

# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

## Intake Packet



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### USEFUL CONTACT INFORMATION

- VA Hotline
  - 800-827-1000
- James A Lovell Federal Health Care Center
  - Main: 847-688-1900
  - Enrollment: 224-610-1463
  - Billing: 877-874-2273
- Lake County Assessors Office
  - 847-377-2050
- Defense Finance Accounting Services
  - 888-332-7411
- Illinois Department of Veterans Affairs
  - 800-437-9824
- Lake County Veterans and Family Services
  - 847-986-4622
- Illinois Armed Forces Legal Aid Network
  - 855-452-3526

### CONTACT US AT:



**847-377-3344**



**847-984-5750**



**[veterans@lakecountyil.gov](mailto:veterans@lakecountyil.gov)**



**501 N Riverside Dr  
Suite 106  
Gurnee, IL 60031**

## WELCOME TO THE VAC.

Thank you for reaching out to us for assistance and congratulations on taking the first step towards acquiring your VA benefits. Our staff of highly trained and accredited Veteran Service Officers are ready to work with you, whether this is your first time filing a VA compensation claim, or whether you are looking to appeal wrongfully denied benefits.

This packet contains many of the preliminary tasks and documents that need to be completed in order to get a successful start to the VA claims process. Please review the packet carefully, complete the required sections, and start to gather any supporting documentation that may be beneficial for your claim.

### LAST REVISION

2/23/2021

Feel free to use this timeline to check off your progress through the VA claims process.

# MY TIMELINE



\_\_\_\_\_  
Name

## CLAIMS QUESTIONNAIRE

1

- Complete and submit the questionnaire.
- Call 847-377-3344 to schedule your first appointment with a VSO after submittal.



## GATHER DOCUMENTS

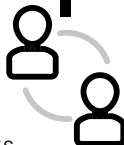
- Prior to your appointment, gather any relevant documentation such as service medical records or private medical records.

2

## FIRST APPOINTMENT

3

- Meet with a VSO to discuss service history, medical history and VA benefits in general.
- You may be tasked with gathering additional evidence to support your claim.



## RECORD REVIEW

- Your VSO will thoroughly review any available service medical records or private treatment records, looking for claimable conditions or previous injuries.

4

## FINAL APPOINTMENT

5

- Before your fully developed claim is submitted, you'll sit down with a VSO one final time to review the compiled claim packet.



## CLAIM SUBMISSION

- With your final approval, the claim packet will be signed and securely transmitted to the VA Regional Office for intake and processing.

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# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

## Appointment Sheet



### CONTACTS

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### I NEED TO...

## MY VAC APPOINTMENTS

Date \_\_\_\_\_

Time \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY



## EXPLANATION OF FORMS

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**PLEASE NOTE: THE SIGNATURE PAGE AND THE CLAIMS QUESTIONNAIRE MUST BE COMPLETED AND RETURNED PRIOR TO YOUR FIRST APPOINTMENT.**

### **VA FORM 21-22**

The VA Form 21-22 will appoint us as your representatives for VA claims and appeals. Additionally, it will grant us access to your VA file so that we can review historical claims and evidence. Samples have been included so that you can review the forms to which your digital signature will be applied.

### **VA FORM 21-0966**

The VA Form 21-0966 establish the earliest possible effective date for benefits and will entitle you to a lump sum retroactive payment if your claim is approved. Samples have been included so that you can review the forms to which your digital signature will be applied.

For example, if this form is filed in July of 2021, and your claim is approved in June 2022, you will be entitled to retroactive pay going back to July 2021.

### **CLAIMS QUESTIONNAIRE**

The claims questionnaire will help us get an initial overview of your situation so that a VSO can get a head start with your claim. Additionally, it helps us prioritize Veterans who are in need of immediate assistance.

### **SIGNATURE PAGE**

With your permission, the signature page will allow us to digitize your signature for easier and faster claims filing in the future. The signature will only be used for VA purposes and with your permission.



