loan funding fee. The VA home-loan funding fee may not be collected from a veteran who is receiving compensation. On a home purchase this is commonly thousands of dollars. It is not a discount a lender volunteers, so veterans should raise it before closing. <https://www.va.gov/housing-assistance/home-loans/funding-fee-and-closing-costs/>

Space-available military flights. This one genuinely turns on permanence. The statute lists veterans with a permanent service-connected disability rated as total among those eligible for space-available travel on Department of Defense aircraft. The same statute sets the limits, and veterans should know them before planning a trip. A veteran flying under this authority may not be given priority over active-duty members or their dependents. The military has no obligation to modify aircraft to accommodate a disability. The flight commander still decides who boards. And the program itself is discretionary. It is a real benefit and it is not guaranteed transportation.

Traps That Cost Veterans Money

Assuming commissary access came with the total rating. The law says a veteran with a service-connected disability may use commissary stores and MWR facilities on the same basis as a retired member. It does not say a total one, and it does not say a permanent one. Any service-connected rating carries it, including 10%. Veterans reach a total rating, assume the benefit is new, and never realize they could have been shopping there since their first grant, sometimes years earlier. *Fix: use it now, and stop counting it as a P&T benefit.*

Filing for CHAMPVA while TRICARE-eligible. A retiree's family is barred from CHAMPVA. *Fix: check TRICARE eligibility first.*

Never reporting a dependent. The rating was high enough the whole time; the record never caught up. *Fix: VA Form 21-686c, and update it after every marriage, birth, or dependent parent moving in.*

Applying to Social Security without the flag. The expedite exists, but a claim that does not identify the veteran as rated 100% P&T is processed like any other. *Fix: say it on the phone, or type "Veteran 100% P&T" in the Remarks field online, and send the VA letter.*

Paying the home-loan funding fee anyway. *Fix: raise the exemption with the lender before closing.*

Treating a 100% rating as if it were P&T. CHAMPVA, Chapter 35, and Space-A need permanence. *Fix: read the decision letter before applying.*

Missing the state tax deadline. It costs a year. *Fix: find the state's deadline the same week the rating letter arrives.*

Not knowing the 10-year clock exists. A veteran who understands it treats the effective date of a total rating as a survivor benefit, and not only as back pay. *Fix: see Ch. 16 and pin the earliest correct effective date.*

The Rule, Briefly

Every citation below is indexed with a plain-English summary and a direct primary-source link in Appendix A1 — Master Citation Index.

- Total and permanent total ratings, and the permanence test — 38 C.F.R. § 3.340
- Reexaminations, and when no periodic exam is scheduled — 38 C.F.R. § 3.327
- Continuance of total ratings, material improvement — 38 C.F.R. § 3.343
- Preservation of ratings after 20 years — 38 C.F.R. § 3.951
- DIC where the veteran was rated totally disabling — 38 U.S.C. § 1318
- CHAMPVA authority — 38 U.S.C. § 1781
- Chapter 35 / DEA eligible persons — 38 U.S.C. § 3501
- Additional compensation for dependents — 38 U.S.C. § 1115
- Special Monthly Compensation authority — 38 U.S.C. § 1114

- VA health care priority groups — 38 C.F.R. § 17.36
- Class IV dental eligibility — 38 C.F.R. § 17.161
- Home-loan funding fee waiver — 38 U.S.C. § 3729
- Commissary, exchange, and MWR access — 10 U.S.C. § 1065
- Space-available travel — 10 U.S.C. § 2641b

Field Notes

- Total and permanent are two findings. Total is severity; permanent is a prediction about the future.
- CHAMPVA, Chapter 35, and Space-A need permanence. Dental, Priority Group 1, the funding-fee waiver, dependent add-ons, SMC, and the Social Security expedite do not.
- TDIU counts. The health care rule names unemployability, and Class IV dental names it too.
- Periodic reexaminations stop in the listed situations, including for veterans over 55. The VA still keeps authority to reexamine at any time.
- A total rating is not reduced without an exam showing material improvement that holds up while working or seeking work.
- Twenty years at an evaluation locks it in, short of fraud.
- Ten years at a total rating can pay a surviving spouse even when the death is unrelated, if the marriage lasted at least a year or produced a child.
- Commissary and MWR are not P&T benefits. Any service-connected rating carries them.
- Dependent add-ons at the total rate are worth \$556.65 a month for a spouse, child, and dependent parent, at the rates effective December 1, 2025. Verify the current figure at production time.
- Nothing here is automatic, and the VA sends no list.

Do This Now

1. Pull the rating decision letter. Confirm whether it says permanent and total. Save a copy where it can be reached fast.
2. Look up the home state's veteran property-tax exemption through the state's department of veterans affairs or its revenue agency. Find the deadline first.
3. If the family is not TRICARE-eligible, file VA Form 10-10d for CHAMPVA.
4. If a spouse or child is headed to school or training, have that dependent file VA Form 22-5490.
5. Confirm every dependent is on file. If not, file VA Form 21-686c.
6. If not enrolled in VA health care, apply, then ask about Class IV dental.
7. If applying to Social Security, self-identify as a veteran rated 100% P&T and enter "Veteran 100% P&T" in the Remarks field. Send the VA letter with it.
8. If buying a home, tell the lender the funding fee is waived for a veteran receiving compensation.
9. If there is an amputation, serious vision loss, or aid-and-attendance need, book a VSO appointment for an SMC review.
10. Note the effective date of the total rating. That date starts the 10-year and 20-year clocks.

Cited Sources

Verify all citations and current thresholds against primary sources before acting. CFR text is verified at eCFR; statute at uscode.house.gov. Rates and program rules change.

- 38 C.F.R. § 3.340 — Total and permanent total ratings; the permanence test.
<https://www.ecfr.gov/current/title-38/section-3.340>
- 38 C.F.R. § 3.327 — Reexaminations; situations where no periodic future examination is scheduled.
<https://www.ecfr.gov/current/title-38/section-3.327>
- 38 C.F.R. § 3.343 — Continuance of total ratings; material improvement.
<https://www.ecfr.gov/current/title-38/section-3.343>
- 38 C.F.R. § 3.951 — Preservation of disability ratings (the 20-year rule).
<https://www.ecfr.gov/current/title-38/section-3.951>
- 38 C.F.R. § 17.36 — VA health care enrollment priority groups. <https://www.ecfr.gov/current/title-38/section-17.36>
- 38 C.F.R. § 17.161 — Authorized dental care by class (Class IV at 100%/TDIU).
<https://www.ecfr.gov/current/title-38/section-17.161>
- 38 U.S.C. § 1318 — DIC where the veteran was continuously rated totally disabling.
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1318&num=0&edition=prelim>
- 38 U.S.C. § 1781 — CHAMPVA authority. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1781&num=0&edition=prelim>
- 38 U.S.C. § 3501 — Chapter 35 / DEA eligible persons. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section3501&num=0&edition=prelim>
- 38 U.S.C. § 1115 — Additional compensation for dependents. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1115&num=0&edition=prelim>
- 38 U.S.C. § 1114 — Special Monthly Compensation authority. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1114&num=0&edition=prelim>
- 38 U.S.C. § 3729 — Home-loan funding fee; waiver for veterans receiving compensation.
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section3729&num=0&edition=prelim>
- 10 U.S.C. § 1065 — Commissary, exchange, and MWR eligibility for any veteran with a service-connected disability. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title10-section1065&num=0&edition=prelim>
- 10 U.S.C. § 2641b — Space-available travel; eligibility and limits. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title10-section2641b&num=0&edition=prelim>
- VA.gov — CHAMPVA (eligibility, the TRICARE bar, Form 10-10d, Spring City address).
<https://www.va.gov/health-care/family-caregiver-benefits/champva/>
- VA.gov — DEA / Chapter 35. <https://www.va.gov/education/survivor-dependent-benefits/dependents-education-assistance/>
- VA.gov — VA Form 22-5490 (Dependents' Application for VA Education Benefits).
<https://www.va.gov/find-forms/about-form-22-5490/>
- VA.gov — Veteran compensation rates (rates effective December 1, 2025).
<https://www.va.gov/disability/compensation-rates/veteran-rates/>

- VA.gov — Special Monthly Compensation rates. <https://www.va.gov/disability/compensation-rates/special-monthly-compensation-rates/>
- VA.gov — View or change dependents (Form 21-686c). <https://www.va.gov/view-change-dependents/>
- VA.gov — VA dental care. <https://www.va.gov/health-care/about-va-health-benefits/dental-care/>
- VA.gov — Funding fee and closing costs. <https://www.va.gov/housing-assistance/home-loans/funding-fee-and-closing-costs/>
- VA.gov — Apply for VA health care. <https://www.va.gov/health-care/apply/application/introduction>
- SSA Publication EN-05-10565 — Expedited Processing of Veteran's 100% Disability Claims (May 2021). <https://www.ssa.gov/pubs/EN-05-10565.pdf>
- State veterans affairs and revenue agencies — Property-tax exemptions vary by state; no federal source applies.

Ch. 31 — Special Monthly Compensation (SMC)

Pay Above the Rating Scale

BLUF: Special Monthly Compensation (SMC) is extra monthly pay — above and beyond the normal 0–100% disability rating — for veterans who have suffered specific severe losses that a percentage rating alone cannot capture. The law (38 U.S.C. § 1114) sets out lettered levels: K, L, M, N, O, P, R, S, and T. SMC is one of the most frequently missed benefits in the VA system. Any veteran with a serious loss of a body part or function, or who needs help with daily activities, should ask whether SMC applies. Verify current rates at VA.gov — they adjust annually.

The Ground Truth

The normal VA disability rating system answers one question: *how disabled is this veteran?* It assigns a percentage from 0 to 100 and pays accordingly. That system works well for most conditions.

But some veterans have losses so specific — a hand, a foot, an eye, the ability to care for themselves — that a percentage alone does not cover it. Congress built a second track for those situations. That second track is Special Monthly Compensation, or SMC.

SMC is not a penalty or a gift. It is a separate statutory payment tied to particular facts. A veteran must have a specific qualifying condition (the law names them), and the VA assigns a letter level that determines the additional amount owed. The levels run from K (a single add-on for specific losses) up through L, M, N, O, P, R, and S, with T handling a specialized traumatic brain injury situation at the top.

Two key things to understand before the letters

First: SMC stacks on top of the regular rating. The normal monthly compensation does not go away. A veteran at 70% keeps that 70% check. SMC is an additional amount paid on top. In the case of SMC-K, it can even stack on top of another SMC level.

Second: SMC is badly missed. Veterans and their families often do not know it exists. The VA does not always raise it proactively. A veteran who needs help getting dressed or bathing may be sitting on an unclaimed SMC entitlement for years. This chapter exists to close that gap.

The SMC levels — plain English

SMC-K is the foundational add-on level. It pays extra for the loss or loss of use of one specific body part or function. The statute (38 U.S.C. § 1114(k)) names the qualifying conditions: an anatomical loss or loss of use of one foot, one hand, a creative organ, both buttocks; blindness in one eye with only light perception remaining; complete organic aphonia (inability to speak); deafness of both ears without air or bone conduction; or, for a woman veteran, the anatomical loss of one or both breasts or the loss of use of one or both breasts. A veteran can receive more than one K award if multiple qualifying losses exist, and a K award can also be added on top of higher SMC levels.

SMC-L through O are escalating levels based on combinations of severe losses. The trigger is losing the use of multiple limbs, total blindness, being permanently bedridden, or — critically — needing regular aid and attendance. "Aid and attendance" means the veteran needs another person's help with daily tasks: eating, dressing, bathing, using the toilet. A veteran who can no longer manage basic self-care because of service-connected disabilities may qualify here even without limb loss.

The levels within L through O step up based on what is lost and how many losses are combined. The VA assigns the specific letter by comparing the veteran's situation to a detailed grid spelled out in 38 CFR § 3.350. The intermediate half-steps — L 1/2, M 1/2, N 1/2 — exist for situations that fall between the named levels.

SMC-S (Housebound) is a level specifically for veterans who are substantially confined to their home. Two paths qualify. The first: the veteran has a single service-connected disability rated at 100% *and* at least one additional service-connected disability independently ratable at 60% or more. The second: the veteran is permanently housebound due to service-connected disabilities, even without the 60% add-on. This is sometimes called the "housebound" benefit and is important for veterans who cannot work or leave home because of their conditions. It sits apart from the L–O ladder.

SMC-R is for veterans who need a high level of aid and attendance — care that goes beyond ordinary A&A. SMC-R has two sub-levels. R-1 covers a veteran who already qualifies at the SMC-O/P level and needs regular aid and attendance. R-2 is for a veteran who needs an even higher level of care: personal health-care services provided daily, in the home, by a licensed provider or someone under licensed supervision. R-2 is for veterans whose care needs are so intensive that without home-based services they would require hospitalization or institutional care.

SMC-T covers veterans with severe traumatic brain injury (TBI) who need in-home care at the R-2 level (daily licensed or supervised health-care services) but whose TBI creates care requirements that go beyond that category. The statute (38 U.S.C. § 1114(t)) treats TBI-driven high-level care as its own classification. Veterans with serious TBI-related care needs should ask specifically about SMC-T.

SMC-P is not a separate trigger level. It is the rate the Secretary can authorize when a veteran's circumstances are severe enough to exceed the standard O requirements but not reach the R level. Think of it as the ceiling of the L–O ladder, available when the facts warrant it.

The Rule, Briefly

A few levels carry most of the practical weight. SMC-K (38 U.S.C. § 1114(k)) is a fixed add-on for anatomical loss or loss of use of specific body parts: a creative organ, a hand or foot, blindness in one eye with light perception only, deafness, aphonia, and, for a woman veteran, loss of 25% or more of breast tissue or breast radiation treatment. The statute pays it "independent of any other compensation provided in subsections (a) through (j) or subsection (s)," meaning on top of the regular percentage check, and a veteran can collect multiple K awards for multiple losses. SMC-S (38 U.S.C. § 1114(s), the housebound level) takes a total 100% service-connected disability plus either an additional, independently ratable 60% disability (a separate condition from the one carrying the 100%) or permanent confinement to the home; it pays a fixed monthly amount, so verify the current figure at VA.gov. SMC-L (38 CFR § 3.350(b), the aid-and-attendance ladder) is payable for loss or loss of use of both feet, one hand and one foot, blindness with 5/200 acuity or less, being permanently bedridden, or being "so helpless as to need regular aid and attendance"; that last phrase is broad, and § 3.352 defines the aid-and-attendance need as requiring another person's help with daily physical functions, so L can reach veterans who haven't lost a limb but can't care for themselves. One combination rule runs through all of § 3.350: each qualifying disability has to be separate and distinct, so the same pathology can't be counted twice to climb a level. The verbatim text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

The VA doesn't always identify SMC on its own, so veterans and survivors should ask the question directly: "Does my situation qualify for SMC?" A VSO can run the checklist quickly, and with this benefit, asking the question is most of the battle.

A few things trip veterans up. Loss of use doesn't require amputation: a limb that's useless, with no effective function left, qualifies the same as one that's gone, so veterans with paralysis or severe nerve damage should check the loss-of-use criteria. Aid and attendance is the gateway people miss most, because a veteran who needs help with basic daily tasks because of service-connected conditions may qualify for SMC-L or higher even without losing a limb, and that reaches bedridden veterans, the severely cognitively impaired, and anyone who can't manage self-care. SMC-K stacks, so a veteran already drawing a higher SMC level who also has a K-qualifying loss (a hand, a creative organ, blindness in one eye) can take the K add-on and the higher level at once. SMC-S is its own lane and needs no limb loss, since a 100% rating with a separate 60%-plus condition, or factual confinement to the home, is enough. TBI veterans should ask about SMC-T specifically, because TBI care needs don't always fit the standard R-2 framework. And the current dollar amounts change every year: Congress set the baseline figures, but annual cost-of-living adjustments move the actual payments, so an old rate table is a wrong rate table, and the current-year numbers live on VA.gov's Special Monthly Compensation Rates page. The full matrix of losses, levels, and stacking rules is dense, and a trained VSO can map a veteran's specific losses to the right level (Ch. 36 — VSOs, Attorneys, and Claim Sharks). The 100% gateway for SMC-S also ties into Ch. 12 — Compensation Rate Tables and Dependent Add-Ons, Ch. 14 — TDIU: Paid at 100% Without a 100% Rating, and Ch. 30 — What a 100% P&T Rating Unlocks, so anyone working through those topics should check whether SMC applies.

Action Steps

The practical drill starts with one question to a VSO: does the veteran's situation qualify for SMC? The VA doesn't always raise it, and a trained representative can map a veteran's losses to the correct level in one sitting at no cost (Ch. 36 — VSOs, Attorneys, and Claim Sharks). Check aid-and-attendance need first, even without limb loss: if a veteran needs help eating, dressing, bathing, or using the toilet because of service-connected conditions, the path to SMC-L or higher is open, and it's the most commonly missed trigger. Verify the current-year SMC rate table at VA.gov before making any financial plans, since rates adjust annually and an old table is a wrong table. And if a K-qualifying loss exists at any rating level, claim it, because SMC-K stacks on top of other SMC levels and the standard percentage check and isn't limited to veterans already at 100%.

Cited Sources

Verify all citations and figures against current primary sources before acting. SMC rates adjust annually — the figures at VA.gov govern, not any number in this document.

- 38 U.S.C. § 1114 — Rates of wartime disability compensation (SMC subsections (k) through (t)).
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1114&num=0&edition=prelim>
- 38 CFR § 3.350 — Special monthly compensation ratings (regulatory criteria for each SMC level).
<https://www.ecfr.gov/current/title-38/section-3.350>
- 38 CFR § 3.352 — Criteria for the aid and attendance benefit and "permanently bedridden."
<https://www.ecfr.gov/current/title-38/section-3.352>

- VA.gov — *Special Monthly Compensation (SMC) rates* (current-year rate tables, updated annually).
<https://www.va.gov/disability/compensation-rates/special-monthly-compensation-rates/>
- VA.gov — *Special Monthly Compensation (SMC) overview*.
<https://www.va.gov/disability/compensation-rates/special-monthly-compensation-rates/>

Ch. 32 — Housing and Auto Grants

BLUF: Veterans with specific severe service-connected disabilities can get a one-time VA grant to build, buy, or modify an accessible home, or a separate grant toward an accessible vehicle. These aren't VA home loans and aren't charity — they're condition-triggered benefits. The trap to avoid: a high rating percentage alone doesn't qualify a veteran; the veteran's *specific* disability has to match the statutory list. And a veteran must apply before signing a purchase or construction contract. Dollar caps change every year, so confirm the current figure at VA.gov, never from a printed number. This chapter is which grant fits, and how to file.

Condition, Not Percentage, Is the Trigger

This is where veterans get it wrong: being rated 100% for, say, a back condition does not qualify a veteran. The grant turns on whether the veteran's *specific* service-connected disability is on the statutory list (38 U.S.C. § 2101 for housing, §§ 3901–3902 for auto). A veteran should cross-check their actual conditions against that list before assuming anything.

Pick the Housing Grant

There are three options under § 2101, and they aren't interchangeable. Specially Adapted Housing (SAH, § 2101(a)) is the larger grant, for the most severe conditions that change how a veteran moves through a home: loss or loss of use of both lower extremities so a veteran can't get around without braces, crutches, a cane, or a wheelchair; certain blindness in both eyes; certain upper- and lower-extremity combinations; and specified post-9/11 disabilities. A veteran can use it to build, buy, or modify an accessible home. Special Home Adaptation (SHA, § 2101(b)) is smaller and keyed to a different set of conditions — severe disabilities affecting hand function, certain blindness, or severe burn or respiratory injuries — and it's used to adapt an existing home rather than buy one. Temporary Residence Adaptation (TRA, § 2102A) is for a veteran living with a family member while sorting out permanent housing: the veteran uses a portion of the SAH or SHA grant to adapt the family member's home now, and the remaining balance rolls forward to the veteran's permanent home.

