

Mark Stinson
Reg #29908-076
777 NW 155th Ln. 911
Miami, Florida 33169-6180
Ph: (786) 299-7499
Email: mstinson1@bellsouth.net
Pro se

March 20, 2025

Clerk of the Court
Supreme Court of the United States
1 First Street, NE
Washington, D.C. 20543

Re: Motion for Leave to Proceed as a Veteran (No. 23-5105)

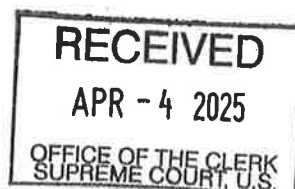
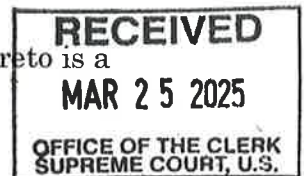
To the Honorable Chief Justice John G. Roberts of the
Supreme Court of the United States:

I. Introduction

I, Mark Stinson, respectfully submit this motion for leave to process my case as a veteran pursuant to Sup. Ct. R. 40 and relevant rules governing proceedings before this Court.

II. Background Information

- I am a veteran of the U.S. Army, I have served my country honorably from February 14, 1984, to February 15, 1988, also a tour of duty to the Gulf War, from 12/10/1990 to 06/04/1991, where I was awarded the National Defense Service Metal, Southwest Asia Service Metal with Three Bronze Stars and an Overseas Service Ribbon. Attached hereto is a copy of my form DD-214, which verifies my status as a veteran.



- I am a 100 % total and permanent disable veteran that has been diagnosed with Post-Traumatic Stress Disorder [PTSD]. My service has instilled in me a profound respect for the rule of law and the judicial system. This motion seeks permission from this esteemed court to allow my case to be processed with consideration given to my status as a veteran. Attached hereto is a copy of my VA letter of Benefit Information, which verifies my status as a veteran.

III. Legal Basis for Motion

- Under 38 U.C.S. § 7261(a)(1), veterans are entitled to certain considerations in legal proceedings due to their service.
- The Eleventh Circuit recognizes the importance of accommodating veterans in its procedural rules and has established guidelines that support their rights in appellate matters.
- The court must also weigh all factual allegations in favor of the appellant unless the facts are clearly baseless; Denton v. Hernandez, 504 U.S. 25, 32 (1992); see Estelle v. Gamble, 429 U.S. 97, 106, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976).
- Under Sup. Ct. R. 40, veterans are entitled to certain considerations in legal proceedings due to their service and sacrifices made for our country. This motion is submitted in accordance with these provisions to ensure that my status as a veteran is recognized throughout these

proceedings. Fincher v. Ga. Pac. LLC, No. 108-cv-3839, 2009 U.S. Dist. LEXIS 33558, 2009 WL 1075269, at *1 (N.D. Ga. Apr. 21, 2009); Desert Palace, Inc. v. Costa, 539 U.S. 90, 123 S.Ct. 2148, 156 L.Ed.2d 84 (2003).

- The court notes the well-recognized principle that complaints drawn by pro se litigants are held to a less stringent standard than those drawn by legal counsel. Haines v. Kerner, 404 U.S. 519 92 S.Ct. 594, 30 L.Ed.2d 652 (1972); U.S. ex rel. Dattola v. Nat. Treasury Emp. Union, 86 F.R.D. 496 (W.D. Pa. 1980).

IV. Argument

The circumstances surrounding my case warrant special consideration due to my status as a veteran. Specifically:

- The issues presented in this case involve matters that directly affect veterans' rights and benefits.
- My military service has impacted my ability to navigate and investigate this complex illegal, malicious intentional fraudulent, deceptive, cruel and unusual punishment and voluminous challenges effectively.
- The Petitioner only must apply for this procedure because the Veterans Affairs Office (VA) has not approved his Veteran's Application for Increased Compensation Based on Unemployability at this time filed on 08/12/2023. The application is attached.