## SECTION IV: AUTHORIZATION INFORMATION

**19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.** - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

- ☒ I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

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

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

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

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

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

## SECTION V: SIGNATURES

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

22A. SIGNATURE OF VETERAN CLAIMANT (Do Not Print)

22B. DATE SIGNED (MM/DD/YYYY)

23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A  
(Do Not Print)

23B. DATE SIGNED (MM/DD/YYYY)

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

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)
	<input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> LG FILE <input type="checkbox"/> INSURANCE FILE			

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





**VA DATE STAMP**  
(DO NOT WRITE IN THIS SPACE)

**INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION,  
OR SURVIVORS PENSION AND/OR DIC**

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

**NOTE:** Please read the Privacy Act and Respondent Burden below before completing the form.

**SECTION I: CLAIMANT/VETERAN IDENTIFICATION**

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

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

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

2. CLAIMANT'S SOCIAL SECURITY NUMBER

\_\_\_\_-\_\_\_\_-\_\_\_\_  
\_\_\_\_-\_\_\_\_-\_\_\_\_  
\_\_\_\_-\_\_\_\_-\_\_\_\_

3. VA FILE NUMBER (If applicable)

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

4. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_

5. VETERAN'S NAME (First, Middle Initial, Last) (If different from claimant)

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

6. VETERAN'S SOCIAL SECURITY NUMBER

\_\_\_\_-\_\_\_\_-\_\_\_\_  
\_\_\_\_-\_\_\_\_-\_\_\_\_  
\_\_\_\_-\_\_\_\_-\_\_\_\_

7. VETERAN'S SEX

☐ MALE ☐ FEMALE

8. VETERAN'S SERVICE NUMBER (If applicable)

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

9. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code, and Country)

No. & Street: \_\_\_\_\_  
Apt./Unit Number: \_\_\_\_\_ City: \_\_\_\_\_  
State/Province: \_\_\_\_\_ Country: \_\_\_\_\_ ZIP Code/Post Code: \_\_\_\_\_

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?

☐ YES ☐ NO

11. TELEPHONE NUMBER (Include Area Code)

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

12. EMAIL ADDRESS (If applicable)

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

**SECTION II: GENERAL BENEFIT ELECTION**

**IMPORTANT:** VA may not be able to use this form to establish an effective date for benefits if you do not select one or more of the general benefits listed below.

13. I intend to file for the general benefit(s) checked below: (Choose all that apply)

☐ COMPENSATION ☐ PENSION

**NOTE:** Only check the box below if you are a surviving dependent of the veteran.

☐ SURVIVORS PENSION AND/OR DEPENDENT AND INDEMNITY COMPENSATION (DIC)

**IMPORTANT:** After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at [www.va.gov](http://www.va.gov). If you give VA a completed application for the selected general benefit within one year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the first completed application for each selected general benefit that is received after this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

**SECTION III: DECLARATION OF INTENT**

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is not a claim for benefits; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE

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

14B. DATE SIGNED (MM/DD/YYYY)

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (Please Print)

(NOTE: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

**RESPONDENT BURDEN:** We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/foia/PRMain](http://www.reginfo.gov/public/foia/PRMain). If desired, you can call 1-800-427-1050 to get information on where to send comments or suggestions about this form.

# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

## SIGNATURE PAGE

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### PLEASE SIGN LEGIBLY INSIDE THE BOX BELOW

With your consent, this signature will be scanned and used as a digital signature for future claim forms or documents that need to be submitted to the VA.

For VA purposes only





Andrew Tangen, Superintendent  
Sherry Kruse, Assistant Superintendent  
Veterans Assistance Commission of Lake County  
501 N. Riverside Dr, Ste 106  
Gurnee, IL 60031  
P: 847-377-3344 F: 847-984-5750  
veterans@lakecountyil.gov  
www.facebook.com/lakecountyvac

## Claim Questionnaire

### Applicant Information

Veteran Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
*Last First M.I.*  
Birthplace: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*  
Phone: \_\_\_\_\_ Email \_\_\_\_\_

Spouse Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(if applicable) \_\_\_\_\_  
*Last First M.I.*  
Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*  
Phone: \_\_\_\_\_ Email \_\_\_\_\_

### Military Service Information

Are you a Vietnam Veteran with service in Vietnam?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you a Blue Water Navy Veteran?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Did you serve at Camp Lejeune between August 1, 1953 and December 31, 1987?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you an OIF/OEF Veteran with service in Southwest Asia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Branch of service? \_\_\_\_\_ Dates of service? \_\_\_\_\_ Type of Discharge? \_\_\_\_\_

## VA Compensation Status

Have you ever filed a VA compensation claim before?