Both housing grants pay for accessibility — widened doorways, roll-in showers, ramps, lowered counters — not a general remodel. They aren't once-in-a-lifetime either: the law sets a maximum number of uses and a lifetime dollar cap, and any unused balance carries to a future home. The dollar caps change yearly, so confirm the figure at va.gov/housing-assistance/disability-housing-grants/. These stack with Special Monthly Compensation and don't reduce the veteran's monthly check (Ch. 31 — Special Monthly Compensation (SMC); the P&T cascade is Ch. 30 — What a 100% P&T Rating Unlocks).

The Auto Track (Allowance and Adaptive Equipment)

Separate from housing, under §§ 3901–3902, there are two pieces. The automobile allowance (§ 3902(a)) covers loss or loss of use of a hand or foot, certain severe vision loss, a severe burn, or ALS, and pays a one-time amount toward a vehicle; the VA pays the seller directly, up to the lesser of the price or the adjusted statutory cap (the cap adjusts over time, so verify the current figure at VA.gov), and if the vehicle costs more, the veteran covers the difference. Adaptive equipment (§ 3902(b)) is hand controls, wheelchair lifts, steering modifications, and the like, plus repair and replacement over time; it's a separate, ongoing benefit and isn't

subject to the vehicle cap. One exception is written into the statute: veterans with ankylosis of a knee or hip qualify for adaptive equipment only, not the vehicle allowance. Eligibility and the current cap are at va.gov/disability/eligibility/special-claims/automobile-allowance-adaptive-equipment/.

Apply Before Signing

The order matters, and getting it wrong can forfeit the grant on a deal already in motion. For housing, file VA Form 26-4555 (from va.gov/find-forms/about-form-26-4555/) before signing any purchase contract or construction agreement, because the VA has to determine eligibility and appraise first. For the auto benefit, file VA Form 21-4502 (from va.gov/find-forms/about-form-21-4502/) with evidence of the qualifying condition. And if a veteran is in a family member's home right now, file TRA immediately; there's no reason to wait for a permanent housing plan. A veteran can pair these with a VA-guaranteed home loan, where the loan finances the purchase and the SAH grant covers the accessibility cost, though the loan program is separate (Vol. 4 — Home Loan Guaranty).

Traps That Cost Veterans Money

- Assuming a 100% rating qualifies a veteran — the *specific* condition must be on the list.
- Signing a purchase or construction contract before filing 26-4555 — the VA must approve and appraise first.
- Waiting for permanent housing before using TRA — it can start adapting a family member's home now.
- Treating the grant as one-and-done — an unused balance carries forward, up to the statutory limits.
- Knee/hip ankylosis veterans expecting the vehicle allowance — it's adaptive equipment only.

The Rule, Briefly

The housing grants run on 38 U.S.C. § 2101: SAH under (a) for the most severe conditions, SHA under (b) for a different severe set, and TRA under § 2102A. The auto benefits run on 38 U.S.C. § 3901, which defines the eligible person, and § 3902, where (a) is the one-time vehicle payment to the seller and (b) is ongoing adaptive equipment. The dollar caps adjust over time, so never state a current figure without confirming it at VA.gov. These sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index.

Do This Now

1. Cross-check the veteran's specific service-connected conditions against the § 2101 / § 3902 lists — don't go by rating percentage.
 2. Decide which housing grant fits (SAH / SHA / TRA) and confirm the current dollar cap at va.gov/housing-assistance/disability-housing-grants/.
 3. File VA Form 26-4555 before signing any purchase or construction contract.
 4. If a qualifying condition fits the auto list, file VA Form 21-4502; remember ankylosis = equipment only.
 5. Run the SMC checklist alongside it — these benefits stack (Ch. 31).
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Cited Sources

Verify all citations and figures against current primary sources before acting. SAH/SHA and the auto-allowance dollar caps adjust annually — never state a current figure without confirming at VA.gov. VA.gov reorganizes pages; confirm a link if it moves.

- 38 U.S.C. § 2101 — Acquisition and adaptation of housing (SAH (a); SHA (b)).
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section2101&num=0&edition=prelim>
- 38 U.S.C. § 2102A — Temporary Residence Adaptation. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section2102A&num=0&edition=prelim>
- 38 U.S.C. § 3901 — Definitions ("eligible person" for auto allowance).
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section3901&num=0&edition=prelim>
- 38 U.S.C. § 3902 — Automobile and adaptive equipment ((a) vehicle allowance; (b) equipment).
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section3902&num=0&edition=prelim>
- VA.gov — Disability housing grants (SAH/SHA eligibility, caps, application).
<https://www.va.gov/housing-assistance/disability-housing-grants/>
- VA.gov — Automobile allowance and adaptive equipment.
<https://www.va.gov/disability/eligibility/special-claims/automobile-allowance-adaptive-equipment/>
- VA Form 26-4555 — Specially Adapted Housing / Special Home Adaptation grant application.
<https://www.va.gov/find-forms/about-form-26-4555/>
- VA Form 21-4502 — Automobile or Other Conveyance and Adaptive Equipment application.
<https://www.va.gov/find-forms/about-form-21-4502/>
- Ch. 30 / Ch. 31 — cross-references named inline; Vol. 4 — Home Loan Guaranty (separate program).

Ch. 33 — State-Level Veteran Benefits

BLUF: Federal VA disability compensation is only half the picture. Every state — and every U.S. territory, including Guam — adds its own layer of veteran benefits that stack on top of federal benefits. Most of those state benefits are free money that veterans are already entitled to and simply have not claimed. Property-tax relief, tuition waivers, license discounts, and employment preference are common examples. The action step: after settling federal benefits, veterans should audit what their state or territory offers. This chapter covers the categories; the deep state-by-state treatment lives in Vol. 12 — State & Local Benefits.

The Ground Truth

Federal VA benefits — compensation, pension, healthcare, education — come from the U.S. Department of Veterans Affairs. Those benefits apply the same way in Alabama as they do in Alaska. They are the floor.

States build on top of that floor. Each state has its own Department of Veterans Affairs (or equivalent agency), funded separately, with rules written by its own legislature. The result is a second layer of benefits, and that layer looks completely different depending on where a veteran lives.

Most veterans do not know the second layer exists. They get their federal rating, move on, and leave unclaimed money on the table for years. Sometimes for the rest of their lives.

State benefits almost always stack. A 70% federal rating does not cancel out state property-tax relief. The state program does not care that the federal check already arrived. Both pay.

Here is what veterans will typically find in that second layer.

Property-Tax Exemptions

For many veterans, this is the biggest dollar value in the entire stack. A large number of states reduce or eliminate property taxes for disabled veterans, and the discount often scales with the disability rating, reaching a full exemption for veterans rated 100% or designated Permanent and Total (P&T).

A full property-tax exemption on an average American home can be worth several thousand dollars per year, every year, for life. That is real money on top of any monthly VA check.

The details vary enormously. Some states apply the exemption to the primary residence only. Some cap the home's assessed value. Some require the veteran to be totally disabled; others start the benefit at lower ratings. Veterans must verify the current rules with their state agency. General knowledge about "what most states do" is not a substitute for the actual law in the veteran's state.

Note for veterans in Guam: Guam has its own property-tax framework administered through the Guam Department of Revenue and Taxation in coordination with the Guam Veterans Affairs Office. Rules differ from any U.S. state. Verify directly with those offices.

Tuition and Education Benefits

Many states offer free or reduced tuition at state universities and colleges, either for veterans themselves or for their dependents. A common version waives tuition entirely at public institutions for children or spouses of veterans who were killed in action, died of a service-connected condition, or are rated 100% P&T.

Some programs also benefit the veteran directly, covering courses at community colleges or state universities as part of a retraining or upgrade path.

These benefits do not replace federal GI Bill entitlement. They can supplement it or serve as a separate track. A veteran or dependent who uses a state tuition waiver at a state school may be able to preserve GI Bill entitlement for a private institution or graduate program later.

Eligibility rules, covered institutions, and the scope of the waiver all vary. Verify with the state higher-education agency and the state veterans agency.

License and Access Discounts

Most states offer reduced-cost or free hunting and fishing licenses to veterans, particularly those with service-connected disabilities. State park access is another common benefit: free or discounted admission and camping.

Vehicle-related benefits are also common. Discounted or waived registration fees, reduced-cost or free specialty veteran plates, and in some states, exemptions from certain vehicle taxes.

These benefits are smaller in dollar terms than property-tax relief, but they cost nothing to claim. A veteran who hunts, fishes, or uses state parks regularly can accumulate meaningful savings over time, often through a single one-time application.

Employment Preference

Most states maintain a veterans' preference in state government hiring. Federal law already requires preference in federal civil service hiring (5 U.S.C. § 3309 and related statutes). State laws mirror and sometimes extend that preference at the state and local level.

The mechanics differ. Some states add points to a civil service exam score; some place veterans at the top of a ranked list; some extend additional preference to disabled veterans or Purple Heart recipients. The preference typically covers state agency positions, state university staff roles, and positions in state-funded entities.

Veterans seeking state or local government employment should check the veterans' preference rules before applying. The benefit is automatic only if the application process is completed correctly.

State Veterans Homes

All 50 states, the District of Columbia, and most territories operate state veterans homes. These are long-term care facilities providing nursing home, domiciliary, and adult day health services to eligible veterans. They are separate from VA Medical Centers and are administered by the state with partial federal funding.

Entry criteria, cost, and quality vary by state. A veteran or family researching long-term care options should include their state veterans home alongside VA Community Living Centers and private facilities.

Bonuses and Other Programs

Some states offer a one-time bonus to veterans who served during specific conflicts or periods. These programs come and go as legislatures act. Some are funded by bond measures; others draw from general appropriations and can run dry before all eligible veterans apply.

State employment assistance programs, business licensing fee waivers, and small business support round out the picture in several states.

By the Rules

This chapter covers state and territorial programs, not federal law. There is no single federal CFR section that governs what states offer their veterans. Each state's legislature writes its own statute, and those statutes are amended regularly.

Congress generally encourages but does not dictate state veteran benefits. Where Congress does act — as with federal veterans' preference in civil service under 5 U.S.C. Chapter 33 — states may adopt analogous laws. Some state programs are partially federally funded (state veterans homes receive per-diem payments under 38 U.S.C. Chapter 81), but the eligibility rules remain state-controlled.

There is no universal rulebook. The authoritative source for any specific state benefit is the state statute and the regulations that state's veterans agency publishes. The National Association of State Directors of Veterans Affairs (NASDVA) connects the directors of all 50 state agencies, D.C., and all U.S. territories, including Guam. Its member directory at nasdva.us is the starting point for finding any state or territorial agency.

What This Means in Practice

Once a federal rating is in hand, run a full audit of the state's offerings. Start with the state veterans agency website, then call or visit the county or parish Veterans Service Officer (VSO), who's free and knows which local programs have funding, which have open application windows, and what documentation each one takes. For homeowners, property-tax relief is the first call, because it's the highest-dollar item in most stacks; apply as soon as the federal rating lands, since in many states the exemption isn't automatic and takes a separate application. Audit for the whole family rather than just the veteran, because tuition waivers and survivor benefits in many states reach spouses and children. Veterans in Guam, Puerto Rico, American Samoa, the U.S. Virgin Islands, and the Northern Mariana Islands are covered by NASDVA and have their own veterans offices, so the territorial agency is the right contact, not a mainland state's. Bonus programs carry deadlines and limited funding, so anyone who suspects they qualify for a time-limited program should apply promptly. And because most state benefits are tied to residency, a veteran who moves from Texas to Florida inherits Florida's rules and loses Texas's; for a high-rated disabled veteran the difference in property-tax relief alone can run thousands of dollars a year, so compare state packages before relocating. Veterans rated 100% or P&T should look hardest at all of it, since the full property-tax exemptions, the most generous tuition waivers, and the strongest employment preferences are usually reserved for that designation (Ch. 30 — What a 100% P&T Rating Unlocks); state benefits are often the largest practical consequence of earning P&T status.

Action Steps

The drill is concrete. Go to nasdva.us, find the member entry for the veteran's state or territory (Guam included), and pull the agency website and phone number. A veteran who owns a home and holds a federal disability rating should apply for the property-tax exemption now, because it isn't automatic in most jurisdictions and doesn't pay retroactively once a deadline passes. Veterans rated 100% or P&T should contact the state higher-education agency to confirm whether a spouse or children qualify for tuition waivers, since some programs run on enrollment-cycle deadlines. And request a full state-benefit audit from a county or state Veterans Service Officer, who knows which local programs are funded, which have open windows, and what documentation each one takes; the help is free.

Cited Sources

Verify all citations and figures against current primary sources before acting. State benefit rules change — confirm with the applicable state or territorial veterans agency before advising any individual.

- National Association of State Directors of Veterans Affairs (NASDVA) — Member directory covering all 50 states, D.C., and U.S. territories including Guam. The starting point for locating any state or territorial veterans agency. <https://nasdva.us/>
- 38 U.S.C. Chapter 81 — State home facilities; federal per-diem payments to state veterans homes. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section8101&num=0&edition=prelim>
- 5 U.S.C. § 3309 — Federal veterans' preference in civil service hiring (the federal model that state laws frequently mirror). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title5-section3309&num=0&edition=prelim>
- State Departments of Veterans Affairs directory — every state's own veterans office, the door to state-level benefits. <https://www.va.gov/statedva.htm>
- Guam Veterans Affairs Office — Territorial veterans agency for veterans residing in Guam. Contact directly for current property-tax, tuition, and other territorial programs. (contact details change; confirm them through NASDVA or the Government of Guam portal at guam.gov.)

Ch. 34 — VA Healthcare Enrollment & Priority Groups

BLUF: A disability rating does two things. It generates a monthly compensation check, and it shapes how VA healthcare works. VA uses a Priority Group system (Groups 1–8) to manage who gets care first and who pays a copay. A higher service-connected rating means a lower group number, which means faster access and lower or zero copays. Veterans with any service-connected rating should enroll. The form is simple. The long-term financial value is significant.

The Ground Truth

Most veterans think about VA disability in terms of the monthly check. The rating does a second job that often goes unnoticed: it determines where a veteran lands in the VA healthcare system.

VA healthcare is not automatic. A veteran has to enroll. Once enrolled, VA assigns that veteran to one of eight priority groups. Think of it like a boarding tier on a plane. Group 1 boards first. Group 8 boards last. The lower the group number, the higher the priority and the lower the cost.

Why this matters to a rated veteran

The monthly compensation check and the healthcare card are linked at the rating. A 50% or higher service-connected rating moves a veteran into Priority Group 1, the highest tier. That typically means no copays for most VA care. A 30–40% rating lands in Priority Group 2. A 10–20% rating, or a special status such as former POW or Purple Heart recipient, lands in Priority Group 3. Even a 0% service-connected rating, where VA confirmed the condition is linked to service but it is not yet disabling enough to pay out, still qualifies a veteran for enhanced eligibility and places them in Priority Group 6.

Service-connected conditions get better placement than non-service-connected ones. The worse the service-connected disability, the higher the priority.

Care for service-connected conditions

Regardless of priority group, care that is directly related to a service-connected condition is generally provided without a copay. A veteran rated for knee damage goes to physical therapy for that knee without paying out of pocket. Copays come into play for care unrelated to the service-connected condition: a routine checkup, a cold, an unrelated surgery. Whether those copays apply, and how much they are, depends on the group and the veteran's income. Specific copay dollar amounts change regularly; veterans should verify current rates at [VA.gov](https://www.va.gov) or by calling their VA medical center.

Catastrophically disabled veterans

Veterans who are catastrophically disabled, meaning they have a severe condition such as blindness in both eyes, loss of limbs, or permanent neurological impairment, are placed in Priority Group 4 regardless of their service-connected rating. Priority Group 4 veterans generally receive all their VA care without copays. The VA makes the catastrophically disabled determination; it is not the same as a 100% rating, though the two can overlap.

Priority Group 5 — the income track

A veteran who has no service-connected condition but whose income falls below certain thresholds may still qualify for Priority Group 5. This is the financial-hardship path. Income limits are set by regulation and adjusted periodically; veterans should verify the current threshold at [VA.gov](https://www.va.gov). Priority Groups 6, 7, and 8 cover lower-priority non-service-connected veterans, with copays applying for most services.

The PACT Act changed the enrollment picture

The Sergeant First Class Heath Robinson PACT Act of 2022 is the largest expansion of VA healthcare eligibility in decades. It extended eligibility to millions of veterans exposed to toxic substances — burn pits, Agent Orange, radiation, and other hazards. Many veterans who could not previously qualify now can. PACT Act eligibility for healthcare is covered fully in Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure. The short version for enrollment purposes: if a veteran was denied healthcare eligibility in the past because of exposure type or era of service, PACT Act may have changed that. Re-check.

How to enroll

Enrollment is done with VA Form 10-10EZ, Application for Health Benefits. There are three ways to submit it:

1. Online at va.gov/health-care/how-to-apply/ (fastest)
2. In person at any VA medical center or community-based outpatient clinic (CBOC)
3. By phone at 1-877-222-8387, submitting information verbally

The form asks for service history, discharge information, income (for groups that require it), and any existing health insurance. It costs nothing to apply. VA will notify the veteran of the assigned priority group after processing.

Why a low-rated veteran should still enroll

The logic of "I'm only 10%, why bother?" is wrong, because enrollment delivers real value even at a low rating. All care for the service-connected condition is generally copay-free no matter the group, and the VA also provides preventive care: screenings, mental health services, and substance use treatment. Enrollment locks in the date, which matters because some benefits and programs are tied to enrollment status and trying to establish it years later leaves gaps. Ratings also climb, so a veteran enrolled now at 10% who later reaches 50% keeps the healthcare card and moves to Group 1 automatically. And the VA is now required to give every enrolled veteran a toxic-exposure screening, which is the front door to future claims. The form takes minutes; the healthcare card can be worth years of free or low-cost care.

The Rule, Briefly

The priority-group system is 38 CFR § 17.36(b): Groups 1 through 8 set a ranked order of obligation, not a "may provide care," so Group 1 (a 50%-plus rating, unemployability, or the Medal of Honor) gets first call on appointments and resources while Group 8 gets last; the full group-by-group breakdown is in the Quick-Reference table below. A veteran is placed in the highest group they qualify for, so a 50% rating plus a Purple Heart lands in Group 1 rather than Group 3, and the system resolves in the veteran's favor. Enrollment stability differs across the ladder: Groups 1 through 6 carry more stable enrollment rights, while enrollment for Groups 7 and 8 can be suspended based on capacity. Enrollment itself is § 17.36(d)(1): submit VA Form 10-10EZ at a VA facility, by mail, online, or by phone. And the copay framework rests on 38 U.S.C. § 1710, the statute that authorizes copays for non-service-connected care and limits them for higher-priority groups, read together with the regulation. The verbatim text of these sections is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

What This Means in Practice

Enroll now: the 10-10EZ takes under thirty minutes, waiting costs nothing, and not enrolling costs access. The VA mails a notice with the assigned priority group after enrollment, so keep that document and understand what it means. If a condition is service-connected, the visit for that condition shouldn't generate a copay, and if a bill arrives for a service-connected appointment, question it immediately. Treat every rating increase as a healthcare upgrade, not just a bigger check: a jump from 20% to 50% moves a veteran from Group 3 to Group 1 and can wipe out most copays. TDIU veterans land in Group 1, because Total Disability based on Individual Unemployability is treated as equivalent to a 50%-plus rating under the regulation (Ch. 14 — TDIU: Paid at 100% Without a 100% Rating), and a Permanent and Total rating at 100% is Group 1 with the most stable enrollment rights (Ch. 30 — What a 100% P&T Rating Unlocks). Every enrolled veteran should request or accept the toxic-exposure screening, since a positive result creates a record that may support future claims. Income thresholds for Groups 5 through 8 change regularly, so a veteran who qualified for Group 5 years ago should re-verify, because a change in circumstances may now mean a better group. None of this touches the monthly disability check; priority groups affect healthcare access and copays only.