- The Petitioner only must apply for this procedure because the (VA) has not given him back the over \$5,000 that was held for the attorneys that did not represent Stinson in any VA matters, also the attorneys would not sign a release of financial obligation form for Stinson and give it to the VA filed on 10/11/2023. The Decision Review Request form is attached. The Florida Bar was contacted in December 2024, and their final response letter is attached.
- The Petitioner only must apply for this procedure because the VA started on 02/2025, deducting \$852 monthly, for an over payment of compensation from Stinson which Stinson has appealed on 09/25/2024, but the deduction has started deducting \$30,659.95 in total. The Decision Review Request form is attached.
- The Petitioner only must apply for this procedure because the disabled benefits from the Social Security Office (ssa)is still pending since August 30, 2022. The Form SSA-1695 is attached.
- Granting this motion will allow me access to necessary resources and support available for veterans involved in litigation.

V. Request for Relief

- I respectfully request that this Court grant me leave to proceed as a veteran in this matter.
- This request is made in good faith and is not intended to cause delay or prejudice against any party involved.

VI. Conclusion

Therefore, for the foregoing reasons stated above, Mr. Stinson, Sr. respectfully pray that this Honorable Court grants my motion for leave to proceed as a veteran in this matter, without delay.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Mark T. Stinson, Sr.", written over a horizontal line.

Mark T. Stinson, Sr.

Reg# 29908-076

777 NW 155th Ln. 911

Miami, FL 33169-6180

Ph: (786) 299-7499

Email: mstinson1@bellsouth.net

March 20, 2025

Pro Se

**CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION,
TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS**

As required by Supreme Court Rule 33.1(h), I certify that the petition for leave to proceed as a veteran contains 797 words, excluding the parts of the petition that are exempted by Supreme Court Rule 33.1(d).

I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 20, 2025.



Mark T. Stinson, Sr.
Pro se

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing motion for Leave to Proceed as a Veteran, was sent to the respondent via electronic mail this 20th day of March 2025, to the following:

Mary H. Morris Assistant United States Attorney
167 N. Main, Room 800
Memphis, TN 38103
(9091) 544-4231
Email: mary.morris@usdoj.gov



Mark T. Stinson, Sr.