YES  
☐

NO  
☐

If yes, what is your current overall rating?

Do you have your Service Medical Records?

YES  
☐

NO  
☐

Do you have relevant private medical records?

YES  
☐

NO  
☐

Examples:

- X-rays from your non-VA physician related to the back condition you would like to claim
- Mental health treatment record from your non-VA physician with a diagnosis of PTSD
- Prescription record from your non-VA physician

**In the spaces below, please list any medical conditions that you believe to be incurred in or caused by service**

Condition	How is it related to service?


**Additional Comments**

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**Once complete, please return this eligibility application to**

Veterans Assistance Commission of Lake County  
501 North Riverside Dr, Suite 106  
Gurnee, IL 60031

Email: [veterans@lakecountyil.gov](mailto:veterans@lakecountyil.gov)  
Fax: (847) 984-5750

Thank you for submitting the VA Claim Questionnaire. Please have the above questionnaire and documents completed and returned prior to your initial appointment with a Veteran Service Officer.



Andrew Tangen, Superintendent  
Sherry Kruse, Assistant Superintendent  
Veterans Assistance Commission of Lake County  
501 N. Riverside Dr, Suite 106  
Gurnee, IL 60031  
P: 847-377-3344 F: 847-984-5750  
[www.facebook.com/lakecountylvac](http://www.facebook.com/lakecountylvac)

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## Client To-Do List

Please provide any applicable documents or information listed.

- ☐ **DD 214 – (Member 4)**
  - DD 215 (If applicable)
  - Any discharge paperwork before DD 214's were issued upon discharge
  - Discharge documents from Reserve or National Guard
    - Line of Duty documents for claimed conditions (If applicable)
  - If you have multiple DD 214's from reenlistments or breaks in service, bring in copies
- ☐ **Social Security Number**
  - Spouse Social Security Number
  - Dependent/Stepchildren/Parent (If applicable) Social Security Number
- ☐ **Birth Certificate / Place of Birth**
  - Spouse's Birth Certificate/Place of Birth
  - Dependent's & Stepchildren Birth Certificate/Place of Birth
  - Parent Birth Certificate/Place of birth (Only if applying for parental dependency status)
- ☐ **Banking information**
  - Banking Institution
  - Account Number
  - Routing Number
- ☐ **Service Medical Records**
  - Review your records and identify and separate any medical records related to the conditions that your claiming. If you have multiple medical records detailing treatment or diagnosis of the condition, injury, or illness, group the documents together in chronological order.
  - If you don't have your service medical records you can order them online from the National Personnel Records Center (NPRC)/website: [vetrecs.archives.gov](http://vetrecs.archives.gov)
- ☐ **Civilian Medical Records**
  - Typically, we will fill out a 21-4142 & 21-4142a to have VA request medical records from the private facility
  - Another option; Veteran obtains the problem list, medication list, surgical history, labs, x-ray reports, and MRI's from any private primary care provider, specialists, alternative treatments (chiropractor, massage therapist, acupuncturist, etc). Ensure that they are relevant to your claimed conditions
  - Ensure you have your private provider **name, address, treatment dates from start to finish** for any condition you want to submit a claim for



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[www.facebook.com/lakecountyvac](http://www.facebook.com/lakecountyvac)

☐ **VA Medical Records**

- Request and review your VA medical records and identify and separate any medical records related to the conditions that your claiming. If you have multiple medical records detailing treatment or diagnosis of the condition, injury, or illness, group the documents together in chronological order.
- Include Problem list, medication list, diagnosis history, labs, x-rays and surgeries

☐ **Death Certificate**

- Ensure at least one service-connected condition is listed on the death certificate (Copy Only)

☐ **Marriage Certificate**

- Need copy of marriage certificate/license

☐ **Divorce Decree**

- Prior marriage and divorce information for Veteran and spouse if applicable
  - To include marriage date, city/state of marriage, divorce date, city/state of divorce for each prior marriage

☐ **Lay statements in Support of Claim**

- Ensure that statements are relevant to your claimed condition or are helpful to your claim
- Ensure that statements include the following phrase at the end:
  - *"I certify that the statements on this form are true and correct to the best of my knowledge and belief."*
- Ensure that statements are signed and dated by the author.
  - Personal statement
    - Include duty station
    - Deployments
    - Locations
    - Unit assigned
    - Awards received (If applicable)
    - Triggers (If applicable)
    - Describe overall picture of what is going on
  - Spousal statement
    - Elaborate on what their observations/experiences are regarding the Veterans claimed conditions
  - Buddy statement
    - Elaborate on what their observations/experiences are regarding the Veterans claimed conditions