Action Steps

The drill is short. Submit VA Form 10-10EZ at va.gov/health-care/how-to-apply/; the online application takes under thirty minutes and locks the enrollment date. After the VA mails the enrollment notice, confirm the assigned priority-group number and what copay rules apply to the veteran's service-connected conditions. Request the toxic-exposure screening at the first VA appointment, since the PACT Act requires the VA to offer it to every enrolled veteran and a positive result builds the record for future claims (Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure). And verify the copay impact of any pending rating increase, because a jump from 20% to 50% moves a veteran from Group 3 to Group 1, so know the healthcare savings before the next rating decision lands.

Priority Group Quick-Reference

Use Table 34-1 to find the correct group based on the veteran's circumstances. VA assigns the highest group for which the veteran qualifies.

Table 34-1. VA Healthcare Priority Group Routing by Veteran Circumstance.

Rule	If the veteran...	Priority Group	What it affects (enrollment / copays)
1	Has a service-connected disability rating of 50% or higher, or is granted TDIU/unemployability, or holds the Medal of Honor	1	Highest enrollment stability; generally no copays for most VA care
2	Has a service-connected disability rating of 30% or 40%	2	High enrollment stability; copays apply for non-service-connected care (rates change every year; the current ones are at VA.gov)
3	Has a service-connected disability rating of 10% or 20%, OR is a former POW, Purple Heart recipient, or was discharged from active duty for a disability incurred or aggravated in the line of duty	3	Strong enrollment rights; copays apply for non-service-connected care (rates change every year; the current ones are at VA.gov)

Rule	If the veteran...	Priority Group	What it affects (enrollment / copays)
4	Is determined by VA to be catastrophically disabled (for example, bilateral blindness, loss of limbs, or permanent neurological impairment), regardless of service-connected rating	4	Generally no copays for all VA care; VA makes the catastrophically disabled determination
5	Has no compensable service-connected condition and income falls below the VA means-test threshold	5	Reduced or no copays; income threshold adjusted periodically (this limit changes every year; the current one is at VA.gov)
6	Has a 0% noncompensable service-connected condition confirmed by VA, OR qualifies under PACT Act as a toxic-exposure veteran (burn pits, Agent Orange, radiation, etc.)	6	Enhanced eligibility; copays apply for non-service-connected care; care for the confirmed service-connected condition is generally copay-free
7	Has no service-connected condition and income is above the means-test threshold but below the geographic-based threshold	7	Copays apply for most care; enrollment may be suspended in capacity-constrained years
8	Has no service-connected condition and income exceeds both the means-test and geographic thresholds	8	Copays apply for most care; enrollment may be suspended in capacity-constrained years

Note: Regardless of priority group, care directly related to a confirmed service-connected condition is generally provided without a copay. Copay dollar amounts and income thresholds change regularly; verify current figures at VA.gov before acting.

Cited Sources

Verify all citations and figures against current primary sources before acting. Income thresholds and copay dollar amounts are adjusted regularly — do not publish specific dollar figures without confirming the current-year rate at VA.gov.

- 38 CFR § 17.36 — Provision of hospital and outpatient care to veterans; priority categories (b)(1)–(8); enrollment process (d)(1). <https://www.ecfr.gov/current/title-38/section-17.36>
- 38 U.S.C. § 1710 — Eligibility for hospital, nursing home, and domiciliary care; copayment authority. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1710&num=0&edition=prelim>
- VA.gov — *Eligibility for VA Health Care* (priority groups; enhanced eligibility; PACT Act overview). <https://www.va.gov/health-care/eligibility/>
- VA.gov — *VA Priority Groups* (group-by-group breakdown; copay implications). <https://www.va.gov/health-care/eligibility/priority-groups>
- VA.gov — *Apply for VA Health Care* (Form 10-10EZ online portal). <https://www.va.gov/health-care/how-to-apply/>
- VA.gov — *The PACT Act and Your VA Benefits* (expanded eligibility for toxic-exposure veterans). <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/>

Ch. 35 — Top Mistakes That Tank Claims

BLUF: Most denied or underrated VA claims did not fail because of bad luck. They failed because veterans made one or more of ten well-documented mistakes — mistakes that are fully preventable. Knowing the mistakes and the fixes before filing is the difference between earning what the law already promises and leaving money on the table for years.

The Ground Truth

Veterans earn these benefits through service. The law is on their side: 38 U.S.C. §§ 1110 and 1131 say the United States *will* pay when the elements are met, and 38 C.F.R. § 3.102 requires the VA to give veterans the benefit of the doubt when the evidence is about equal.

So why do so many claims get denied, underrated, or slow-walked?

Because the system is not automatic. It is a process, and that process has pressure points where veterans routinely lose ground they should have kept.

What follows is the unfiltered list. Ten mistakes. Ten fixes. No fluff.

By Hard Experience

Mistake 1 — Not Filing at All, or Waiting Too Long

What it costs: VA compensation is paid from the date the VA receives the claim, not the date the condition started. Every month that passes without a claim on file is a month of back pay the VA will never owe. A veteran who waits five years to file cannot go back and collect five years of benefits. Those months are gone.

What to do instead: File an Intent to File (ITF) *today*, even if the paperwork is not ready. An ITF locks the effective date for up to one year (38 C.F.R. § 3.155). If a completed claim is filed within that year, back pay runs from the ITF date. The claim can be messy and incomplete; it just needs to get on record. Full ITF mechanics are in Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates.

Mistake 2 — No Nexus, or a Weak Nexus

This is the single most common reason direct-service-connection claims are denied. Without a credible medical opinion linking the condition to service, the claim fails on the most basic element. "I hurt my knee in service" is a personal statement, not a nexus. The VA needs a medical professional to connect the dots, and if the veteran does not provide one, the VA's examiner often will not provide a favorable one either.

The move: get a private nexus opinion from a doctor or qualified clinician before filing, or ensure the records clearly document the in-service event and its connection to the current diagnosis. A strong nexus letter says the condition is *at least as likely as not* caused by or related to service, which is the exact legal standard under § 3.102. Nexus evidence is covered in Ch. 15 — The Elements of Service Connection and Ch. 18 — Evidence That Wins Claims.

Mistake 3 — Underclaiming (Ignoring Secondary Conditions)

A veteran who files for a bad knee but skips the hip problem, lower back pain, and sleep disorder that the knee caused leaves significant money unfilled. Secondary service connection (38 C.F.R. § 3.310) allows a veteran to claim any condition proximately caused by, or aggravated by, an already-rated service-connected condition. Every unrated secondary is lost rating points.

Map the dominoes before filing. If the primary condition affects how the veteran walks, stands, sleeps, or feels, ask a doctor whether those downstream effects meet the "caused by or aggravated by" standard. File the secondaries at the same time. Secondary service connection is covered in Ch. 25 — Secondary Conditions: The Underused Multiplier.

Mistake 4 — Missing the C&P Exam

A no-show on a Compensation and Pension exam is treated as an abandonment in most cases. The VA will deny or continue the pending claim based on existing evidence, which is usually not enough. Missing the C&P is one of the fastest ways to hand the VA a reason to deny.

When the VA schedules a C&P exam, attend. Period. If the date does not work, reschedule *before* the appointment, not after. Veterans should arrive prepared: know the condition being examined, bring a copy of service records and buddy statements if possible, and understand that the examiner's report will carry heavy weight in the rating decision. Full C&P exam preparation is in Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

Mistake 5 — Downplaying Symptoms at the C&P Exam

Veterans are trained to push through pain and say "I'm fine." At a C&P exam, that instinct costs rating points. The examiner documents what the veteran reports. If a veteran says the knee "bothers them sometimes," the examiner records mild limitation, the rater assigns a low rating, and the bad days — the days the veteran can barely walk — never made it into the report.

Describe the *worst day*, not the average day. The rating criteria in 38 C.F.R. Part 4 are written around functional loss at the worst end of a condition's spectrum. The veteran should tell the examiner how the condition affects work, sleep, physical activity, and daily tasks, and be specific. This is not exaggerating. It is giving the examiner the complete picture the law requires. C&P exam conduct is in Ch. 19 — The C&P Exam: What to Expect and How to Prepare.

Mistake 6 — Skipping the Intent to File

Veterans who file a completed claim without first submitting an ITF miss the opportunity to capture earlier back pay. The ITF costs nothing and takes minutes, but without it, the effective date is the date the VA receives the fully developed claim, not the earlier date when the veteran first decided to file.

Before any paperwork, submit VA Form 21-0966 (Intent to File) online, by phone, or in person at a VA Regional Office. The ITF is good for one year. File the completed claim before that year expires. Details are in Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates (also directly relevant to Mistake 1 above).

Mistake 7 — Accepting a Denial Without Reading the Reasons and Bases

Many denial letters contain beatable logic. The VA may have used the wrong diagnostic code, ignored evidence, or applied the wrong standard. Veterans who accept the decision and move on lose the appeal window and permanently cement a wrong result, including effective dates that will never be recovered.

Read the decision letter *in full*, specifically the section called "Reasons and Bases." That section explains what evidence the VA considered and why it ruled as it did. If the logic is wrong, the evidence is incomplete, or a new medical opinion would change the outcome, appeal options exist. Supplemental claims under the newer decision review process allow submission of new and relevant evidence that was not part of the original claim. The decision letter is covered in Ch. 26 — Reading the Rating Decision Letter and the full appeals framework in Ch. 27 — The Appeals Process Under the AMA.

Mistake 8 — Filing for an Increase Without Understanding the Risk

Requesting a rating increase reopens the current rating for review. If the VA re-examines the condition and finds improvement, the rating can go *down*, not up. Veterans with a protected rating (one in place for five or more years) have some procedural protection, but re-examination can still happen. Filing for an increase without understanding the downside is gambling without knowing the odds.

Before filing for increase, think through what a re-examination might show. If the condition has clearly worsened *and* the medical records support it, an increase claim is often worth it. If the records are thin or the condition sits at borderline criteria, the risk calculation is different. Rating protection rules — the five-year rule, ten-year rule, and twenty-year rule — are in Ch. 29 — Protected Ratings. Increase strategy is in Ch. 28 — Increasing an Existing Rating.

Mistake 9 — Paying for Help That Is Free

VSOs, accredited claims agents, and VA-accredited attorneys who work on contingency are the legitimate avenues. But the internet is full of claim sharks: companies that charge upfront fees or ongoing monthly subscriptions to help veterans file claims. Under 38 U.S.C. § 5904, those fees are often illegal. Veterans who pay claim mills do not get better results. They often get slower results and less money in their pockets.

Use a VSO (American Legion, DAV, VFW, AMVETS, or others) at no charge. VSOs are federally chartered, VA-recognized, and their accredited representatives are trained to build and file claims. If paid representation is needed at the appeals stage, use a VA-accredited attorney or claims agent, and understand the fee structure before signing anything. Choosing representation is covered in Ch. 36 — VSOs, Attorneys, and Claim Sharks.

Mistake 10 — Not Checking Presumptives or PACT Act Eligibility

Presumptive service connection means the veteran does not need to prove a nexus. The law presumes the condition is related to a specific type of service. Veterans who file a standard direct-service-connection claim for a presumptive condition are doing extra work and risking denial on a ground that does not legally apply to them. Under the PACT Act, the list of presumptives was substantially expanded to cover toxic exposures from burn pits, Agent Orange, radiation, and other hazards. Veterans who do not know the presumptive list may be filing the wrong type of claim, or not filing at all for a condition that qualifies.

Before filing, check whether the condition qualifies as a presumptive for the veteran's era and location of service. If it does, say so in the claim and cite the regulation. Presumptive conditions are covered in Ch. 21 — Presumptive Conditions Explained and Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure. The PACT Act alone opened presumptive eligibility for millions of veterans who had previously been denied or discouraged from filing.

What This Means in Practice

A few principles run through all ten. File the ITF first, every time, because it protects the effective date and costs nothing; veterans who skip it and later win lose months of back pay they can't recover. Medical nexus isn't optional: a personal statement establishes the in-service event, but a medical opinion establishes the connection, and direct service connection needs both, so a missing nexus is a denial waiting to happen. Think downstream before filing, because primary conditions cause secondary ones, and filing for the primary alone leaves half the claim unfilled; map every condition the primary has affected before submitting. Treat the C&P exam as a gate rather than a formality: skipping it or understating symptoms shapes the rating for years, so prepare, attend, and describe the worst functional day. Read the denial letter before accepting it, since the Reasons and Bases section often exposes flawed logic or missing evidence that a Supplemental Claim or appeal can fix. Use the free help, because VSO service officers are trained for this work and charge nothing, while paying for claim help is usually unnecessary and sometimes illegal. Know the presumptive list before building a nexus case, because proving what the law already presumes wastes time and risks a wrong-path denial. And understand that reopening a rating carries risk, so learn the five-, ten-, and twenty-year protection rules before requesting an increase on an established rating. One more, easy to miss: any veteran rated below 100% who can't hold substantially gainful employment should check eligibility for Total Disability based on Individual Unemployability (38 C.F.R. § 4.16), covered in Ch. 14 — TDIU: Paid at 100% Without a 100% Rating.

Do This Now

1. Run the ten-mistake checklist against the current claim before filing: ITF on record, nexus obtained, secondaries listed, C&P scheduled, presumptives checked. Fix every gap first.
 2. File VA Form 21-0966 (Intent to File) immediately, online or by phone at 1-800-827-1000 or in person at a VA Regional Office, to lock the effective date before the rest of the claim is built (Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates).
 3. Get a VSO to review the package before submission; a service officer spots weak nexus evidence, missing secondaries, and diagnostic-code mismatches at no cost (Ch. 36 — VSOs, Attorneys, and Claim Sharks).
 4. Check the presumptive list before drafting the nexus argument. If the condition qualifies under the PACT Act or another presumptive framework, cite the regulation instead of filing a direct-connection claim for something the law already presumes (Ch. 21 — Presumptive Conditions Explained).
-

Cited Sources

Verify all citations and figures against current primary sources before acting.

- 38 U.S.C. §§ 1110 / 1131 — Basic entitlement (peacetime/wartime). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1110&num=0&edition=prelim> · <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1131&num=0&edition=prelim>

- 38 C.F.R. § 3.102 — Benefit of the doubt. <https://www.ecfr.gov/current/title-38/chapter-I/part-3/subpart-A/section-3.102>
- 38 C.F.R. § 3.155 — Intent to File; effective dates for informal claims. <https://www.ecfr.gov/current/title-38/chapter-I/part-3/subpart-A/section-3.155>
- 38 C.F.R. § 3.310 — Secondary service connection (proximately due to or aggravated by). <https://www.ecfr.gov/current/title-38/chapter-I/part-3/subpart-A/section-3.310>
- 38 C.F.R. § 3.400 — Effective dates — general. <https://www.ecfr.gov/current/title-38/chapter-I/part-3/subpart-A/section-3.400>
- 38 C.F.R. § 4.16 — Total disability ratings for compensation based on unemployability (TDIU). <https://www.ecfr.gov/current/title-38/chapter-I/part-4/subpart-A/section-4.16>
- 38 U.S.C. § 5904 — Recognition of agents and attorneys; fees; prohibition on prepayment. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5904&num=0&edition=prelim>
- VA Form 21-0966 — Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC. <https://www.va.gov/find-forms/about-form-21-0966/>
- VA.gov — *PACT Act and your VA benefits*. <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/>
- VA.gov — *Decision Review and Appeals*. <https://www.va.gov/decision-reviews/>

Ch. 36 — VSOs, Attorneys, and Claim Sharks

Who to Trust With a Claim

BLUF: Filing a VA claim is free, and so is expert help — for a veteran who knows where to look. Federal law lets only VA-accredited people represent a veteran, Veterans Service Organizations (VSOs) do it for free and are the right first call, and accredited attorneys can charge a fee only after the first decision, never to prepare the original claim. Anyone charging to "file" or "prepare" an initial claim, or who isn't on the VA's accreditation roster, is operating outside the law and leaves a veteran poorer, not better off. This chapter is how to get the free help, verify who's legit in two minutes, and spot the shark.

Call a VSO First, Because the Help Is Free

The single most important fact in this chapter is that the help is free. Three kinds of people work the claims-help space, only two of them are legal, and the free one is usually the best. Veterans Service Organizations — the VFW, Disabled American Veterans, the American Legion, Vietnam Veterans of America, and others — employ trained, VA-accredited representatives who help from first contact through appeal at no charge. They aren't second-string help, either; many reps have filed hundreds of claims and know exactly what evidence the VA wants and when a rating looks wrong, so a veteran should exhaust this option before paying anyone a dime. County and state veterans service offices fall in the same category: many states and counties fund offices staffed by accredited reps offering the same free help locally, which a veteran can find by searching "[state] department of veterans affairs" or "[county] veterans services." Find and appoint a VSO through va.gov/get-help-from-accredited-representative/ (and [/find-rep/](https://va.gov/find-rep/) to search by name or organization); the how-to of appointing one to file a 21-526EZ is in Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates.

Verify Accreditation in Two Minutes

Before signing anything or handing over a single document, confirm the person is actually VA-accredited. The VA keeps a public, searchable roster at va.gov/ogc/apps/accreditation/index.asp — search by name or organization and check that they're accredited and in good standing. If a name isn't on that list, that person can't legally charge to represent a veteran in a VA claim, and this one search is the best filter available.

Know the Fee Rules

Accredited attorneys and claims agents can charge fees, but only under strict limits. No fee can be charged for any work done before the VA issues its first decision — that covers claim preparation, evidence gathering, and form submission — because the fee clock doesn't start until the initial decision notice, so anyone who wants money before that is acting illegally, and a veteran should walk away. After the first decision, a contingency fee paid directly from past-due benefits is capped at 20% of that award; other arrangements are allowed but have to be reasonable, and the VA can reject excessive fees. The honest use case for a paid attorney is a complex appeal, after a denial or a clearly wrong rating, where legal skill in front of the Board or the Court of Appeals for Veterans Claims actually matters (Ch. 27 — The Appeals Process Under the AMA) — not a routine initial claim.

Spot the Claim Shark

The third category is the illegal one: unaccredited consultants and companies that charge an upfront fee, or take a cut of the retroactive award, to "help" file or prepare an initial claim. The business model is to promise a 70% rating instead of the 30% the VA would have awarded anyway, take 20 to 40% of the back-pay lump sum, and submit the same forms a veteran could have filed for free — so the veteran gets nothing a VSO couldn't have done at no cost. The warning signs are consistent, and any one of them is reason to walk away: asking for a percentage of future or retroactive benefits before an initial decision even exists, guaranteeing a rating or outcome ("we get 100% ratings"), not appearing on the VA accreditation roster, pressure to sign a fee agreement fast, or promises of "insider" knowledge and a special process. None of it makes the claim stronger, because the VA rates on the medical evidence and the law, not on who filed the paperwork.

Traps That Cost Veterans Money

- Paying anyone to prepare an initial claim. It's free through a VSO, and a fee for initial-claim work is illegal.
- Signing before checking the accreditation roster. Two minutes prevents the whole problem.
- Believing a "guaranteed rating" pitch. No one can guarantee a rating; the evidence and the law decide it.
- Handing a shark a cut of a veteran's back pay for filing free forms.
- Hiring an attorney for a routine initial claim instead of saving paid help for the appeal where it earns its fee.

The Rule, Briefly

Only accredited people may represent a veteran: under 38 U.S.C. § 5901, no one may act as an agent or attorney in a VA claim unless the Secretary has recognized them. Fees are barred before the first decision by § 5904(c)(1), which prohibits charging for services before the agency of original jurisdiction's initial decision, and a contingency fee paid from past-due benefits is capped at 20% of that award under § 5904(c)(3)(A). The accreditation standards themselves — good character, training, and conduct — come from 38 CFR § 14.629. Each section is indexed with its official primary-source link in Appendix A1 — Master Citation Index.