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

| 1. NAME (Last, First, Middle) STINSON, MARK TYRONE | | 2. DEPARTMENT, COMPONENT AND BRANCH ARMY/USAR | | 3. SOCIAL SECURITY NO. [REDACTED] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----------------------|--|--------|---|--------------------------------------|--|---------|----------|--------|--------------------------------|----|----|----|--------------------------------|----|----|----|-----------------------------------|----|----|----|-------------------------------|----|----|----|---------------------------------|----|----|----|--------------------|----|----|----|----------------|----|----|----|--------------------------------|----|----|----|
| 4a. GRADE, RATE OR RANK DET | 4b. PAY GRADE E-5 | 5. DATE OF BIRTH (YYMMDD) [REDACTED] | | 6. RESERVE OBLIG. TERM DATE Year 94 Month 01 Day 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. PLACE OF ENTRY INTO ACTIVE DUTY MEMPHIS, TN | | 7b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) 2863 WHITNEY MEMPHIS, TN 38127 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND 577TH CSN W/DUTY AT FT BRAGG NC | | 8b. STATION WHERE SEPARATED FT BRAGG, NC 28307-5000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. COMMAND TO WHICH TRANSFERRED 125TH ARCOM 443 DONELSON PIKE NASHVILLE TN 37241-3358 | | | | 10. SBU COVERAGE Amount: \$0,000.00 None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.) P1020 PRACTICAL NURSE 00YRS 06MOS// 53820 LIGHT WHEEL VEHICLE POWER GENERATOR 00YRS 06MOS// NOTHING FOLLOWS// | | 12. RECORD OF SERVICE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | <table border="1"> <thead> <tr> <th></th> <th>Year(s)</th> <th>Month(s)</th> <th>Day(s)</th> </tr> </thead> <tbody> <tr> <td>a. Date Entered AD This Period</td> <td>90</td> <td>12</td> <td>11</td> </tr> <tr> <td>b. Separation Date This Period</td> <td>91</td> <td>06</td> <td>04</td> </tr> <tr> <td>c. Not Active Service This Period</td> <td>00</td> <td>05</td> <td>24</td> </tr> <tr> <td>d. Total Prior Active Service</td> <td>04</td> <td>02</td> <td>28</td> </tr> <tr> <td>e. Total Prior Inactive Service</td> <td>02</td> <td>08</td> <td>01</td> </tr> <tr> <td>f. Foreign Service</td> <td>00</td> <td>04</td> <td>00</td> </tr> <tr> <td>g. Sea Service</td> <td>00</td> <td>00</td> <td>00</td> </tr> <tr> <td>h. Effective Date of Pay Grade</td> <td>90</td> <td>10</td> <td>12</td> </tr> </tbody> </table> | | | | | Year(s) | Month(s) | Day(s) | a. Date Entered AD This Period | 90 | 12 | 11 | b. Separation Date This Period | 91 | 06 | 04 | c. Not Active Service This Period | 00 | 05 | 24 | d. Total Prior Active Service | 04 | 02 | 28 | e. Total Prior Inactive Service | 02 | 08 | 01 | f. Foreign Service | 00 | 04 | 00 | g. Sea Service | 00 | 00 | 00 | h. Effective Date of Pay Grade | 90 | 10 | 12 |
| | Year(s) | Month(s) | Day(s) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Date Entered AD This Period | 90 | 12 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Separation Date This Period | 91 | 06 | 04 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Not Active Service This Period | 00 | 05 | 24 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Total Prior Active Service | 04 | 02 | 28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. Total Prior Inactive Service | 02 | 08 | 01 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f. Foreign Service | 00 | 04 | 00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g. Sea Service | 00 | 00 | 00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h. Effective Date of Pay Grade | 90 | 10 | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) ARMY SERVICE RIBBON//NATIONAL DEFENSE SERVICE MEDAL//ARMY LAPEL BUTTON//EXPERT M-16 BADGE// OVERSEAS SERVICE RIBBON//DRIVERS-MECHANIC BADGE//NOTHING FOLLOWS// | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed) NONE//NOTHING FOLLOWS// | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15a. MEMBER CONTINUED TO NON-VIETNAM ERA VETERAN EDUCATIONAL ASSISTANT PROGRAM | | Yes | No | 15b. HIGH SCHOOL GRADUATE OR EQUIVALENT | Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | 15c. DAYS ACCRUED LEAVE PAID NONE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION YES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. REMARKS SUBJECT TO ACTIVE DUTY RECALL AND/OR ANNUAL SCREENING//INDIVIDUAL COMPLETED PERIOD FOR WHICH ORDERED TO ACTIVE DUTY FOR PURPOSE OF POST-SERVICE BENEFITS AND ENTITLEMENT//ORDERED TO ACTIVE DUTY IN SUPPORT OF OPERATION DESERT SHIELD/DESERT STORM IAW 10 USC 6738//ITEM 120 ABOVE DOES NOT ACCOUNT FOR ANNUAL AND/OR WEEKEND TRAINING THIS SOLDIER MAY HAVE ACCOMPLISHED PRIOR TO DATE ENTERED IN ITEM 12a//SERVICE IN SWA FROM 910109-910508//CONT FROM ITEM 8a: AT FT BRAGG//NOTHING FOLLOWS// | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. MAILING ADDRESS AFTER SEPARATION (include Zip Code) 2809 NINA APT 8 MEMPHIS, TN 38127 | | 19b. NEAREST RELATIVE (Name and address - include Zip Code) BERALDINE D. PERRY 2863 WHITNEY RD. MEMPHIS, TN 38127 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20. MEMBER REQUESTS COPY 6 BE SENT TO TN | | 22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and signature) DORRIS L. HENDERSON MSG USA CH FT BRAGG, NC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. SIGNATURE OF MEMBER BEING SEPARATED SOLDIER NOT AVAILABLE FOR SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