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[www.facebook.com/lakecountyvac](http://www.facebook.com/lakecountyvac)

## VA Presumptive Conditions

VA presumes that specific disabilities diagnosed in certain veterans were caused by their military service. VA does this because of the unique circumstances of their military service. If one of these conditions is diagnosed in a Veteran in one of these groups, VA presumes that the circumstances of his/her service caused the condition, and disability compensation can be awarded.

Former Prisoners of War	Vietnam Veterans	Atomic Veterans	Gulf War Veterans
<b>(1) Imprisoned for any length of time.</b> <ul style="list-style-type: none"> <li>Psychosis</li> <li>Any of the Anxiety States</li> <li>Dysthymic Disorder</li> <li>Organic Residuals of Frostbite</li> <li>Post-Traumatic Osteoarthritis</li> <li>Heart Disease or Hypertensive Vascular Disease and their Complications</li> <li>Stroke and its Residuals</li> </ul> <b>(2) Imprisoned for at least 30 days.</b> <ul style="list-style-type: none"> <li>Avitaminosis</li> <li>Beriberi</li> <li>Chronic Dysentery</li> <li>Helminthiasis</li> <li>Malnutrition</li> <li>Pellagra</li> <li>Any other Nutritional Deficiency</li> <li>Irritable Bowel Syndrome</li> <li>Peptic Ulcer Disease</li> <li>Peripheral Neuropathy</li> <li>Cirrhosis of the Liver</li> </ul>	<b>Served in the Republic of Vietnam between 1/9/62 to 5/7/75.</b> <ul style="list-style-type: none"> <li>Acute and Subacute Peripheral Neuropathy</li> <li>AL Amyloidosis</li> <li>B-Cell Leukemias</li> <li>Chloracne or other Acne Form Disease</li> <li>Chronic Lymphocytic Leukemia</li> <li>Diabetes Type II</li> <li>Hodgkin's Disease</li> <li>Ischemic Heart Disease</li> <li>Multiple Myeloma</li> <li>Non-Hodgkin's Lymphoma</li> <li>Parkinson's Disease</li> <li>Porphyria Cutanea Tarda</li> <li>Prostate Cancer</li> <li>Respiratory Cancers</li> <li>Soft Tissue Sarcoma</li> </ul> <b>New conditions added in 2021.</b> <ul style="list-style-type: none"> <li>Bladder Cancer</li> <li>Hypothyroidism</li> <li>Parkinson's-Like Symptoms</li> </ul>	<ul style="list-style-type: none"> <li>All Forms of Leukemia, except Chronic Lymphocytic Leukemia</li> <li>Cancer of the Thyroid, Breast, Pharynx, Esophagus, Stomach, Small Intestine, Pancreas, Bile Ducts, Gall Bladder, Salivary Gland, Urinary Tract, Brain, Bone, Lung, Colon or Ovary</li> <li>Bronchioloalveolar Carcinoma</li> <li>Multiple Myeloma</li> <li>Lymphomas, other than Hodgkin's Disease</li> <li>Primary Liver Cancer, Except if there are indications of Cirrhosis or Hepatitis B</li> </ul>	<b>Medically Unexplained Chronic Multi-Symptom Illnesses that exist for six months or more, such as:</b> <ul style="list-style-type: none"> <li>Chronic Fatigue Syndrome</li> <li>Fibromyalgia</li> <li>Irritable Bowel Syndrome</li> <li>Any diagnosed or undiagnosed illness that warrants a presumption of service connection, as determined by the Secretary of Veterans Affairs.</li> </ul> <b>Signs and Symptoms of an Undiagnosed Illness include:</b> <ul style="list-style-type: none"> <li>Fatigue</li> <li>Skin Symptoms</li> <li>Headaches</li> <li>Muscle Pain</li> <li>Joint Pain</li> <li>Neurological Symptoms</li> <li>Sleep Disturbance</li> <li>GI Symptoms</li> <li>Cardiovascular Symptoms</li> <li>Weight Loss</li> <li>Menstrual Disorders</li> </ul>