Do This Now

1. Call a VSO — American Legion, DAV, VFW, or the veteran's state/county service office — before filing anything; appoint one at va.gov/get-help-from-accredited-representative/.
2. Run any rep or company through va.gov/ogc/apps/accreditation/index.asp before signing or sharing documents.
3. Refuse any fee request on an initial claim — it's illegal under § 5904(c)(1); report it to the VA Office of General Counsel.
4. Save a paid, accredited attorney for a complex appeal heading to the Board (Ch. 27), and confirm the fee is reasonable ($\leq 20\%$ contingency from past-due benefits).

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 U.S.C. § 5901 — Prohibition against unaccredited representation.
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5901&num=0&edition=prelim>
- 38 U.S.C. § 5904 — Recognition of agents/attorneys; fee rules; no fee before initial decision; 20% contingency cap. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5904&num=0&edition=prelim>
- 38 CFR § 14.629 — Accreditation requirements for reps, agents, and attorneys.
<https://www.ecfr.gov/current/title-38/section-14.629>
- VA OGC Accreditation Search — verify any rep/agent/attorney.
<https://www.va.gov/ogc/apps/accreditation/index.asp>
- VA.gov — Get help from an accredited representative (find and appoint a VSO). <https://www.va.gov/get-help-from-accredited-representative/>
- Ch. 17 / Ch. 27 / Ch. 35 — cross-references named inline.

Ch. 37 — Avoiding a Rating Reduction

BLUF: A VA rating isn't automatically permanent, but the law stacks the deck in the veteran's favor: the VA has to prove the veteran got *better*, and not just on one exam — better in a way that holds up in real daily life. Before any cut takes effect, the VA must mail a written notice and give the veteran 60 days to fight it. Silence is a concession. Veterans who know their rating's age, keep treatment current, and answer every proposed-reduction notice on time hold most of the cards. This chapter is the defense drill.

Know the Exposure (A Rating's Age Is the Veteran's Armor)

The VA's power to reduce is tightly limited, and the limits get stronger the longer a veteran has held the rating: the veteran doesn't have to prove they got worse, the VA has to prove they got better. The ladder runs through § 3.344 and the protection rules in Ch. 29 — Protected Ratings. Under five years held, the VA still can't cut on a single inadequate exam; it has to review the whole medical record. At five or more years, it has to show material improvement that's real rather than marginal, and that the improvement will hold up under the ordinary conditions of life, not on a good day in a hospital bed. At ten or more years, a reduction takes clear and convincing evidence of improvement, and service connection generally can't be severed. And at twenty or more years, the rating can't drop below the lowest level it's held during that period.

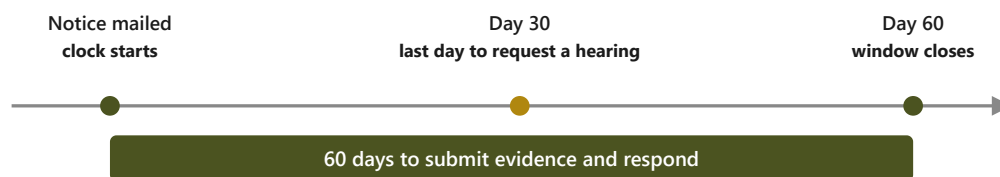
Also know which of a veteran's ratings are coded static or Permanent & Total (P&T), because those generally aren't re-examined at all. Three things put a veteran back in front of an examiner: filing for an increase (the exam then reviews all conditions, not just the one the veteran raised; Ch. 28 — Increasing an Existing Rating), a future exam scheduled at the original decision, or a note of improvement in the record.

Defend the Rating Year-Round (Before Any Notice)

The fight is won before the notice arrives. Keep treatment current: stop seeing a doctor for the condition and a veteran hands the VA an "it improved" argument, while regular visits document that it persists, and gaps are the VA's main tool. Never skip a VA-ordered re-exam, since a no-show without good cause is one of the fastest ways to lose a rating. And keep the veteran's address current at va.gov/profile, because the proposed-reduction notice goes to the veteran's address of record and the 60-day clock starts when it's mailed, not when the veteran reads it; an old address can burn the whole window without the veteran ever knowing.

The 60-Day Drill (When the Notice Lands)

The VA can't cut a veteran's rating overnight. It must first mail a written proposed-reduction rating laying out its facts and reasoning (§ 3.105(e)), and from the date of that notice the veteran has 60 days. What the veteran does in that window decides the outcome — silence means the cut goes through. Work Table 37-1 the day it arrives.



The clock runs from the mailing date, not the day it is read. Silence lets the cut go through.

Figure 37-1. The due-process clock under § 3.105(e): the proposed-reduction notice starts a 60-day window, with the hearing request due by day 30. Miss it and the reduction takes effect.

Table 37-1. Due-process steps after a proposed-reduction notice.

If the situation is...	Then...	Deadline	Action
The VA mailed a written proposed-reduction notice (§ 3.105(e))	The 60-day window opens; no cut until it closes	60 days from the notice date	Read it fully; note the mail date; confirm the VA address on file is current so nothing else is missed
A hearing is wanted before the decision	Request a predetermination hearing in writing	Within the first 30 days	Have a VSO/attorney file the written request before the 30-day mark
Medical evidence is being submitted	Gather and submit everything	Within 60 days	Private exam, VA treatment notes, lay statements — address the <i>specific</i> criteria the VA cited
Evidence is submitted and the wait is on	The VA reviews all evidence before a final decision	None unless the VA decides	Confirm receipt; keep copies of everything
60 days pass with no response	The VA finalizes the reduction	Window closes at 60 days	Now pursue Higher-Level Review or a Board appeal (Ch. 27 — The Appeals Process Under the AMA)

Attack the Exam Behind the Reduction

One of the strongest defenses is going after the exam itself. The law requires a VA exam to be *adequate* — it has to account for the full range of the condition, including a veteran's worst days and flare-ups, not just how the veteran presented that morning (the *Correia* and *DeLuca* standards, in Ch. 9 — Landmark Court Cases That Shaped Veteran Rights and Ch. 19 — The C&P Exam: What to Expect and How to Prepare). A reduction built on a rushed or incomplete exam can be challenged and reversed. Practical move: at the re-exam, the veteran or their rep notes any limitation on the spot — too little time, no repetitive-motion testing, no questions about flare-ups — and those notes become part of the record. The single strongest rebuttal is a private physician's report that directly answers the exact criteria the VA used to propose the cut.

These cases are adversarial; a VSO or accredited attorney can read the rating history, name the protective standard that applies, and frame the response (Ch. 36 — VSOs, Attorneys, and Claim Sharks).

Traps That Cost Veterans Money

- Letting treatment lapse — the gap becomes the VA's "improvement" argument.
- An out-of-date address — the 60-day clock runs whether or not the veteran saw the letter.
- Skipping the re-exam — a no-show can cost the rating outright.
- Letting 60 days pass in silence — that's a concession; the cut finalizes.
- Treating the proposed notice as the final decision — it isn't; it's the veteran's window to fight.

The Rule, Briefly

The stabilization rule is 38 CFR § 3.344: a long-held rating can't be cut without material improvement that will hold under the ordinary conditions of life, and an exam less complete than the one that set the rating can't be the basis for a cut. The due-process rule is 38 CFR § 3.105(e): before reducing, the VA has to send a written proposed reduction with its reasons and give 60 days to submit evidence. And the time-based

protections run through 38 U.S.C. § 110 (the 10-year rule), 38 CFR § 3.951 (the 20-year floor), and § 3.952 (the 10-year protection). These sections are indexed with their official primary-source links in Appendix A1 — Master Citation Index and Ch. 29 — Protected Ratings.

Do This Now

1. Write down the assignment date of every rated condition and mark which have been held 5, 10, or 20+ years.
 2. Keep (or restart) regular treatment for every service-connected condition — gaps are the VA's main weapon.
 3. Update the veteran's address at va.gov/profile today so no notice is missed.
 4. The day any proposed-reduction notice arrives, call a VSO, run Table 37-1, and get a private exam addressing the exact criteria the VA cited — all within 60 days (hearing request within 30).
 5. If the cut finalizes anyway, appeal it (Ch. 27).
-

Cited Sources

Verify all citations, links, and figures against current primary sources before acting. VA.gov reorganizes pages; confirm a link if it moves.

- 38 CFR § 3.344 — Stabilization of disability evaluations. <https://www.ecfr.gov/current/title-38/section-3.344>
- 38 CFR § 3.105 — Revision of decisions; proposed-reduction procedure (§ 3.105(e)). <https://www.ecfr.gov/current/title-38/section-3.105>
- 38 CFR § 3.327 — Reexaminations. <https://www.ecfr.gov/current/title-38/section-3.327>
- 38 U.S.C. § 110 — Protection of service connection (10-year rule). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section110&num=0&edition=prelim>
- 38 CFR § 3.951 / § 3.952 — 20-year floor / 10-year protection. <https://www.ecfr.gov/current/title-38/section-3.951> · <https://www.ecfr.gov/current/title-38/section-3.952>
- *Correia v. McDonald*, 28 Vet. App. 158 (2016) and *DeLuca v. Brown*, 8 Vet. App. 202 (1995) — exam-adequacy / range-of-motion standards (full cites in Ch. 9 and Appendix A1).
- VA.gov — About VA disability ratings (re-evaluation). <https://www.va.gov/disability/about-disability-ratings/>
- VA.gov — Board Appeal (after a final reduction). <https://www.va.gov/decision-reviews/board-appeal/>
- Ch. 9 / Ch. 19 / Ch. 27 / Ch. 28 / Ch. 29 / Ch. 36 — cross-references named inline.

Appendix A1 — Master Citation Index

BLUF: This appendix lists every statute, regulation, and court case cited across the 37 chapters of Vol. 1. Its one purpose: a veteran or advocate can look up any authority cited in the manual, read the plain-English summary, and then verify the current version at the primary source. The groupings follow the legal hierarchy (Congress passes the law, the VA writes the regulation, the courts interpret both). **Always verify against primary sources before relying on any citation in a claim, appeal, or legal argument. Regulations change. Court decisions get superseded.**

Title 38 U.S.C. (the statutes — the law Congress passed)

Congress writes these into law. They define who qualifies, what benefits exist, and what rights veterans have. The VA cannot override them. Official primary source:

<https://uscode.house.gov/browse/prelim@title38&edition=prelim> (read any section at uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-sectionN&num=0&edition=prelim).

Table A1-1. Title 38 U.S. Code Citations.

Citation	What it does (plain English)	Chapter(s)
38 U.S.C. § 101	Defines key terms — "veteran," "active duty," "active duty for training" (ACDUTRA), "inactive duty training" (INACDUTRA), "period of war," and others. The foundation for who the law covers and how Guard/Reserve service counts.	Ch.2, Ch.2A
38 U.S.C. § 110	Prohibits the VA from reducing a disability rating that has been in place five years or more without clear evidence of sustained improvement.	Ch.29, Ch.37
38 U.S.C. § 501	Grants the VA Secretary authority to write regulations carrying out the law. All of 38 CFR flows from this.	Ch.4
38 U.S.C. § 511	Bars most courts from reviewing VA benefit decisions — the specialized veterans court system (CAVC → Federal Circuit → Supreme Court) is the review path.	Ch.4
38 U.S.C. § 1110	The core compensation statute for peacetime veterans. The VA shall pay monthly compensation for a service-connected disability — "shall," not "may."	Ch.1
38 U.S.C. § 1112	Creates presumptions of service connection for certain chronic diseases that appear within one year of discharge and for former prisoners of war.	Ch.21
38 U.S.C. § 1114	Sets the compensation rate structure, including the Special Monthly Compensation (SMC) rates for veterans with the most severe disabilities.	Ch.12, Ch.31
38 U.S.C. § 1115	Authorizes additional compensation for a veteran's dependents (spouse, children, dependent parents) based on the veteran's combined rating.	Ch.12, Ch.30
38 U.S.C. § 1116	Creates presumptive service connection for diseases associated with Agent Orange and other herbicide exposure — the legal backbone of the Agent Orange program.	Ch.8, Ch.21, Ch.23
38 U.S.C. § 1117	Authorizes the Secretary to establish presumptions for veterans who served in areas with unidentified environmental hazards — the authority behind Gulf War illness presumptions.	Ch.23
38 U.S.C. § 1119	Directs the Secretary to establish a process for reviewing scientific evidence on toxic exposures and adding conditions to the presumptive list. Expanded by the PACT Act.	Ch.22
38 U.S.C. § 1120	Requires the VA to contract for periodic reviews of the science on toxic exposures and update presumptives accordingly.	Ch.22

Citation	What it does (plain English)	Chapter(s)
38 U.S.C. § 1131	The core compensation statute for wartime veterans — the peacetime equivalent is § 1110. Together, they cover all veterans regardless of era.	Ch.1
38 U.S.C. § 1153	Authorizes compensation for a new or separate disability directly caused by VA treatment or by an injury sustained on VA property (aggravation by VA care).	Ch.16
38 U.S.C. § 1154	Provides combat veterans with a liberalized standard for establishing in-service incurrence — a combat veteran's lay statement can substitute for official records if consistent with the circumstances of service.	Ch.7
38 U.S.C. § 1155	Directs the Secretary to publish and maintain the rating schedule (VASRD). Ratings must be based on average impairment in earning capacity.	Ch.4
38 U.S.C. § 1159	Protects service-connection status itself from severance — once a disability is service-connected, the VA cannot cut it off without clear and unmistakable evidence it was based on fraud or clear error.	Ch.29
38 U.S.C. § 1710	Establishes VA healthcare eligibility and the priority group system that determines cost-sharing and enrollment.	Ch.34
38 U.S.C. § 1781	Authorizes CHAMPVA — healthcare coverage for the spouse and dependents of a veteran who is 100% P&T disabled.	Ch.30
38 U.S.C. § 2101	Authorizes the Specially Adapted Housing (SAH) grant program for veterans with severe service-connected disabilities affecting mobility.	Ch.32
38 U.S.C. § 2102	Sets the SAH grant dollar limits and permits the grant to be used more than once (up to the statutory maximum).	Ch.32
38 U.S.C. § 3501	Defines "eligible person" for VA education benefits — the statutory anchor for Dependents' Educational Assistance (DEA/Chapter 35).	Ch.30
38 U.S.C. § 3901	Authorizes the Automobile Adaptive Equipment grant for veterans whose service-connected disabilities prevent normal vehicle operation.	Ch.32
38 U.S.C. § 3902	Sets the automobile adaptive equipment grant terms, including what modifications qualify and the amount limits.	Ch.32
38 U.S.C. § 5101	Requires a veteran to submit a complete claim on a prescribed form — the statute that establishes the claims-initiation rule.	Ch.20
38 U.S.C. § 5103	The Veterans Claims Assistance Act (VCAA) notice requirement — VA must tell a claimant what information is needed and what VA will help obtain.	Ch.7, Ch.8, Ch.18, Ch.20
38 U.S.C. § 5104	Requires the VA to provide a written decision with reasons and bases, and to notify the veteran of their appeal rights.	Ch.27, Ch.36
38 U.S.C. § 5107	Establishes the benefit-of-the-doubt standard — when the evidence is in equipoise, the VA decides in the veteran's favor.	Ch.7, Ch.15
38 U.S.C. § 5110	Sets the effective-date rules for compensation — generally the date the claim was received or the date of the Intent to File.	Ch.17, Ch.28
38 U.S.C. § 5301	Makes VA disability compensation exempt from taxation and generally exempt from creditor attachment and garnishment.	Ch.1
38 U.S.C. § 5303	Lists the character-of-discharge bars — the types of discharge (dishonorable, under dishonorable conditions, etc.) that make a veteran ineligible for most VA benefits.	Ch.2
38 U.S.C. § 5304	Prohibition against duplication of benefits — bars more than one award (pension, compensation, retirement pay) for the same service at once, and bars VA compensation for any period the veteran receives active service pay. Names the title 10 § 1414 (CRDP) exception.	Ch.2A

Citation	What it does (plain English)	Chapter(s)
38 U.S.C. § 5305	Waiver of retired pay — lets a military retiree waive an amount of retired pay equal to the VA benefit in order to receive VA compensation or pension.	Ch.2A
38 U.S.C. § 5312	Directs the VA to adjust compensation rates for cost-of-living increases (COLA) in line with Social Security adjustments.	Ch.12
38 U.S.C. § 5901	Authorizes the VA to accredit attorneys, claims agents, and Veterans Service Organizations (VSOs) to assist veterans with claims.	Ch.36
38 U.S.C. § 5904	Governs the fees that accredited attorneys and agents may charge veterans — the statute that caps and regulates claim-shark fees.	Ch.35, Ch.36
38 U.S.C. § 7104	Authorizes the Board of Veterans' Appeals (BVA) and sets the one-member decision rule.	Ch.4
38 U.S.C. § 7105	Establishes the Notice of Disagreement (NOD) / decision review request as the trigger for the appeals process.	Ch.27
38 U.S.C. § 7252	Creates the U.S. Court of Appeals for Veterans Claims (CAVC) and establishes its jurisdiction over final BVA decisions.	Ch.4
38 U.S.C. § 7292	Authorizes appeals from CAVC to the U.S. Court of Appeals for the Federal Circuit on questions of law.	Ch.4

38 CFR Part 3 (adjudication regulations)

Part 3 is the VA's rulebook for how it processes and decides claims. It translates the statutes into specific adjudication procedures. Official primary source: <https://www.ecfr.gov/current/title-38/part-3> (read any section at [ecfr.gov/current/title-38/section-3.NNN](https://www.ecfr.gov/current/title-38/section-3.NNN)).

Table A1-2. Title 38 CFR Part 3 Adjudication Regulations.