| | | | |
|---|--|--|------------------------|
| 23. TYPE OF SEPARATION RELEASE FROM ACTIVE DUTY | | 24. CHARACTER OF SERVICE (include upgrades) HONORABLE | |
| 25. SEPARATION AUTHORITY AR 635-200 CHAPTER 4 | | 26. SEPARATION CODE LBR | 27. REENTRY CODE NA |
| 28. NARRATIVE REASON FOR SEPARATION EXPIRATION TERM OF SERVICE | | | |
| 29. DATES OF TIME LOST DURING THIS PERIOD NONE | | 30. MEMBER REQUESTS COPY 4 initials | |

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD SAFEGUARD IT

ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

| DD FORM 214 1 JUN 79 | | PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE | | CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-----------------------------|--|--|---|--|--|---------|---------|--------|--------------------------------|----|----|----|--------------------------------|----|----|----|-----------------------------------|----|----|----|---------------------------------|----|----|----|-----------------------------------|----|----|----|--------------------|----|----|----|----------------|----|----|----|-----------------------------------|----|----|----|-----------------------------|----|----|----|
| 1. NAME (Last, first, middle) STINSON, MARK TYRONE | | 2. DEPARTMENT, COMPONENT AND BRANCH ARMY/RA | | 3. SOCIAL SECURITY NO. [REDACTED] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4A. GRADE, RATE OR RANK SP4 | 4B. PAY GRADE E-4 | 5. DATE OF BIRTH [REDACTED] | 6. PLACE OF ENTRY INTO ACTIVE DUTY Memphis, TN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. LAST DUTY ASSIGNMENT AND MAJOR COMMAND FORSCUM FC 86EN | | | 8. LOCATION WHERE SEPARATED Fort Campbell, KY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. COMMAND TO WHICH TRANSFERRED 330 Hosp (Gen) (1000B), 360 W. California Ave., Memphis, TN 38106 | | | 10. SGLI COVERAGE AMOUNT \$ 50,000 <input type="checkbox"/> NONE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. PRIMARY SPECIALTY NUMBER, TITLE AND YEARS AND MONTHS IN SPECIALTY (Additional specialty numbers and titles including periods of one or more years) 63B10 Light Wheel Vehicle Mechanic//3 Years and 7 Months//NOTHING FOLLOWS// | | | 12. RECORD OF SERVICE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | <table border="1"> <thead> <tr> <th></th> <th>YEAR(S)</th> <th>MON (S)</th> <th>DAY(S)</th> </tr> </thead> <tbody> <tr> <td>a. Date Entered AD This Period</td> <td>84</td> <td>02</td> <td>15</td> </tr> <tr> <td>b. Separation Date This Period</td> <td>88</td> <td>02</td> <td>14</td> </tr> <tr> <td>c. Not Active Service Time Period</td> <td>04</td> <td>00</td> <td>00</td> </tr> <tr> <td>d. Initial Prior Active Service</td> <td>00</td> <td>00</td> <td>00</td> </tr> <tr> <td>e. Initial Prior Inactive Service</td> <td>00</td> <td>01</td> <td>04</td> </tr> <tr> <td>f. Foreign Service</td> <td>02</td> <td>02</td> <td>17</td> </tr> <tr> <td>g. Sea Service</td> <td>00</td> <td>00</td> <td>00</td> </tr> <tr> <td>h. Effective Date of Pay, Credits</td> <td>85</td> <td>03</td> <td>01</td> </tr> <tr> <td>i. Reserve Duty Term (Days)</td> <td>90</td> <td>01</td> <td>10</td> </tr> </tbody> </table> | | | | YEAR(S) | MON (S) | DAY(S) | a. Date Entered AD This Period | 84 | 02 | 15 | b. Separation Date This Period | 88 | 02 | 14 | c. Not Active Service Time Period | 04 | 00 | 00 | d. Initial Prior Active Service | 00 | 00 | 00 | e. Initial Prior Inactive Service | 00 | 01 | 04 | f. Foreign Service | 02 | 02 | 17 | g. Sea Service | 00 | 00 | 00 | h. Effective Date of Pay, Credits | 85 | 03 | 01 | i. Reserve Duty Term (Days) | 90 | 01 | 10 |