Citation	What it does (plain English)	Chapter(s)
38 CFR § 3.1	Definitions section — plain language definitions of terms used throughout Part 3 adjudication (e.g., "veteran," "wartime service," "period of war," "in line of duty").	Ch.2, Ch.2A
38 CFR § 3.6	Duty periods — defines active duty, active duty for training (ACDUTRA), and inactive duty training (INACDUTRA), and the rule that ACDUTRA covers a disease or injury while INACDUTRA covers only an injury (plus heart attack, cardiac arrest, or stroke).	Ch.2A
38 CFR § 3.12	Spells out the character-of-discharge bars to benefits and the limited exceptions (e.g., insanity at time of offense).	Ch.2
38 CFR § 3.102	Benefit-of-the-doubt rule — when positive and negative evidence are in rough balance, the VA must resolve the tie in the veteran's favor.	Ch.6, Ch.7, Ch.18, Ch.35
38 CFR § 3.103	Veterans' rights during the claims process: right to representation, right to a hearing, right to submit evidence, right to know what the VA needs.	Ch.26
38 CFR § 3.105	Governs reduction of existing ratings — sets the procedural requirements and evidentiary standards before the VA can lower a rating already on record.	Ch.29, Ch.37
38 CFR § 3.151	Formal claim requirements for compensation — what a completed claim form must include to start the rating process.	Ch.20
38 CFR § 3.155	Intent to File (ITF) — allows a veteran to establish an effective date up to one year in advance of a formal claim by filing a simple notice of intent.	Ch.17, Ch.35

Citation	What it does (plain English)	Chapter(s)
38 CFR § 3.156	New and relevant evidence — the standard for reopening a previously denied claim or submitting new evidence after a rating decision.	Ch.6, Ch.27
38 CFR § 3.159	VA's duty to assist — the regulation implementing VCAA; requires VA to notify claimants of needed evidence and to make reasonable efforts to obtain records.	Ch.18, Ch.20
38 CFR § 3.300	Principles of direct service connection — an injury or disease incurred or aggravated during active duty is service-connected.	Ch.16, Ch.25
38 CFR § 3.303	Direct service connection rules, including the continuity-of-symptomatology pathway for chronic conditions (but see Walker v. Shinseki for scope limits).	Ch.6, Ch.9, Ch.10, Ch.15, Ch.16
38 CFR § 3.304	Specific evidentiary and procedural rules for direct service connection, including the PTSD regulation and stressor documentation requirements.	Ch.6, Ch.7
38 CFR § 3.306	Service connection for aggravation — a pre-existing condition worsened beyond its natural progression by active duty is compensable.	Ch.6, Ch.7, Ch.16
38 CFR § 3.307	Presumptive service connection for chronic diseases — conditions listed in § 3.309(a) that appear within one year of discharge are presumed service-connected.	Ch.6, Ch.16, Ch.21, Ch.23
38 CFR § 3.309	The chronic-disease list — the specific conditions eligible for presumptive service connection, including the Agent Orange disease list and Gulf War list subparts.	Ch.6, Ch.9, Ch.16, Ch.21
38 CFR § 3.310	Secondary service connection — a disability caused or aggravated by a service-connected condition is itself service-connected.	Ch.6, Ch.16, Ch.25, Ch.35
38 CFR § 3.317	Gulf War illness and undiagnosed illness presumptions — the regulatory implementation of the Gulf War chronic-disability program.	Ch.23
38 CFR § 3.321	Extra-schedular ratings — when a rating under the VASRD doesn't adequately reflect how disabling a condition is, a referral for an extra-schedular evaluation is authorized.	Ch.6
38 CFR § 3.326	Compensation and Pension (C&P) examination requirements — when the VA must order an exam and what that exam must cover.	Ch.19
38 CFR § 3.327	Reexamination — sets the conditions under which the VA may call a veteran back for a follow-up C&P exam.	Ch.37
38 CFR § 3.340	Total disability based on individual unemployability (TDIU) — the regulatory definition and criteria, cross-referencing § 4.16.	Ch.14
38 CFR § 3.344	Stabilization of disability ratings — a rating continuously held for five or more years requires more evidence to reduce than a newer rating; same protection for 20-year ratings.	Ch.6, Ch.28, Ch.29, Ch.37
38 CFR § 3.350	Special Monthly Compensation (SMC) — the regulatory framework for SMC grades (K through T) for the most severe disabilities.	Ch.31
38 CFR § 3.352	Aid and attendance and housebound ratings — the criteria for the additional compensation paid to veterans who need help with daily activities.	Ch.31
38 CFR § 3.354	Defines willful misconduct — relevant to whether an in-service injury or illness that resulted from a veteran's own misconduct can be service-connected.	Ch.2
38 CFR § 3.400	Effective dates — the detailed rules for when compensation begins: generally the date the claim was received or the Intent to File date, subject to specific exceptions.	Ch.6, Ch.17, Ch.26, Ch.28, Ch.35
38 CFR § 3.700	One award at a time; no VA compensation, pension, or retirement pay for any period the veteran receives active service pay; lets reservists waive compensation for drill and training days (the drill-pay waiver, VA Form 21-8951-2).	Ch.2A

Citation	What it does (plain English)	Chapter(s)
38 CFR § 3.951	Protected status for ratings held 20 years or more — a 20-year rating cannot be reduced below its lowest point during that period absent fraud.	Ch.29, Ch.37
38 CFR § 3.952	Protected status for combined 100% ratings — special protection against reduction once a combined 100% has been in place for 20 years.	Ch.29, Ch.37
38 CFR § 3.957	Schedular 100% rating protection — cannot be reduced without a full rating board evaluation showing improvement under ordinary conditions of life.	Ch.29
38 CFR § 3.2500	Appeals under the Appeals Modernization Act (AMA) — sets the three-lane AMA decision-review framework (Supplemental, Higher-Level, Board).	Ch.27, Ch.28
38 CFR § 3.2501	Supplemental Claim lane rules — what counts as "new and relevant evidence" to reopen a decision through a Supplemental Claim.	Ch.27

38 CFR Part 4 (the rating schedule — VASRD)

Part 4 is the schedule the VA uses to translate medical findings into a percentage rating. Every body system has its own section; the Diagnostic Codes within each section set the criteria for each rating level. Official primary source: <https://www.ecfr.gov/current/title-38/part-4> (read any section at [ecfr.gov/current/title-38/section-4.NN](https://www.ecfr.gov/current/title-38/section-4.NN)).

Table A1-3. Title 38 CFR Part 4 Rating Schedule (VASRD) Citations.

Citation	What it does (plain English)	Chapter(s)
38 CFR § 4.1	General rating principles — ratings represent average impairment in earning capacity for the condition at that level of severity.	Ch.3
38 CFR § 4.2	Requires the VA to interpret old examination reports in light of the current rating schedule, and to request a new exam if the old one is inadequate.	Ch.3, Ch.19
38 CFR § 4.3	Reasonable doubt in ratings — when the evidence allows for more than one rating level, assign the higher one.	Ch.5
38 CFR § 4.7	Higher of two evaluations — when a condition is on the boundary between two ratings, give the higher rating if the disability is at least as close to the higher criteria.	Ch.5
38 CFR § 4.10	General instructions — ratings consider the veteran's whole condition, occupational adaptability, and ability to lead a normal life.	Ch.3
38 CFR § 4.14	Pyramiding rule — the VA cannot rate the same disability or the same manifestation of a disability twice under different diagnostic codes.	Ch.5
38 CFR § 4.16	Total disability based on individual unemployability (TDIU) — a veteran unable to maintain substantially gainful employment due to service-connected disabilities can receive a 100% rate even if the schedular combined rating is below 100%.	Ch.14, Ch.35
38 CFR § 4.18	Unemployability — clarifies the standard and requires the rating decision to address whether TDIU applies if a veteran raises inability to work.	Ch.14
38 CFR § 4.20	Analogous ratings — when no diagnostic code covers a condition, the VA rates it analogously to the closest listed condition.	Ch.24
38 CFR § 4.25	Combined ratings table — the math the VA uses to combine multiple disability ratings (the "whole-person" method; not simple addition).	Ch.11, Ch.13
38 CFR § 4.26	Bilateral factor — an additional percentage added when a veteran has ratable disabilities affecting both paired extremities or both paired sensory organs.	Ch.11, Ch.13

Citation	What it does (plain English)	Chapter(s)
38 CFR § 4.40	Functional loss — rating muscle conditions based on what the muscle cannot do, not just its diagnosed pathology.	Ch.5
38 CFR § 4.45	Joints — the factors the VA must consider when rating joint conditions: pain, weakness, fatigability, incoordination, and range of motion.	Ch.5
38 CFR § 4.59	Painful motion — any motion of a joint that is painful at any point in its range must be rated at least at the minimum compensable rating for that joint.	Ch.5, Ch.24
38 CFR § 4.71	Schedule of ratings for musculoskeletal conditions — the diagnostic codes for bones, muscles, and joints (the most-used section of the VASRD).	Ch.5, Ch.24
38 CFR § 4.87	Schedule of ratings for ear and hearing conditions — diagnostic codes for hearing loss and tinnitus.	Ch.24
38 CFR § 4.97	Schedule of ratings for respiratory conditions — diagnostic codes for lung diseases, sleep apnea, and related pulmonary conditions.	Ch.24
38 CFR § 4.114	Schedule of ratings for digestive conditions — diagnostic codes for gastrointestinal and digestive system disabilities.	Ch.24
38 CFR § 4.124	Schedule of ratings for neurological conditions — diagnostic codes for peripheral nerve injuries, radiculopathy, and similar conditions.	Ch.24
38 CFR § 4.130	Schedule of ratings for mental disorders — the diagnostic codes for PTSD, depression, anxiety, and other mental health conditions, rated on a General Rating Formula for Mental Disorders.	Ch.5, Ch.24

Other regulations (Part 14, Part 17, Part 21)

Table A1-4. Other CFR Regulations (Parts 14, 17, and 21).

Citation	What it does (plain English)	Chapter(s)
38 CFR § 14.629	VA accreditation of attorneys, claims agents, and VSO representatives — the rule that governs who can legally charge a veteran for claims help and under what conditions.	Ch.36
38 CFR § 17.36	VA healthcare enrollment and priority groups — the regulatory framework for how veterans are assigned to priority groups and what that means for cost-sharing in VA medical care.	Ch.30, Ch.34
38 CFR § 21.3021	Dependents' Educational Assistance (DEA / Chapter 35) — the regulation authorizing education benefits for the dependent children and spouse of a veteran rated 100% P&T.	Ch.30

Landmark court cases

Every case below was verified against the CourtListener database on 2026-07-16: case name, reporter citation, deciding court, and filing date each confirmed against the docket record. Readers who want to read an opinion in full can pull it at CourtListener (<https://www.courtlistener.com>) or the CAVC's own decision search (<http://search.uscourts.cavc.gov/>).

Table A1-5. Landmark Veterans Court Cases.

Case	Holding (plain English)	Chapter(s)
Caluza v. Brown, 7 Vet. App. 498 (CAVC 1995)	Established the three-part test every service-connection claim must satisfy: (1) a current disability, (2) an in-service event or aggravation, and (3) a nexus linking the two. Every service-connection denial must identify which element is missing.	Ch.9, Ch.15

Case	Holding (plain English)	Chapter(s)
DeLuca v. Brown, 8 Vet. App. 202 (CAVC 1995)	Held that C&P exams for joint disabilities must test range of motion through pain — not just maximum range before pain begins. A joint that hurts at 30 degrees but can move to 80 is not the same as a painless 80-degree joint.	Ch.9, Ch.19, Ch.37
Correia v. McDonald, 28 Vet. App. 158 (CAVC 2016)	Extended DeLuca: joint exams must test both active motion (veteran moves the joint) and passive motion (examiner moves it). An exam missing either is legally inadequate.	Ch.9, Ch.19, Ch.37
Saunders v. Wilkie, 886 F.3d 1356 (Fed. Cir. 2018)	Pain alone — without a formal diagnosis — can be a compensable disability if it causes functional impairment. The statute uses "disability," not "disease."	Ch.9, Ch.15
Clemons v. Shinseki, 23 Vet. App. 1 (CAVC 2009)	A claim for a mental health condition covers all conditions reasonably fitting the described symptoms, not just the specific diagnosis the veteran named on the form.	Ch.9
Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007)	A veteran's lay statements — personal observations about symptoms, pain, and in-service events — are competent and credible evidence that the VA must weigh. The VA cannot dismiss them simply because they are not in medical records.	Ch.9, Ch.18
Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006)	The absence of a contemporaneous service medical record does not automatically defeat a veteran's lay testimony. Missing records alone are not a reason to disbelieve a veteran.	Ch.9, Ch.18
Nieves-Rodriguez v. Peake, 22 Vet. App. 295 (CAVC 2008)	A medical opinion's value comes from the quality of its reasoning, not the title or specialty of the person who wrote it. A thorough, well-reasoned private nexus letter can outweigh a conclusory VA exam opinion.	Ch.9, Ch.18
Walker v. Shinseki, 708 F.3d 1331 (Fed. Cir. 2013)	Continuity of symptomatology as a service-connection pathway (under 38 CFR § 3.303(b)) applies only to chronic diseases listed in 38 CFR § 3.309(a). For conditions not on that list, the standard Caluza three-part test is the only route.	Ch.9
George v. McDonough, 596 U.S. 740 (SCOTUS 2022)	A later change in how a regulation is interpreted does not make every prior final decision that used the old interpretation into Clear and Unmistakable Error (CUE). CUE requires an error that was obvious at the time the original decision was made.	Ch.9, Ch.29

Key public laws

These are the major acts of Congress that expanded or reformed the VA benefits system. Ch. 8 covers all of them in detail.

Table A1-6. Key Public Laws Affecting VA Benefits.

Law	Year enacted	What it did
Agent Orange Act (Pub. L. 102-4)	1991	Directed the VA to establish presumptive service connection for diseases associated with Agent Orange / dioxin exposure for Vietnam-era veterans. Established the ongoing scientific review process through the National Academy of Sciences.
Veterans' Judicial Review Act (Pub. L. 100-687)	1988	Created the U.S. Court of Appeals for Veterans Claims (CAVC), giving veterans the right to appeal VA decisions to an independent federal court for the first time. Confirmed at the source credit to 38 U.S.C. § 7251: "Added Pub. L. 100-687, div. A, title III, § 301(a), Nov. 18, 1988, 102 Stat. 4113."
Veterans Claims Assistance Act — VCAA (Pub. L. 106-475)	2000	Eliminated the "well-grounded claim" requirement that had blocked many veterans' claims; imposed a duty on the VA to assist claimants in developing evidence and to notify them of what the VA needs.

Law	Year enacted	What it did
Appeals Modernization Act — AMA (Pub. L. 115-55)	2017	Overhauled the appeals process, replacing the single legacy appeal track with three lanes: Supplemental Claim, Higher-Level Review, and direct appeal to the Board of Veterans' Appeals.
Blue Water Navy Vietnam Veterans Act (Pub. L. 116-23)	2019	Extended Agent Orange presumptive service connection to "Blue Water Navy" veterans who served on U.S. ships in the waters off Vietnam — reversing a prior VA interpretation that required foot on ground.
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act — PACT Act (Pub. L. 117-168)	2022	The largest expansion of VA benefits in decades. Extended toxic-exposure presumptives to post-9/11 burn-pit veterans, Gulf War veterans, and other eras; added dozens of presumptive conditions; required the VA to screen all veterans for toxic exposures.
Camp Lejeune Justice Act (included in Pub. L. 117-168)	2022	Gave veterans (and family members) who lived or worked at Camp Lejeune between 1953 and 1987 the right to sue the federal government for harm caused by contaminated drinking water — a right that had previously been blocked by state law. Also created VA healthcare eligibility for 15 qualifying conditions.

Appendix A2 — Glossary & Acronyms

Vol. 1 uses a lot of government shorthand and legal language. This appendix gives every acronym its full name and every key term a plain-English definition a tired veteran can read once and understand.

Acronyms

Table A2-1. Acronyms.

Acronym	Stands for	Plain meaning
ACDUTRA	Active Duty for Training	Full-time training duty performed by National Guard and Reserve members (annual training, service schools). A disease or an injury incurred in line of duty during ACDUTRA can support a claim. See Ch. 2A.
AMA	Appeals Modernization Act	The 2019 law that replaced the old appeals system with three lanes: Supplemental Claim, Higher-Level Review, and Board appeal.
BCD	Bad Conduct Discharge	A punitive discharge issued by a military court-martial. May bar some VA benefits depending on the period of service involved.
BCMR	Board for Correction of Military Records	A service-branch board that can change official military records, including the character of a discharge.
CAVC	U.S. Court of Appeals for Veterans Claims	A federal court — separate from the VA — that reviews Board of Veterans' Appeals decisions a veteran disagrees with.
C&P	Compensation & Pension (exam)	A medical examination ordered by the VA to assess whether a condition is service-connected and how severe it is.
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs	A VA health-care benefit for qualifying dependents and survivors of veterans who are permanently and totally disabled or who died from a service-connected condition.
CFR	Code of Federal Regulations	The published rules that federal agencies use to carry out laws passed by Congress. VA regulations live in Title 38 CFR.
COE	Certificate of Eligibility	A document from the VA confirming a veteran's or survivor's eligibility for a specific benefit, most commonly the VA home loan guaranty.
COLA	Cost-of-Living Adjustment	An annual increase to VA compensation rates tied to inflation. Congress authorizes it; the dollar figure changes each year.
CRDP	Concurrent Retirement and Disability Pay	A program that lets qualifying military retirees receive both their full retired pay and their full VA compensation at the same time, phasing out the old dollar-for-dollar offset.
CRSC	Combat-Related Special Compensation	A tax-free payment for military retirees whose disability is combat-related. An alternative to CRDP for those who qualify.
CUE	Clear and Unmistakable Error	A specific legal standard for overturning a past VA decision. The error must be obvious from the record at the time — not just a different opinion in hindsight.
DBQ	Disability Benefits Questionnaire	A structured VA form a treating physician fills out to document a veteran's condition. A completed DBQ can substitute for or supplement a C&P exam.
DEA	Dependents' Educational Assistance (Ch. 35)	A VA education benefit for eligible dependents and survivors of veterans who are permanently and totally disabled or who died in service or from a service-connected cause.

Acronym	Stands for	Plain meaning
DFAS	Defense Finance and Accounting Service	The Defense Department office that processes military pay, including retired pay. Separate from the VA.
DIC	Dependency and Indemnity Compensation	A tax-free monthly payment to surviving spouses, children, and parents of a service member or veteran who died in service or from a service-connected condition.
DRB	Discharge Review Board	A service-branch board that reviews and may upgrade a veteran's discharge characterization. Separate from the BCMR.
EED	Earlier Effective Date	An earlier start date for a VA benefit (sometimes called an "earlier effective date claim") that can result in retroactive back pay if granted.
FDC	Fully Developed Claim	A claim the veteran submits with all supporting evidence already gathered, allowing the VA to process it faster under a separate lane.
HLR	Higher-Level Review	One of the three AMA appeal lanes. A more senior VA adjudicator reviews the same evidence on record without the veteran adding anything new.
ITF	Intent to File	A notice to the VA that a veteran plans to file a claim. It locks in an earlier potential effective date for up to one year.
IU	Individual Unemployability (see TDIU)	A benefit that pays a veteran at the 100% rate when service-connected disabilities prevent substantially gainful employment, even if the combined rating is below 100%. See TDIU.
INACDUTRA	Inactive Duty Training	The drill: weekend assemblies and part-time training for Guard and Reserve members. Only an injury (or a heart attack, cardiac arrest, or stroke during the training) incurred in line of duty can support a claim — a disease generally cannot. See Ch. 2A.
LOD	Line of Duty	A military determination that an injury or illness happened while a member was performing authorized duty and not from their own misconduct. Often the decisive evidence in a Guard or Reserve training-period claim.
M21-1	VA Adjudication Procedures Manual (M21-1)	The internal VA handbook that guides how claims examiners process and decide claims. Not legally binding on veterans but important to understand how decisions are made.
NGB 23	National Guard Bureau Form 23 (Retirement Points History / service record)	The National Guard record of a member's points and service history; used to prove which periods were active duty, ACDUTRA, or INACDUTRA.
NOD	Notice of Disagreement	The formal document a veteran files to start the appeals process after receiving a decision the veteran disagrees with.
OTH	Other Than Honorable (discharge)	A characterization of discharge that may bar some VA benefits. Eligibility depends on the specific circumstance and benefit sought.
P&T	Permanent & Total	A VA status indicating the veteran's combined disability rating is 100% and the disabilities are considered permanent (unlikely to improve). Opens additional benefits including CHAMPVA and DEA.
PACT	Presumptive Act (PACT Act, 2022)	A major 2022 law that expanded VA presumptive eligibility for veterans exposed to burn pits, Agent Orange, radiation, and other toxins. Added many conditions and extended eligibility to more veterans.
SAH	Specially Adapted Housing grant	A VA grant for veterans with severe service-connected disabilities to build, buy, or modify a home for accessibility.

Acronym	Stands for	Plain meaning
SAD	State Active Duty	National Guard service ordered by a state's governor under state law and paid with state funds. Generally not federal service, so it usually cannot establish veteran status for a VA disability claim. See Ch. 2A.
SC	Service Connected	A VA determination that a veteran's condition is linked to military service and therefore eligible for compensation.
SHA	Special Home Adaptation grant	A smaller VA grant (compared to SAH) for veterans with qualifying service-connected disabilities to adapt an existing home.
SMC	Special Monthly Compensation	Additional VA compensation paid on top of regular disability compensation for veterans with specific severe conditions — such as loss of a limb, blindness, or needing aid and attendance.
TDIU	Total Disability Individual Unemployability	A benefit that pays at the 100% rate when service-connected conditions prevent substantially gainful employment. Requires meeting minimum rating thresholds. See Ch. 14.
U.S.C.	United States Code	The published body of federal law passed by Congress. VA benefit law lives primarily in Title 38 U.S.C.
VA	Department of Veterans Affairs	The federal agency responsible for administering benefits and services for eligible veterans, service members, and their dependents.
VASRD	VA Schedule for Rating Disabilities	The master list of medical conditions the VA rates, organized by body system, with Diagnostic Codes and the criteria for each rating percentage. Found at 38 CFR Part 4.
VCAA	Veterans Claims Assistance Act	A 2000 law that codified the VA's duty to assist veterans in developing their claims and the duty to notify veterans of what evidence is needed.
VSO	Veterans Service Organization	A nonprofit organization (such as DAV, VFW, or American Legion) that provides free claims representation and advocacy to veterans. VA-accredited VSO representatives can help file and develop claims at no charge.