| | YEAR(S) | MON (S) | DAY(S) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Date Entered AD This Period | 84 | 02 | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Separation Date This Period | 88 | 02 | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Not Active Service Time Period | 04 | 00 | 00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Initial Prior Active Service | 00 | 00 | 00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. Initial Prior Inactive Service | 00 | 01 | 04 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f. Foreign Service | 02 | 02 | 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g. Sea Service | 00 | 00 | 00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h. Effective Date of Pay, Credits | 85 | 03 | 01 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| i. Reserve Duty Term (Days) | 90 | 01 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) Army Service Ribbon//Overseas Service Ribbon//Good Conduct Medal//Army Lapel Button//Expert Badge M16 Rifle//Drivers Mechanic Badge-W//NOTHING FOLLOWS// | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. MILITARY EDUCATION (Course Title, number weeks, and month and year completed) Light Wheel Vehicle and Power Generator Mechanic Course, 11 Weeks, (Jul 84)//NOTHING FOLLOWS// | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERAN'S EDUCATIONAL ASSISTANCE PROGRAM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 16. HIGH SCHOOL GRADUATE OR EQUIVALENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 17. DAYS ACCRUED LEAVE PAID 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. REMARKS Dental care was not provided within 90 days prior to separation//NOTHING FOLLOWS// | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. MAILING ADDRESS AFTER SEPARATION 3863 Whitney Road Memphis, TN 38127 | | | 20. MEMBER REQUESTS COPY A BE SENT TO TN DE, OF YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. SIGNATURE OF MEMBER BEING SEPARATED [Signature] | | 22.Typed Name, Grade, Title and Signature of Official AUTHORIZED TO SIGN [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. TYPE OF SEPARATION RELEASE FROM ACTIVE DUTY | | 24. CHARACTER OF SERVICE (Includes upgrades) HONORABLE | | 25. SEPARATION CODE 1BK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. SEPARATION AUTHORITY CHAPTER 4, AR 635-200 | | 27. REQUISITION CODE DV-14 | | 28. MEMBER REQUESTS COPY A [Signature] INITIALS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29. NARRATIVE REASON FOR SEPARATION EXPIRATION TERM OF SERVICE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. DATES OF TIME FOR DURING THIS PERIOD [REDACTED] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