Glossary

Table A2-2. Glossary of Terms.

Term	Plain-English definition
Active duty for training (ACDUTRA)	Full-time training duty for Guard and Reserve members. Both a disease and an injury incurred in line of duty during ACDUTRA can establish veteran status and support a claim.
Aggravation	Military service made a pre-existing condition measurably worse — beyond normal disease progression. Veterans can receive compensation for the difference between where the condition was at entry and where it is now.
Aid and attendance	A type of Special Monthly Compensation (SMC) for veterans who need regular help from another person with basic daily activities — bathing, dressing, eating, or who are bedridden or in a nursing home.
Back pay	Retroactive compensation paid from the effective date of a claim to the date the VA grants the benefit. The earlier the effective date, the larger the lump sum.
Benefit of the doubt	A legal standard unique to VA claims: when the evidence for and against a veteran's claim is roughly equal, the VA must decide in the veteran's favor. Codified at 38 U.S.C. § 5107(b).
Bilateral factor	An additional percentage the VA adds to a combined rating when a veteran has ratable disabilities in both arms, both legs, or both pairs of extremities. It is added before the combined rating is calculated.

Term	Plain-English definition
Board appeal	One of the three AMA appeal lanes. The veteran asks the Board of Veterans' Appeals — an independent body within VA — to review the decision. Three sub-options exist: direct review, evidence submission, or a hearing.
Character of discharge	The official label on a veteran's DD-214 for how they left the military (Honorable, General, Other Than Honorable, Bad Conduct, or Dishonorable). It affects eligibility for VA benefits.
Combined rating	The method VA uses to calculate a total disability percentage when a veteran has multiple service-connected conditions. It is not simple addition — each condition is applied to the veteran's remaining ability, using the VA's Combined Ratings Table. Result is rounded to the nearest 10.
Continuity of symptomatology	A way to establish service connection by showing that symptoms of a condition have been continuous (or nearly so) from military service to the present, even without a formal diagnosis in service records.
Diagnostic Code	A four-digit code in the VASRD that identifies a specific condition and lists the criteria for each rating percentage. For example, DC 5003 covers degenerative arthritis.
Drill-pay waiver	The rule that a veteran cannot draw VA disability compensation and military pay for the same day. A rated Guard or Reserve member waives one day of VA compensation for each day of drill, training, or active-duty pay, elected each year on VA Form 21-8951-2. It does not lower the rating. See Ch. 2A.
Duty to assist	The VA's legal obligation to help veterans gather evidence for their claims — ordering C&P exams, requesting service records, and getting medical records from VA facilities. Codified by the VCAA.
Duty to notify	The VA's obligation to tell a veteran in writing what information or evidence is needed to decide a claim, and what the VA will do to help gather it. Part of the VCAA framework.
Effective date	The date from which VA compensation or benefits begin to accrue. Generally the date the VA receives a claim, or the date entitlement arose — whichever is later. An earlier effective date means more back pay.
Equipose	The point where the evidence for and against a claim is approximately equal — a tie. Under the benefit of the doubt rule, the VA resolves a tie in the veteran's favor.
Extraschedular rating	A rating above the normal VASRD schedule, granted when a veteran's disability causes unusual employment and social impairment that the standard rating criteria do not capture. Requires referral to a VA central office.
Higher-level review	An AMA appeal where a more senior VA adjudicator reviews the existing record — no new evidence allowed. The reviewer looks for errors of fact or law in the original decision.
Housebound	A type of Special Monthly Compensation (SMC) for veterans who are substantially confined to their home due to service-connected disabilities. Less severe than aid and attendance.
Intent to file	A formal notice to the VA that a veteran plans to submit a claim. It reserves a potential effective date for up to 12 months, protecting back-pay rights while evidence is gathered.
Inactive duty training (INACDUTRA)	Part-time training — the drill weekend and similar assemblies. Only an injury (or a heart attack, cardiac arrest, or stroke during the training) counts; a disease that merely appears during INACDUTRA generally does not.
Lay evidence	Written or oral statements from a veteran or others — not a medical professional — about symptoms, events, or observations. It is valid evidence before the VA and can help establish service connection or severity.
Line of duty	A finding that an injury or disease occurred while a member was on authorized duty, not from their own willful misconduct. For Guard and Reserve training-period claims, the line-of-duty determination is often the hinge of the case.
Marginal employment	Employment with earnings below the federal poverty threshold for one person, or work done in a protected work environment (like a VA compensated work therapy program). Under TDIU rules, marginal employment is not "substantially gainful" employment.

Term	Plain-English definition
Nexus	The medical or evidentiary link connecting a veteran's current condition to their military service. Nexus is one of the three required elements for service connection (along with a current diagnosis and an in-service event or injury).
Nexus letter	A written medical opinion from a physician stating that a veteran's current condition is at least as likely as not related to military service. A strong nexus letter is one of the most important documents in a service-connection claim.
Presumption of soundness	A legal rule that a veteran who entered service without a noted defect is presumed to have been in sound condition at entry. The VA bears the burden of proving a pre-existing condition, not the veteran.
Presumptive condition	A condition the VA automatically connects to a specific type of service, location, or exposure — without the veteran having to prove the individual link. Veterans still need a current diagnosis, but nexus is presumed.
Pyramiding	The prohibited practice of rating the same disability — or overlapping symptoms — under multiple Diagnostic Codes to inflate a rating. The VA must evaluate each symptom only once.
Rating code sheet	The VA's internal worksheet listing every rated condition with its Diagnostic Code, percentage, and effective date. It is not the same as the decision/notification letter, which summarizes the outcome but does not list Diagnostic Codes, and the VA does not send the code sheet automatically. It is requested from the veteran's VA Regional Office in person or through a FOIA/Privacy Act request.
Rating decision	The VA's formal written decision on a claim. It states whether each condition is service-connected, what rating percentage is assigned, and what the effective date is. It is the document veterans appeal if they disagree. The notification letter that conveys it is a summary; the Diagnostic Codes appear on the separate rating code sheet (see above).
Reasons and bases	The part of a VA rating decision or Board decision that explains the legal and factual reasoning behind the outcome. A decision must give adequate reasons and bases for each finding — vague or conclusory explanations are grounds for appeal.
Schedular rating	A disability rating assigned by directly applying the criteria in the VASRD. This is the standard method. When those criteria do not fully capture a disability's real-world impact, the veteran may seek an extraschedular rating.
Secondary condition	A condition caused or aggravated by an already service-connected condition. It can be service-connected on a secondary basis even if the secondary condition itself has no direct tie to military service.
Service connection	The official VA determination that a veteran's current disability is related to military service. It is the gateway to compensation. Requires: a current diagnosis, an in-service event or injury, and a nexus linking them.
State Active Duty (SAD)	National Guard service ordered by a state's governor under state law and paid with state funds (such as a disaster response). It is generally not federal service, so it usually cannot establish veteran status for a VA disability claim, though it may carry separate state benefits.
Substantially gainful employment	Employment that provides a living wage above the federal poverty level for one person, in a competitive work environment. Veterans who cannot maintain this level of employment due to service-connected conditions may qualify for TDIU.
Title 10 (active duty)	Federal active-duty service. When a Guard or Reserve member is mobilized or deployed under Title 10 authority, they are treated as active duty for VA purposes, with the full active-duty presumptions.
Title 32 (duty)	Full-time National Guard duty that is federally funded but commanded by the state's governor. For VA purposes it generally runs through the ACDUTRA or INACDUTRA rules rather than counting as Title 10 active duty.
Supplemental claim	One of the three AMA decision-review lanes. The veteran submits new and relevant evidence the VA did not previously consider. The VA must take another look at the claim with the new evidence.

Term	Plain-English definition
Prostrating attack	A severe episode of a condition — such as a migraine, seizure, or Meniere's disease attack — that forces the veteran to stop normal activity. The frequency and severity of prostrating attacks affects the rating for some conditions.

Cited Sources

Verify all citations against current primary sources before acting.

- **38 U.S.C. § 5107(b)** — Benefit of the doubt. <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section5107&num=0&edition=prelim>
- **38 U.S.C. § 1110 / § 1131** — Basic entitlement (wartime / peacetime).
<https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1110&num=0&edition=prelim> · <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1131&num=0&edition=prelim>
- **38 U.S.C. § 101(21)–(24)** — Definitions of active duty, active duty for training, and inactive duty training (Guard/Reserve). <https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section101&num=0&edition=prelim>
- **38 CFR § 3.6** — Duty periods (disease-vs-injury rule for ACDUTRA and INACDUTRA).
<https://www.ecfr.gov/current/title-38/section-3.6>
- **38 CFR Part 4** — Schedule for Rating Disabilities (VASRD). <https://www.ecfr.gov/current/title-38/part-4>
- **38 CFR § 3.102** — Benefit of the doubt. <https://www.ecfr.gov/current/title-38/section-3.102>
- **38 CFR § 3.303** — Principles relating to service connection. <https://www.ecfr.gov/current/title-38/section-3.303>
- **38 CFR § 3.310** — Disabilities that are proximately due to, or aggravated by, service-connected disease or injury (secondary conditions). <https://www.ecfr.gov/current/title-38/section-3.310>
- **38 CFR § 4.25** — Combined ratings table. <https://www.ecfr.gov/current/title-38/section-4.25>
- **38 CFR § 4.26** — Bilateral factor. <https://www.ecfr.gov/current/title-38/section-4.26>
- **38 CFR § 4.14** — Avoidance of pyramiding. <https://www.ecfr.gov/current/title-38/section-4.14>
- **38 CFR § 3.340 / § 3.341** — Total disability ratings / TDIU. <https://www.ecfr.gov/current/title-38/section-3.340> · <https://www.ecfr.gov/current/title-38/section-3.341>
- **38 CFR § 3.655** — Consequences of failure to respond to notice (ITF-related).
<https://www.ecfr.gov/current/title-38/section-3.655>
- **VA.gov** — Appeals Modernization Act overview. <https://www.va.gov/decision-reviews/>
- **VA.gov** — Special Monthly Compensation. <https://www.va.gov/disability/compensation-rates/special-monthly-compensation-rates/>
- **VA.gov** — CHAMPVA. <https://www.va.gov/health-care/family-caregiver-benefits/champva/>
- **VA.gov** — Specially Adapted Housing grants. <https://www.va.gov/housing-assistance/disability-housing-grants/>
- **PACT Act summary** — <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/>

Appendix A3 — Key Forms & Where to Find Them

A VA claim lives or dies on paper. Knowing the right form for each step keeps things moving and prevents mistakes that cost months of back pay.

Every form listed below is available free of charge at **VA.gov/find-forms**. Form numbers are stable but do change. Veterans should verify the current number and download the latest version directly from VA.gov before filing. A VSO can help locate and complete any of these forms at no cost (see **Ch. 36 — VSOs, Attorneys, and Claim Sharks**).

IMPORTANT: Verify all form numbers and download links at <https://www.va.gov/find-forms/> before filing. Outdated form versions can result in rejected claims.

Forms by Purpose

Filing a New Disability Claim

Table A3-1. Filing a New Disability Claim.

Form	Name	What it's for	Related chapter
VA 21-526EZ	Application for Disability Compensation and Related Compensation Benefits	The primary form to open a new disability compensation claim. Covers initial claims, reopened claims, and increases.	Ch. 17
VA 21-0966	Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC	Locks in an effective (start) date while a veteran gathers evidence. Protects potential back pay for up to one year.	Ch. 17

Submitting Evidence & Records

Table A3-2. Submitting Evidence and Records.

Form	Name	What it's for	Related chapter
VA 21-4138	Statement in Support of Claim	A lay statement form. Used by a veteran, buddy, or family member to describe in writing how a condition affects daily life or to document an in-service event.	Ch. 18
VA 21-4142	Authorization to Disclose Information to the Department of Veterans Affairs	Authorizes the VA to request private medical records from a doctor, hospital, or other private provider on the veteran's behalf.	Ch. 18
VA 21-4142a	General Release for Medical Provider Information to the Department of Veterans Affairs	Companion to VA 21-4142. Used when the veteran has multiple private providers or facilities to list.	Ch. 18

Appeals

Table A3-3. Appeals.

Form	Name	What it's for	Related chapter
VA 20-0995	Decision Review Request: Supplemental Claim	Requests a Supplemental Claim lane review. Used to submit new and relevant evidence after an unfavorable decision.	Ch. 27
VA 20-0996	Decision Review Request: Higher-Level Review	Requests a Higher-Level Review lane review. A senior VA claims adjudicator reviews the prior decision for clear error — no new evidence.	Ch. 27
VA 10182	Decision Review Request: Board Appeal (Notice of Disagreement)	Appeals a decision to the Board of Veterans' Appeals (BVA). Veterans choose one of three BVA dockets: Direct Review, Evidence Submission, or Hearing Request.	Ch. 27
VA 21-0958	Notice of Disagreement (LEGACY)	The old NOD form used in the legacy appeals system. Only relevant for claims still pending in the legacy system. Do not use for AMA (post-Feb 2019) decisions.	Ch. 27

Special Compensation & Aid

Table A3-4. Special Compensation and Aid.

Form	Name	What it's for	Related chapter
VA 21-2680	Examination for Housebound Status or Permanent Need for Regular Aid and Attendance	Used to apply for the Aid & Attendance (A&A) or Housebound benefit. Completed by a licensed health care provider.	Ch. 31
VA 21-8951-2	Notice of Waiver of VA Compensation or Pension to Receive Military Pay and Allowances	The drill-pay waiver. A rated Guard or Reserve member returns it each year to waive one day of VA compensation for each day of drill, training, or active-duty pay (a member cannot draw both for the same day). Confirm the current form designation at va.gov/find-forms/ before submitting.	Ch. 2A

Dependents

Table A3-5. Dependents.

Form	Name	What it's for	Related chapter
VA 21-686c	Declaration of Status of Dependents	Used to add or remove dependents (spouse, children, dependent parents) to a veteran's compensation award. A dependent can increase the monthly payment.	Ch. 12

VA Health Care

Table A3-6. VA Health Care.

Form	Name	What it's for	Related chapter
VA 10-10EZ	Application for Health Benefits	Applies for enrollment in VA health care. Separate from disability compensation — veterans must apply for health care independently.	Ch. 34

Home Loan

Table A3-7. Home Loan.

Form	Name	What it's for	Related volume
VA 26-1880	Request for a Certificate of Eligibility	Requests a VA Home Loan Certificate of Eligibility (COE) from VA. The COE documents the veteran's entitlement to the VA home loan benefit.	Vol. 4

Representation

Table A3-8. Representation.

Form	Name	What it's for	Related chapter
VA 21-22	Appointment of Veterans Service Organization as Claimant's Representative	Appoints a Veterans Service Organization (VSO) as the veteran's authorized representative. VSOs are free.	Ch. 36
VA 21-22a	Appointment of Individual as Claimant's Representative	Appoints an individual (VA-accredited attorney or claims agent) as the veteran's authorized representative. Attorneys and agents may charge fees; VSOs do not.	Ch. 36

Discharge Document (not a VA form)

Table A3-9. Discharge Document.

Form	Name	What it's for	Related chapter
DD-214	Certificate of Release or Discharge from Active Duty	Proof of military service and discharge character. This is a Department of Defense form, not a VA form. Every VA claim starts here. Requests go through the National Archives (milConnect or SF-180), not VA.	Ch. 2

How to File

Online is fastest. Most forms can be submitted through VA.gov or the AccessVA portal. Online submissions timestamp immediately and cut down on mail delays.

Mail addresses change. When mailing a form, use the address printed on the form's current instructions, not an address from memory or a third-party site. Routing can change by form type or claim category.

A VSO files for free. A Veterans Service Organization representative can locate, complete, and submit these forms on a veteran's behalf at no charge. See **Ch. 36 — VSOs, Attorneys, and Claim Sharks** for how to appoint a VSO and what to expect.

Cited Sources

Verify all form numbers and versions against current primary sources before acting.

- **VA Find Forms** — the official VA forms search portal. <https://www.va.gov/find-forms/>
- **National Archives — Military Service Records** — request a DD-214 or official service records from the National Personnel Records Center. <https://www.archives.gov/veterans/military-service-records>
- **milConnect (Defense Manpower Data Center)** — the Defense Department's own portal for DD-214 and service record access. <https://milconnect.dmdc.osd.mil/>
- **VA Appeals Modernization Act (AMA) lanes** — overview of Supplemental Claim, HLR, and Board Appeal. <https://www.va.gov/decision-reviews/>

Appendix A4 — Verification Sources & Staying Current

This manual teaches the rules. But the numbers, rates, and lists that govern VA disability benefits change, sometimes every year, sometimes mid-year. This appendix is the toolkit for confirming any figure or rule before relying on it at the moment of filing. Accuracy at that moment is the veteran's responsibility, not the manual's.

The primary sources (where the real law lives)

Table A4-1. Primary Verification Sources.

Source	What it gives	URL
eCFR (Electronic Code of Federal Regulations)	The current, authoritative text of 38 CFR — Part 3 (adjudication rules) and Part 4 (rating schedule). Updated when rules change. Every section shows an effective date.	https://www.ecfr.gov/current/title-38
Cornell LII (Legal Information Institute)	Free, readable versions of the U.S. Code (Title 38 statutes) and the CFR. Good for reading the statutes behind the regs.	https://www.law.cornell.edu/uscode/text/38 · https://www.law.cornell.edu/cfr/text/38
VA.gov	Plain-language benefit guides, official current forms, compensation rate tables, and the current PACT Act covered-condition lists. Use for forms and rates, not the legal standard.	https://www.va.gov/disability/
Federal Register / GovInfo	Where proposed and final rule changes are published. GovInfo archives past annual CFR volumes for historical criteria.	https://www.federalregister.gov/ · https://www.govinfo.gov/app/collection/CFR
M21-1 Adjudication Procedures Manual	The VA's internal rater guidebook. Not binding law, but it shows how the VA interprets its own rules and what evidence raters are trained to look for.	https://benefits.va.gov/warms/M21_1.asp
CAVC / U.S. Court of Appeals for the Federal Circuit	Published court decisions that interpret VA statutes and regulations. When courts define what a rule means, that definition carries legal weight.	https://www.uscourts.cavc.gov/ · https://cafc.uscourts.gov/
VA accreditation search	Confirms whether an attorney, claims agent, or VSO representative is currently accredited to assist veterans. Check a rep's credentials here before granting access to a claim.	https://www.va.gov/ogc/apps/accreditation/index.asp

What changes most often (check these every time)

- **Annual compensation rates (COLA).** The base rates for each combined rating (10% through 100%) are adjusted each year, tied to the Social Security cost-of-living increase. The new rate takes effect December 1, paid January 1. Current rates are on VA.gov.

- **Dependent add-on amounts.** The additional pay for a spouse, dependent children, and dependent parents adjusts with the annual COLA, on the same schedule as the base rate.
 - **SMC (Special Monthly Compensation) rates.** SMC categories (SMC-S, SMC-L, SMC-R, and others) each carry their own rate tables, all of which adjust annually. A veteran receiving SMC should verify the current amount every January.
 - **VA grant dollar caps (SAH/SHA/HISA).** The Specially Adapted Housing, Special Home Adaptation, and Home Improvement grants carry dollar caps set by law. The cap in effect on the date of approval controls the award.
 - **PACT Act / presumptive condition lists.** The PACT Act expanded which conditions are presumptively service-connected, and the lists are still being updated as the VA adds new conditions or locations. Veterans denied in the past should recheck the current presumptive list before refiling.
 - **VASRD rating criteria (modernization rewrites).** The VA is rewriting the Schedule for Rating Disabilities body system by body system. When criteria change, old rating standards may no longer apply. Always read the current Part 4 text on eCFR, not a saved screenshot from an earlier date.
 - **Form numbers and download links.** VA forms are revised periodically. An old version downloaded from a third-party site or saved locally may be rejected. Pull the current form directly from VA.gov.
 - **Income and copay thresholds.** VA health care eligibility and copay amounts for certain programs are income-based and adjust annually on their own calendar, not the COLA schedule.
 - **State veterans benefits.** Every state runs its own programs: property tax exemptions, education benefits, employment preferences, and more. State programs change on their own legislative schedules. A benefit that was correct last year may carry different eligibility rules this year.
-

How to verify a figure or rule (a simple checklist)

1. **Identify the exact citation.** Note the statute (e.g., 38 U.S.C. § 1110), the regulation (e.g., 38 CFR § 3.303), or the diagnostic code (e.g., DC 5260). Vague references cannot be verified.
 2. **Open the current primary source.** For a regulation, that means eCFR, not a PDF, a blog, or this manual. For a statute, Cornell LII or the U.S. Code on govinfo.gov. For a rate, VA.gov's current rate table.
 3. **Check the effective date.** Every eCFR section shows the date the current text took effect. Confirm it is the version that applies to the claim: the current date, or the date of a past decision.
 4. **Confirm the number or criteria.** Read the actual text. Transcription errors and outdated copies are common; don't trust a quote or paraphrase without checking.
 5. **Note the date checked.** Write down when the verification was done and what source was used. If a claim is later questioned, that record matters.
 6. When this manual and a primary source disagree, the primary source wins. Always.
-

A word on this manual

The Veteran Field Manual is an independent educational resource. It was written to be accurate as of its draft date, and every chapter cites the primary sources it draws from. But it is not a government publication, it does not update automatically when rules change, and it carries no legal authority. When a veteran reads this manual, then checks the current primary source and finds something different, the primary source is correct. That is not a flaw. That is the system working exactly as intended.

Appendix A5 — Templates & Sample Language

Veterans are routinely told they need a nexus letter, a buddy statement, or a personal statement, but nobody shows them what those documents actually look like. This appendix fills that gap. Each section explains what a document is for, what makes it strong, gives a clean fill-in template, and then walks through each blank.

How to read every template here

Each template has two parts, and keeping them straight is the whole point:

1. **The letter.** This is the document itself, shown in a plain box. Anything inside **[SQUARE BRACKETS IN CAPITAL LETTERS]** is a blank to replace with real information. Type the information, not the brackets. Everything else in the box is the actual wording to keep.
2. **"How to fill it in."** This is the numbered guide directly under the letter. It explains each blank and gives examples. These notes are *not* part of the letter. Do not copy them into the document.

So: the box is what gets signed and sent. The list under it is the coaching. They never mix.

Three cautions apply to everything here. First, a medical nexus opinion must be written and signed by a qualified medical provider. A veteran cannot write their own nexus. The nexus template is a structure to hand a doctor so the doctor understands what the VA needs; the provider applies clinical judgment and signs the result. Second, these are educational examples, not legal or medical advice. Have an accredited claims agent, VSO, or VA-accredited attorney review the package before submitting (see **Ch. 36 — VSOs, Attorneys, and Claim Sharks**). Third, every statement must be truthful. A fabricated or exaggerated statement is fraud. It can bar a veteran from benefits and lead to criminal prosecution. Specific, honest detail is what wins claims.

1. Nexus Letter (a medical provider completes this)

What it is and why it matters

A nexus letter is a private medical opinion on the link between a veteran's current condition and their military service. It is often the difference between a grant and a denial. (See **Ch. 18 — Evidence That Wins Claims** for why the nexus is the leg most claims fail on, and **Ch. 15 — The Elements of Service Connection** for the three elements every claim must establish.)

An opinion that says the condition "may be related to service" does not move a claim. The VA gives little weight to a bare conclusion. A strong nexus letter does four things: it names the records the provider reviewed, states the current diagnosis, uses the VA's standard probability phrase, and explains the medical reasoning. The reasoning is the load-bearing part. A nexus letter stands or falls on its logic, not the provider's title (*Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (CAVC 2008)).

One hard limit: a veteran cannot write their own nexus letter. The template below is a briefing tool. Hand it to a treating physician, specialist, or private independent medical examiner so they understand the VA's standard. The provider then writes and signs the opinion in their own words. Use the template to explain the standard, not to "fill in the blanks" for the doctor.

Template — Nexus Letter

Copy the box. The provider replaces each **[CAPS BRACKET]** and writes the rationale in their own words. The notes under the box explain each blank.

[PROVIDER LETTERHEAD OR PRACTICE NAME]
[PROVIDER NAME AND CREDENTIALS]
[DATE]

RE: Medical Nexus Opinion – [VETERAN FULL NAME], [VA CLAIM NUMBER OR LAST 4 OF SSN]

To Whom It May Concern:

I am a [PROVIDER TITLE OR SPECIALTY] licensed in [STATE]. I have reviewed the following records for the veteran named above:

- Service treatment records: [DATE RANGE OR SOURCE]
- Service personnel records: [RELEVANT ITEMS]
- Current medical records: [FACILITY], [DATE RANGE]
- Other records reviewed: [LIST, OR "none"]

CURRENT DIAGNOSIS

[VETERAN FULL NAME] currently has a diagnosis of [DIAGNOSIS]. The condition presents as [BRIEF CLINICAL DESCRIPTION].

IN-SERVICE HISTORY

The records show that during military service, [VETERAN FULL NAME] [IN-SERVICE EVENT OR EXPOSURE].

NEXUS OPINION

It is my medical opinion that [VETERAN FULL NAME]'s [DIAGNOSIS] is at least as likely as not (a 50 percent probability or greater) caused by, or aggravated beyond its natural progression by, their military service.

RATIONALE

[MEDICAL REASONING – the provider's own words.]

This opinion is based on my review of the records listed above, my clinical knowledge, and [MEDICAL LITERATURE, IF CITED].

[SIGNATURE]
[PROVIDER NAME AND CREDENTIALS]
[LICENSE NUMBER AND STATE]
[CONTACT INFORMATION]
[DATE]

How to fill it in:

1. **[VETERAN FULL NAME] / [VA CLAIM NUMBER OR LAST 4 OF SSN]** — the veteran's legal name, and the VA claim file number if one has been assigned (the last four of the SSN works if not).

2. **[PROVIDER TITLE OR SPECIALTY] / [STATE]** — the provider's role and the state of licensure. Examples: physician, licensed psychologist, nurse practitioner.
3. **Records list** — the provider lists what they actually reviewed. Listing real records is what shows the opinion is grounded in evidence rather than guesswork. Personnel-record items might include deployment orders, the DD-214, or MOS documentation.
4. **[DIAGNOSIS] / [BRIEF CLINICAL DESCRIPTION]** — the named condition and how it currently shows up. Examples of conditions: lumbar degenerative disc disease, major depressive disorder, bilateral hearing loss.
5. **[IN-SERVICE EVENT OR EXPOSURE]** — what happened in service that the condition traces to. Examples: "sustained a low-back injury during a road march in [MONTH/YEAR]"; "served in [MOS] with routine exposure to [HAZARD]"; "deployed to [LOCATION] during [PERIOD]." Note any document that corroborates it.
6. **"At least as likely as not"** — keep this phrase exactly. It is the 50/50 probability standard the VA requires. "May be related" or "possibly" falls below it.
7. **[MEDICAL REASONING]** — the most important block, and the provider writes it. Strong reasoning covers: the medical basis for the connection (clinical knowledge, pathophysiology, or literature); why the in-service event fits the development of this condition; any alternative causes and why service is still at least as likely; and the specific records that support the conclusion.

2. Buddy / Lay Statement (VA Form 21-10210 or VA Form 21-4138)

What it is and why it matters

A buddy statement is a written account from someone other than the veteran — a fellow service member, a family member, a friend, a coworker — describing what that person personally saw. The veteran's own statement is also lay evidence and can go on the same form.

Lay statements are legally competent evidence under 38 C.F.R. § 3.159(a)(2). They can establish two things a medical record often cannot: an undocumented in-service event, and continuity of symptoms over time. A squad leader who saw a training accident, or a spouse who has watched chronic pain for twenty years, is giving exactly the firsthand testimony the regulation authorizes (*Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007)). See **Ch. 18 — Evidence That Wins Claims** for the full treatment.

What a lay statement cannot do is diagnose a condition or supply the medical nexus. That is the provider's job. It describes observable facts: what happened, when, where, and what the symptoms look like day to day. A weak statement says "he's always had a bad back." A strong one names when the injury happened, who was there, what the veteran's condition was right after, and how the symptoms have shown up over the years in specific, observable ways. The person signing makes a legal declaration; fabrication is fraud.

Template — Buddy / Lay Statement

Copy the box. Replace each **[CAPS BRACKET]**. Use the in-service section only if the writer served with the veteran; otherwise delete it and use the observations section.

STATEMENT IN SUPPORT OF CLAIM

(VA Form 21-10210, or VA Form 21-4138 — confirm the current form at va.gov)

I, [WRITER FULL NAME], am making this statement in support of the VA disability

claim of [VETERAN FULL NAME].

My relationship to the veteran: [RELATIONSHIP]

The following is true to the best of my knowledge and belief.

IN-SERVICE EVENTS (only if the writer served with the veteran)

I served with [VETERAN FULL NAME] in [UNIT] from [START DATE] to [END DATE].
During that time I personally witnessed [IN-SERVICE EVENT].

After the incident I observed that [WHAT YOU PERSONALLY SAW].

[ADDITIONAL FIRSTHAND OBSERVATIONS FROM SERVICE, IF ANY.]

WHAT I HAVE OBSERVED SINCE THEN

I have known [VETERAN FULL NAME] since [YEAR]. Since then I have personally observed:

- [OBSERVATION 1]
- [OBSERVATION 2]
- [OBSERVATION 3]

This statement reflects what I personally observed. I am not offering a medical opinion.

[SIGNATURE]

[PRINTED NAME]

[DATE]

[CONTACT INFORMATION – optional but helpful]

How to fill it in:

1. **[RELATIONSHIP]** — how the writer knows the veteran. Examples: fellow service member, unit leader, spouse, sibling, former coworker.
2. **[UNIT] / dates** — for a fellow service member, the shared unit and the dates served together. Example unit: "1st Battalion, 75th Ranger Regiment."
3. **[IN-SERVICE EVENT]** — the specific thing the writer saw. Examples: "the vehicle rollover during a convoy near [LOCATION] in [MONTH/YEAR]"; "the obstacle-course accident at [INSTALLATION] in about [MONTH/YEAR]."
4. **[WHAT YOU PERSONALLY SAW]** — the writer's own observation right after. Examples: "he was limping and holding his lower back"; "she could not bear weight on her left knee and was helped off the range"; "he said his ears were ringing right after the blast."

5. **Observations since then** — specific, observable symptoms, not medical conclusions. Examples: "he favors his right knee on stairs"; "I've seen her stop activity from pain several times a month"; "he's awake in visible discomfort at night on many occasions"; "he's cancelled family events because of the pain about [NUMBER] times this year." Put approximate dates or frequencies wherever possible — vague statements carry less weight.

3. Personal Statement — Describing Symptoms Honestly ("the worst day")

What it is and why it matters

A veteran's own written statement is competent lay evidence under the same rules that govern buddy statements. It covers what the veteran experienced in service and what they still live with today.

The most important principle: describe the worst day, not the average day. For many conditions, the VA rating criteria (38 C.F.R. Part 4) turn on the frequency and severity of the worst symptoms — flare-ups, periods of incapacitation, the hardest episodes. "My back is about a 4 out of 10" does not help the rater. "Once or twice a month I can't get out of bed for 24 to 48 hours" does.

That is not exaggerating. It is being complete. Many veterans understate their symptoms, either because they were trained to push through or because they don't want to sound like they're complaining. The statement should honestly cover the full range of what the condition does, the worst episodes included. A strong personal statement covers three things: how often the condition flares, how bad it gets on the worst days and what the veteran cannot do, and how it affects work, sleep, relationships, and daily life.

See **Ch. 19 — The C&P Exam: What to Expect and How to Prepare** for how this same information carries into the exam, and **Ch. 24 — How Common Conditions Are Rated** for how conditions map to specific rating percentages.

Template — Personal Statement (the veteran's own)

Copy the box. Replace each **[CAPS BRACKET]**. The "worst days" section matters most — be specific there.

VETERAN'S PERSONAL STATEMENT IN SUPPORT OF CLAIM

(VA Form 21-10210, or VA Form 21-4138 – confirm the current form at va.gov)

Veteran: [FULL NAME]

VA claim number (if assigned): [NUMBER]

Date: [DATE]

Condition: [CONDITION]

WHAT HAPPENED IN SERVICE

During my service with [UNIT OR BRANCH] from [SERVICE DATES], [IN-SERVICE EVENT OR EXPOSURE]. [WHY I DID OR DID NOT SEEK TREATMENT AT THE TIME.]

CURRENT SYMPTOMS — A TYPICAL DAY

On most days my [CONDITION] causes:

- [TYPICAL SYMPTOM 1]

- [TYPICAL SYMPTOM 2]

CURRENT SYMPTOMS – THE WORST DAYS

About [FREQUENCY], my condition flares badly. During these episodes:

- The symptoms reach about [NUMBER] out of 10.
- I cannot [WHAT I CANNOT DO].
- The flare lasts about [DURATION].
- During it, I [WHAT THE FLARE STOPS ME FROM DOING].

IMPACT ON WORK AND DAILY LIFE

Work: [HOW IT AFFECTS EMPLOYMENT].

Sleep: [HOW IT AFFECTS SLEEP].

Activity: [WHAT I CAN NO LONGER DO, OR ONLY WITH DIFFICULTY].

Relationships: [HOW IT AFFECTS FAMILY AND SOCIAL LIFE].

Self-care: [ANY DIFFICULTY WITH HYGIENE, DRESSING, OR MOBILITY].

SINCE I SEPARATED

Since my separation on [SEPARATION DATE], my condition has [BEEN CONTINUOUS / PROGRESSIVELY WORSENE]. [HISTORY: WHEN SYMPTOMS PERSISTED, WHEN FIRST TREATED, ANY GAP AND WHY.]

I certify that the above is true and accurate to the best of my knowledge and recollection.

[SIGNATURE]

[PRINTED NAME]

[DATE]

How to fill it in:

1. **[IN-SERVICE EVENT OR EXPOSURE] / [WHY I DID OR DID NOT SEEK TREATMENT]** — what happened, in plain language, and why it may not be in the records. Examples: "In about [MONTH/YEAR] I hurt my right knee on a road march at [INSTALLATION]; I didn't go to sick call because no medic was available and I didn't want to fall out, and the pain stayed the rest of my service." Or: "Throughout my deployment to [LOCATION] from [DATES] I breathed burn-pit smoke nearly every day." Note any sick-call record or buddy statement being submitted with it.
2. **Typical-day symptoms** — the day-to-day baseline. Examples: "a dull lower-back ache around 3 to 5 out of 10"; "morning stiffness that takes 30 to 60 minutes to ease"; "trouble concentrating, irritability, and hypervigilance in crowds."
3. **[FREQUENCY] / [NUMBER] / [WHAT I CANNOT DO] / [DURATION]** — the worst-day detail. Be concrete: "once or twice a month," "an 8 out of 10," "can't stand more than 10 minutes," "lasts a full day." Include any episodes of incapacitation (days bedridden or unable to work) — those directly affect the rating for many conditions.

4. **Impact blocks** — fill the lines that apply. Examples: "missed about [NUMBER] workdays in the past year from flares"; "cut my hours"; "my spouse helps me put on socks on bad mornings."
5. **Since separation** — whether symptoms have been continuous or worsened, and when the veteran was first treated. If there's a gap between discharge and first diagnosis, explain it (no insurance, VA access problems, expected it to improve). Those explanations are relevant, not an admission against the claim.

4. Secondary-Condition Statement

What it is and why it matters

A secondary condition is a condition caused or permanently worsened by an already service-connected condition. It is one of the most underused pathways in the system. See **Ch. 25 — Secondary Conditions: The Underused Multiplier** for the full strategy.

The medical nexus standard is the same as a direct claim: a provider must state the secondary condition is "at least as likely as not" caused or aggravated by the primary one. The veteran's statement supports that by describing the observable connection, but the medical opinion still has to come from a provider. The template below is a short personal statement that frames the secondary claim. It travels with the provider's nexus letter; it does not replace it.

Template — Secondary-Condition Personal Statement

Copy the box. Replace each **[CAPS BRACKET]**. Keep only the one mechanism paragraph that fits the situation; delete the others.

PERSONAL STATEMENT — SECONDARY CONDITION CLAIM
(VA Form 21-10210, or VA Form 21-4138)

Veteran: [FULL NAME]

VA claim number (if assigned): [NUMBER]

Date: [DATE]

Primary service-connected condition: [PRIMARY CONDITION], rated [X]%, since [YEAR]

Secondary condition claimed: [SECONDARY CONDITION]

I am submitting this statement in support of my claim for [SECONDARY CONDITION] as secondary to my service-connected [PRIMARY CONDITION].

My [PRIMARY CONDITION] has been service-connected since [YEAR] at [X]%. It causes [ONGOING EFFECTS].

Because of my [PRIMARY CONDITION], [HOW IT CAUSED OR WORSENERED THE SECONDARY CONDITION].

I am submitting a supporting medical opinion from [PROVIDER NAME AND CREDENTIALS] that addresses the medical link between my primary and secondary conditions.

[SIGNATURE]

[PRINTED NAME]

[DATE]

How to fill it in:

1. **[PRIMARY CONDITION] / [X]% / [YEAR] / [SECONDARY CONDITION]** — the condition already rated, its percentage and year, and the new condition being claimed. Example primary: lumbar degenerative disc disease. Example secondary: right hip arthritis, major depressive disorder, left knee overuse injury.
2. **[ONGOING EFFECTS]** — what the primary condition does now. Examples: "chronic pain and limited movement in my lower back"; "recurring depressive episodes that wreck my sleep."
3. **[HOW IT CAUSED OR WORSENERED THE SECONDARY CONDITION]** — describe the observable mechanism. Use the one pattern that fits: - **Overuse / mechanical:** "Because of the pain and limited movement in my lower back, I've changed how I walk and put far more weight on my right hip. Over [TIMEFRAME] I developed right hip pain that [PROVIDER] diagnosed as [DIAGNOSIS]." - **Mental health from a physical condition:** "The chronic pain from my [PRIMARY CONDITION] has wrecked my sleep, cut my ability to work and do daily activities, and contributed to [DEPRESSION/ANXIETY], diagnosed by [PROVIDER] on [DATE]." - **Aggravation of something pre-existing:** "I had [CONDITION] before my [PRIMARY CONDITION] worsened, but since [TIMEFRAME] it has gotten significantly worse and is now [CURRENT SEVERITY]. My physician, [PROVIDER], believes the worsening is related to my [PRIMARY CONDITION]."