DEPARTMENT OF VETERANS AFFAIRS

February 17, 2025

Mark Tyrone Stinson
777 Nw 155th Ln Apt 911
Miami, FL 33169

In Reply Refer to:
xxx-xx-0253
27/eBenefits

Dear Mr. Stinson:

This letter certifies that Mark Tyrone Stinson is receiving service-connected disability compensation from the Department of Veterans Affairs.

The current benefit paid is as follows:

| | |
|-----------------------------|------------------|
| Gross Benefit Amount | [REDACTED] |
| Net Amount Paid | [REDACTED] |
| Effective Date | December 1, 2024 |
| Combined Evaluation | 100 percent |

How You Can Contact Us

- If you need general information about benefits and eligibility, please visit us at <https://www.ebenefits.va.gov> or <http://www.va.gov>.
- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.
- Ask a question on the Internet at <https://www.va.gov/contact-us>.

Sincerely Yours,

Regional Office Director



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM

IMPORTANT: Please read the Privacy Act and Respondent Burden information on page 3 before completing the form. Use this form to submit a claim if you disagree with a decision you received. For more information you can contact us online through Ask VA: <https://ask.va.gov/> or call us toll-free at 1-800-698-2411 (TTY:711). If you prefer you may complete and submit the form online [by using the addresses and weblinks listed in the Instructions, Page 1 or 2.](#)

1. BENEFIT TYPE (PLEASE CHECK ONLY ONE BOX)

Note: If you would like to file for multiple benefit types, you must complete a separate VA Form 20-0995 for each benefit type.

- ☐ COMPENSATION ☐ PENSION/DIC/SURVIVORS BENEFITS ☒ FIDUCIARY
☐ EDUCATION ☐ LOAN GUARANTY ☐ LIFE INSURANCE
☐ VETERAN READINESS AND EMPLOYMENT ☐ NATIONAL CEMETERY ADMINISTRATION
☐ VETERANS HEALTH ADMINISTRATION (NOTE: If checked, specify in the space provided below, which benefit type you are claiming for VHA. (e.g., Travel/Mileage Reimbursement, Medical Treatment Reimbursement, Health Care Eligibility, Clothing Allowance, etc.)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable checkbox to help expedite processing of the form.

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

M A R K T S T I N S O N

3. SOCIAL SECURITY NUMBER

● ● ● - ● ● - ● ● ● ●

4. VA FILE NUMBER (If applicable)

● ● ● ● ● ● ● ●

5. DATE OF BIRTH (MM/DD/YYYY)

● ● - ● ● - ● ● ● ●

6. SERVICE NUMBER (If applicable)

● ● ● ● ● ● ● ●

7. VA INSURANCE POLICY NUMBER (If applicable)

● ● ● ● ● ● ● ● ● ● ● ● ● ●

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

No. & Street: 7 7 7 N W 1 5 5 T H L A N E
Apt./Unit Number: 9 1 1 City: N O R T H M I A M I
State/Province: F L Country: U S ZIP Code/Postal Code: 3 3 1 6 9 - 6 1 8 0

9. TELEPHONE NUMBER (Optional) (Include Area Code)

7 8 6 - 2 9 9 - 7 4 9 9

10. E-MAIL ADDRESS (Optional)

MSTINSON1@BELLSOUTH.NET

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION (Complete this section ONLY IF the claimant is NOT the veteran)

11. CLAIMANT'S NAME (First, Middle Initial, Last) (If other than veteran)

● ● ● ● ● ● ● ● ● ● ● ● ● ●

12. SOCIAL SECURITY NUMBER

● ● ● - ● ● - ● ● ● ●

13. VA FILE NUMBER (If applicable)

● ● ● ● ● ● ● ●

14. DATE OF BIRTH (MM/DD/YYYY)

● ● - ● ● - ● ● ● ●

15. VA INSURANCE POLICY NUMBER (If applicable)

● ● ● ● ● ● ● ● ● ● ● ● ● ●

16. RELATIONSHIP TO VETERAN (Check one)

☐ SPOUSE ☐ CHILD ☐ FIDUCIARY ☐ PARENT ☐ OTHER (Specify)

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

No. & Street: ● ● ● ● ● ● ● ● ● ● ● ● ● ●
Apt./Unit Number: ● ● ● ● City: ● ● ● ● ● ● ● ● ● ●
State/Province: ● ● Country: ● ● ZIP Code/Postal Code: ● ● ● ● ● ● - ● ● ● ●

18. TELEPHONE NUMBER (Optional) (Include Area Code)

● ● ● - ● ● ● - ● ● ● ●

19. E-MAIL ADDRESS (Optional)

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 20A through 20D) should **ONLY** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

20A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

☐ YES (If "Yes," complete Items 20B through 20D regarding your living situation)

☒ NO (If "No," skip to Item 21)

20B. WHICH OF THESE STATEMENTS BEST DESCRIBES YOUR LIVING SITUATION? (Select all that apply)