How to Use These Templates

- These are starting points. The strongest evidence is specific: replace every blank with real dates, places, units, and descriptions. Real detail always beats a form-filled answer.
- The nexus letter must come from a provider. A veteran who can't get one from their treating provider can look into a private independent medical examiner (IME). An accredited VSO or claims agent can point to options.
- Have a VSO or accredited representative review the package before submitting. A trained rep catches gaps before the VA does. See **Ch. 36 — VSOs, Attorneys, and Claim Sharks**.
- Keep copies of everything submitted: the claim, the evidence, the correspondence. The VA file can be requested later, but a personal copy is the safe practice.
- Submit the evidence with the claim. A Fully Developed Claim with complete evidence at filing usually moves faster than a standard claim. See **Ch. 20 — Fully Developed Claim vs. Standard Claim**.
- Every statement carries legal weight. Accuracy protects both the claim and the veteran.

Appendix A6 — Deadlines & Quick-Reference Cards

These cards are fast-lookup references: key dates, thresholds, and rules pulled from the chapters so veterans and advocates can verify them in seconds. Volatile figures (dollar amounts, form versions, condition lists) change. Always verify current numbers against primary sources before acting; see **Appendix A4 — Verification Sources & Staying Current**.

Card 1 — Critical Deadlines & Clocks

Table A6-1. Critical Deadlines and Clocks.

Deadline	What It Is	Source / Chapter
Intent to File — 1 year	Filing an ITF locks the effective date for up to 1 year. The complete claim must be filed within that window or the effective date advantage is lost.	Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates
Appeal / Decision Review — generally 1 year	A veteran generally has 1 year from the date of the VA decision notice to choose a review lane (Supplemental Claim, Higher-Level Review, or Board Appeal) and preserve the original effective date. Missing this window makes the decision final.	Ch. 26 — Reading the Rating Decision Letter · Ch. 27 — The Appeals Process Under the AMA
Supplemental Claim — file anytime, but 1 year preserves pursuit	A Supplemental Claim can be filed at any time. Filing within 1 year of the previous decision keeps the chain of "continuously pursued" status, protecting the effective date back to the original claim.	Ch. 27 — The Appeals Process Under the AMA
Rating Reduction — 60 days to respond	When the VA proposes a rating reduction, the veteran generally has 60 days to submit evidence or a written response before the reduction takes effect. A veteran may also request a predetermination hearing (this window and its procedures change; confirm the current ones at VA.gov before relying on this figure).	Ch. 37 — Avoiding a Rating Reduction
Rating Increase — up to 1 year back	An increase claim can reach back up to 1 year if the record shows the condition was worsening during that period.	Ch. 28 — Increasing an Existing Rating

Card 2 — TDIU Thresholds

Schedular path (38 CFR § 4.16(a)) — must meet one of:

Table A6-2. TDIU Schedular Rating Thresholds.

Condition	Threshold
One service-connected disability	Rated 60% or more
Two or more service-connected disabilities	At least one rated 40% or more , AND the combined rating is 70% or more

Extraschedular path (38 CFR § 4.16(b)): Available when the schedular thresholds above are not met, but the veteran is still genuinely unable to secure or maintain substantially gainful employment due to service-connected disabilities. The case goes to the Director of Compensation Service for review and requires strong documentation of work incapacity.

TDIU pays at the 100% compensation rate. The underlying combined rating does not change; only the compensation level reaches 100%.

Cross-ref: **Ch. 14 — TDIU: Paid at 100% Without a 100% Rating**

Card 3 — VA Math in 30 Seconds

VA disability math uses the whole-person method, not simple addition.

The rule: 1. Start with 100% efficiency (the "whole person"). 2. Apply the **highest** rating first. Subtract it from 100%. 3. Apply the next highest rating to the **remaining** efficiency. 4. Continue for each additional disability. 5. Sum the deductions to get the **combined disability value**. 6. Round to the **nearest 10** (5 rounds up, 4 rounds down).

Example structure (not actual dollar amounts): A 50% rating and a 30% rating do not add to 80%. The 30% acts on the 50% remaining efficiency, yielding a combined value of 65%, which rounds to 70%.

Bilateral Factor: Disabilities affecting paired limbs (both arms, both legs, or a combination) get an additional percentage applied before final rounding. See **Ch. 13 — The Bilateral Factor** for the exact multiplier.

Cross-ref: **Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%** · **Ch. 13 — The Bilateral Factor**

Card 4 — Which Appeal Lane?

Table A6-3. Appeal Lane Selection Guide.

Situation	Lane	Form	Chapter
Veteran has new evidence not in the original file (nexus letter, new treatment records, buddy statements)	Supplemental Claim	VA Form 20-0995 — verify at VA.gov	Ch. 27 — The Appeals Process Under the AMA
Veteran believes the rater made a factual or legal error on the existing record	Higher-Level Review	VA Form 20-0996 — verify at VA.gov	Ch. 27 — The Appeals Process Under the AMA
Case is complex, facts are disputed, or veteran wants a Veterans Law Judge	Board Appeal	VA Form 10182 — verify at VA.gov	Ch. 27 — The Appeals Process Under the AMA
Higher-Level Review already failed; new evidence now exists	Supplemental Claim then Board Appeal	20-0995, then 10182 — verify at VA.gov	Ch. 27 — The Appeals Process Under the AMA

Form numbers are subject to change. Verify current versions and filing instructions at VA.gov before submitting.

Filing window: generally **1 year** from the date of each decision notice to enter the next lane and preserve the effective date chain.

Card 5 — Effective-Date Rules (the Short Version)

Table A6-4. Effective Date Rules.

Rule	What It Means
General rule	Effective date is the date the claim was received, or the date entitlement arose, whichever is later .
Intent to File	An ITF filed before the complete claim relates the effective date back to the ITF date, for up to 1 year.

Rule	What It Means
Rating Increase	An increase claim can reach back up to 1 year if the evidence shows the condition was worsening during that period.
Within 1 year of separation	A claim filed within 1 year of discharge from active duty can establish an effective date of the day after discharge .
Continuously pursued	Filing within 1 year of each decision, through any AMA lane, preserves the effective date back to the original claim (38 CFR § 3.2500(h)(1)). Missing any window resets the clock.

Cross-ref: **Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates** · **Ch. 26 — Reading the Rating Decision Letter**

Card 6 — Rating Protection Timeline

Table A6-5. Rating Protection Timeline.

Milestone	What It Protects	Regulation	Exception
5 years — Stabilized Rating	VA cannot reduce on a single exam. Must review the full record and show <i>sustained</i> improvement under ordinary life conditions, not just one better exam.	38 CFR § 3.344	Ratings not yet stabilized (still expected to improve) are not covered.
10 years — Service Connection	VA cannot sever service connection entirely. The rating percentage can still change, but service connection itself is locked. Extends to DIC survivor claims.	38 CFR § 3.957	Fraud, or clear proof from military records of no qualifying service.
20 years — Rating Floor	VA can never reduce the rating below the lowest level it held during the 20+ year period. Ever. The 20-year clock runs from the effective date of the evaluation , not the claim date.	38 CFR § 3.951(b)	Fraud only.
100% Permanent & Total (P&T)	No future scheduled reexaminations. Reduction threat ends entirely. Also unlocks a separate set of benefits.	VA adjudication / 38 CFR § 3.327	None under normal circumstances.

Filing an increase on a protected, stable rating reopens VA authority to examine that condition. If the exam shows improvement, the VA can reduce, even when the veteran only asked for more. Think before touching a protected rating.

Cross-ref: **Ch. 29 — Protected Ratings** · **Ch. 37 — Avoiding a Rating Reduction**

Card 7 — VA Healthcare Priority Groups (1–8) at a Glance

Table A6-6. VA Healthcare Priority Groups 1 Through 8.

Group	Who Qualifies (summary)
1	Veterans with service-connected disabilities rated 50% or more , or receiving TDIU.
2	Veterans with service-connected disabilities rated 30–40% .
3	Veterans with service-connected disabilities rated 10–20% ; former POWs; Medal of Honor recipients; veterans receiving VA pension.
4	Veterans receiving aid and attendance or housebound benefits; veterans determined by VA to be catastrophically disabled.

Group	Who Qualifies (summary)
5	Non-service-connected veterans below the VA income threshold (copay exemption).
6	Veterans with certain compensable 0% conditions; World War I veterans; veterans exposed to specific hazards (the qualifying-condition list changes; veterans should check the current one at VA.gov).
7	Veterans above the VA income threshold who agree to copays; served in a theater of combat operations after November 11, 1998 (these eligibility dates change; veterans should confirm the current ones at VA.gov).
8	Veterans above the income threshold with no compensable service-connected conditions (enrollment subject to VA capacity and policy; verify current status at VA.gov).

Group 1 (50%+ SC or TDIU) = no copays for most VA care. Specific copay rules for Groups 2–8 change; verify current figures at VA.gov.

Cross-ref: **Ch. 34 — VA Healthcare Enrollment & Priority Groups**

Card 8 — Special Monthly Compensation (SMC) Levels at a Glance

SMC is a separate, additional monthly payment on top of regular disability compensation. It is not automatic; it must be claimed or the VA must identify entitlement.

Table A6-7. Special Monthly Compensation Levels.

Level	What It Covers
SMC-K	Loss or loss of use of a specific body part or function (hand, foot, creative organ, etc.). Paid in addition to any other SMC level or regular rating. Verify current dollar add-on at VA.gov.
SMC-L through SMC-O	Escalating levels tied to the need for aid and attendance (requiring help with daily activities) and housebound status. L is the entry level; O is the highest in this range.
SMC-R	The veteran needs regular aid and attendance and the level of need exceeds O. Two sub-levels (R-1 and R-2) based on the degree of required care.
SMC-T	Designated for veterans with severe traumatic brain injury (TBI) who need residential care or residential facility care as an alternative to hospitalization.
SMC-S	Housebound — veteran is substantially confined to their home due to service-connected disabilities. Can be reached either by a single 100% rating plus an additional 60%+ rating, or by a single rating that renders the veteran substantially homebound.

SMC dollar amounts are volatile. Verify current payment rates at VA.gov before any financial planning.

Cross-ref: **Ch. 31 — Special Monthly Compensation (SMC)**

Appendix A7 — Field Checklists

These are working checklists to run at each stage of a VA disability claim, from pre-filing through rating protection. The deeper "why" behind every item is in the chapters named under each checklist.

Checklist 1 — Before Filing (Pre-Claim)

- [] Confirm discharge character (honorable, general under honorable, OTH). A dishonorable discharge blocks compensation entirely. (these rules change; check the current ones at VA.gov)
- [] Confirm active-duty service in the military, naval, air, or space service.
- [] File an **Intent to File (VA Form 21-0966)** online at VA.gov; this locks the effective date while the full claim is assembled. (form numbers change; check the current one at VA.gov)
- [] List every condition being claimed, including **secondaries** (conditions caused or worsened by a service-connected condition).
- [] For each condition, identify which of the **three service-connection elements** is weakest: in-service event, current diagnosis, or nexus linking the two.
- [] Request service treatment records (STRs) through the National Personnel Records Center (NPRC) if not already in hand.
- [] Request personnel records to document the in-service event or MOS duties.
- [] Review the **presumptive conditions list** for the veteran's service era and locations. If a condition qualifies, no nexus opinion is required. (the presumptive lists keep expanding; check the current ones at VA.gov)
- [] Review the **PACT Act toxic-exposure presumptive list** if service included burn-pit exposure or qualifying locations post-9/11 or Gulf War era. (the PACT Act covered-condition list changes; check the current one at VA.gov)
- [] Line up a **nexus opinion** (Independent Medical Opinion) for any condition that is not presumptive and where the medical connection is not self-evident in service records.
- [] Obtain a free **VSO (Veterans Service Organization)** representative. VSOs file, track, and advocate at no cost.
- [] Write a **personal statement (VA Form 21-4138)** documenting the in-service event in the veteran's own words. (form numbers change; check the current one at VA.gov)

Covered in: Ch. 2 — Who Qualifies: Eligibility & Discharge Status, Ch. 15 — The Elements of Service Connection, Ch. 16 — Types of Claims: Direct, Secondary, Presumptive, Aggravation, Ch. 17 — How to Actually File: VA.gov, Intent to File, and Effective Dates, Ch. 18 — Evidence That Wins Claims, Ch. 21 — Presumptive Conditions Explained, Ch. 22 — The PACT Act: Burn Pits and Toxic Exposure, Ch. 36 — VSOs, Attorneys, and Claim Sharks

Checklist 2 — C&P Exam Preparation

- [] Confirm the appointment date, time, and location immediately upon receiving notice. Missing a C&P exam without rescheduling typically results in a denial.
- [] If the date does not work, contact the VA or the contracted vendor before the appointment to reschedule. Do not simply not show up.

- [] Know exactly which conditions are being examined at this appointment; review the exam request letter.
- [] Write out frequency, severity, and worst-day notes for each condition: how often flares occur, how bad symptoms get at worst, and how the condition limits daily function.
- [] Bring copies of any private treatment records or buddy statements not already in the VA file.
- [] Describe **functional impact** honestly and completely: how the condition affects the ability to work, sleep, walk, lift, concentrate, and maintain relationships.
- [] Do not minimize symptoms to appear tough; the rating is based on the severity described and documented.
- [] Note the examiner's name, credentials, and the date of the exam for the record.
- [] Request a copy of the completed DBQ (Disability Benefits Questionnaire) once it is available.

Covered in: Ch. 19 — The C&P Exam: What to Expect and How to Prepare, Ch. 18 — Evidence That Wins Claims, Ch. 24 — How Common Conditions Are Rated

Checklist 3 — When the Decision Arrives

- [] Record the date of the decision letter the day it arrives. The one-year appeal clock starts from the date of the letter, not when it is read.
- [] Read the Reasons and Bases section completely. This is where the VA explains why each condition was granted, denied, or rated at a specific percentage.
- [] Verify every claimed condition appears in the decision. A condition not addressed may have been lost or require a separate action.
- [] Confirm the assigned percentage for each granted condition matches the severity documented.
- [] Confirm the Diagnostic Code (DC) used for each condition. The DC is not on the decision letter — it's on the rating code sheet (request it from the veteran's Regional Office if the packet didn't include it) or found by matching the condition in 38 CFR Part 4. The DC determines which rating criteria apply.
- [] Confirm the effective date for each condition, which determines how far back pay goes.
- [] Recompute the combined rating using the whole-person method to verify the VA's math. (See **Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%** for the formula.)
- [] Check whether any secondary conditions documented in the file were addressed.
- [] Decide the next action for each condition (accept the grant, file for an increase, or appeal), all within one year of the decision letter date.

Covered in: Ch. 26 — Reading the Rating Decision Letter, Ch. 11 — VA Math: Why 50% + 30% Does Not Equal 80%, Ch. 27 — The Appeals Process Under the AMA

Checklist 4 — Choosing an Appeal Lane

- [] Identify the specific weakness in the decision: new evidence not yet submitted, a VA error (wrong DC, missed evidence, wrong date), or a legal or factual dispute requiring a Veterans Law Judge.
- [] Match the weakness to the appeal lane:
- New evidence → Supplemental Claim (VA Form 20-0995) (form numbers change; check the current one at VA.gov)

- VA error, no new evidence needed → Higher-Level Review (VA Form 20-0996) (form numbers change; check the current one at VA.gov)
- Legal dispute or complex factual issue → Board of Veterans' Appeals (choose Direct Review, Evidence Submission, or Hearing track).
- [] File the matching form within one year of the decision letter date to preserve the effective date.
- [] Confirm the filing was received and the appeal is docketed. Get a written confirmation or claims status update.
- [] Do not file a new claim for the same condition while an appeal is pending unless specifically advised otherwise; it can complicate the record.

Covered in: Ch. 27 — The Appeals Process Under the AMA

Checklist 5 — Maximizing an Established Rating

- [] Map every current service-connected condition for **potential secondaries**. Conditions caused or worsened by an already-rated condition may be separately ratable.
- [] If the veteran cannot maintain substantially gainful employment, evaluate **TDIU (Total Disability Individual Unemployability)** eligibility. (these thresholds change; check the current ones at VA.gov)
- [] Check **SMC (Special Monthly Compensation)** eligibility if the veteran has: loss or loss of use of a limb or creative organ; the need for regular Aid & Attendance; or qualifying combinations of disabilities. (SMC rates change every year; the current tables are at VA.gov)
- [] Confirm **dependents are added to the award** if the combined rating is 30% or higher. A spouse, dependent children, and dependent parents each increase the monthly payment. (dependent add-on amounts change every year; the current ones are at VA.gov)
- [] Verify whether any current ratings carry **protected status** (5-year, 10-year, or 20-year) before filing for an increase on a condition that has also worsened. Know what is protected before reopening.

Covered in: Ch. 25 — Secondary Conditions: The Underused Multiplier, Ch. 14 — TDIU: Paid at 100% Without a 100% Rating, Ch. 31 — Special Monthly Compensation (SMC), Ch. 12 — Compensation Rate Tables and Dependent Add-Ons, Ch. 29 — Protected Ratings

Checklist 6 — After 100% / P&T

- [] Confirm whether the 100% rating is **schedular 100%** or **TDIU**. Both pay at the 100% rate, but some downstream benefits require schedular 100% specifically.
- [] Confirm whether the rating carries the "**permanent**" **designation (P&T)**; that designation unlocks additional protections and benefits not available with a temporary 100%.
- [] Apply for **CHAMPVA** (healthcare coverage for eligible dependents) through the VA if not already enrolled. (these eligibility requirements change; the current ones are at VA.gov)
- [] Apply for **Chapter 35 DEA (Dependents' Educational Assistance)** for eligible spouses and children. (DEA eligibility and payment amounts change; the current ones are at VA.gov)
- [] Identify and apply for the applicable **state property-tax exemption**. Most states offer partial or full exemptions for 100% P&T veterans; amounts and application processes vary by state. (confirm with the state's department of veterans affairs)

- [] Activate **commissary and exchange (PX/BX) access** if not currently using it. Verify current access rules at VA.gov or the Defense Commissary Agency.
- [] Confirm **VA healthcare enrollment priority group**. Veterans with service-connected conditions rated 50%+ or P&T status typically receive Priority Group 1 with no copays. (priority group rules change; the current ones are at VA.gov)
- [] Research **state-level veteran benefits** available in the state of residence. State programs vary widely and are separate from federal VA benefits.

Covered in: Ch. 30 — What a 100% P&T Rating Unlocks, Ch. 33 — State-Level Veteran Benefits, Ch. 34 — VA Healthcare Enrollment & Priority Groups

Checklist 7 — Protecting Against a Reduction

- [] Maintain **current, consistent medical treatment** for all rated conditions. Gaps in treatment records are used to justify reduction proposals.
- [] Respond to every **proposed-reduction notice** within the deadline stated in the letter. The deadline is firm; failure to respond can result in automatic reduction.
- [] Request a **hearing before the effective date of any proposed reduction**. The hearing request must be submitted before the proposed effective date.
- [] If a new C&P exam is ordered in connection with a reduction review, prepare as thoroughly as for an original claim. Describe symptoms honestly and completely; do not minimize.
- [] If the exam underlying a proposed reduction appears inadequate, **rebut the exam** in writing with a private medical opinion or supporting evidence.
- [] Know which protections apply to established ratings:
- **5-year rule:** VA must show sustained improvement before reducing a rating continuous for 5 or more years.
- **10-year rule:** VA cannot sever service connection for a condition rated for 10 or more continuous years (fraud exception applies).
- **20-year rule:** VA cannot reduce a rating that has been in place for 20 or more continuous years below its lowest point during that period.
- **P&T protection:** A rating designated permanent and total is not subject to routine reexamination and carries the highest protection.
- (these thresholds and procedures change; the current ones are at VA.gov)

Covered in: Ch. 37 — Avoiding a Rating Reduction, Ch. 29 — Protected Ratings



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ABOUT THE AUTHOR

K. A. Lim spent nearly three decades in the U.S. Army and retired as a Staff Sergeant. He is rated 100 percent permanent and total, and he is paralegal-trained. He went through the claim process himself, then spent years helping other veterans make sense of rules the VA rarely explains. He writes the way a good NCO teaches a battle buddy: direct, honest, and always tied back to the law.

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