☐ I LIVE OR SLEEP IN A PLACE THAT IS NOT MEANT FOR REGULAR SLEEPING (e.g., a car, park, abandoned building, bus station, train station, airport or camp ground)

☐ I LIVE IN A SHELTER (e.g., a hotel or motel that is meant for temporary stays)

☐ I AM STAYING WITH A FRIEND OR FAMILY MEMBER, BECAUSE I AM UNABLE TO OWN A HOME RIGHT NOW

☐ IN THE NEXT 30 DAYS, I WILL HAVE TO LEAVE A FACILITY, LIKE A HOMELESS SHELTER

☐ IN THE NEXT 30 DAYS, I WILL LOSE MY HOME
Note: This selection includes any house, apartment, trailer, or other living space that you own, rent, or live in without paying rent, any hotels or motels that are meant for temporary stays, or a living space that you share with others.)

☐ NONE OF THESE SITUATIONS APPLY TO ME

Note: We understand that you may have other housing risks not listed here. If you feel comfortable sharing more about your situation, you can check 'other' and specify in the space provided. Or you can check 'other' and not include any details. We will use this information only to prioritize your request.

☐ OTHER (Specify)

20C. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

20D. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

SECTION IV: ISSUE(S) FOR SUPPLEMENTAL CLAIM

21. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU WOULD LIKE VA TO REVIEW AS PART OF YOUR **SUPPLEMENTAL CLAIM** (Note: Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's decision.)

If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in Item 21A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.

| 21A. SPECIFIC ISSUE(S) | 21B. DATE OF VA DECISION NOTICE |
|------------------------|---------------------------------|
| REFUND ATTORNEY FEES | 1 0 - 1 0 - 2 0 2 3 |
| | - - |
| | - - |
| | - - |
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| | - - |

SECTION V: NEW AND RELEVANT EVIDENCE

IMPORTANT: To complete your application, you must submit new and relevant evidence to VA or tell us about new and relevant evidence that VA can assist you in gathering in support of your **supplemental claim**. If you have records in your possession, attach the records to this form. List your name and file number on each page. If you would like VA to obtain non-Federal records, review your decision notification letter or read the instructions for this section on Page 3 that lists the appropriate forms to complete and submit those forms to VA with this request form. **Note:** Unless your **supplemental claim** is based on a change in law, you'll need to submit supporting evidence that's **new and relevant** for your application to be complete. You can also identify evidence you'd like us to gather for you.

22A. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply)

- ☐ PRIVATE HEALTH CARE PROVIDER (including non-Federal records)
- ☐ VA VET CENTER
- ☐ COMMUNITY CARE (Paid for by VA)
- ☐ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)
- ☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)
- ☒ OTHER (Specify): **REFUND ATTORNEY FEES**

Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your **private provider**, (excluding community care (paid for by VA)) or VA Vet Center health records, VA requires your consent by completing VA Forms 21-4142, *Authorization to Disclose Information to VA*, and 21-4142a, *General Release for Medical Provider Information to VA*. VA forms are available at www.va.gov/vaforms.

Note: If treatment began from 2005 to present, you **do not** need to provide in Item 22C the date(s) of treatment.

| 22B. NAME AND LOCATION OF THE TREATMENT FACILITY | 22C. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY) | 22D. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT |
|--|--|--|
| | — | <input type="checkbox"/> Don't have date |
| | — | <input type="checkbox"/> Don't have date |
| | — | <input type="checkbox"/> Don't have date |

SECTION VI: 5103 NOTICE OF ACKNOWLEDGMENT

(This section applies to Compensation, Pension, DIC, and Accrued benefit claims only.)

Note: If we issued your decision within the past year, skip to Section VII

23. FOR SPECIFIC EVIDENCE YOU NEED TO PROVIDE WITH YOUR CLAIM, VISIT ONE OF THESE PAGES ON www.va.gov.

- Evidence to support a claim for Veterans Disability Compensation and related Compensation benefits: <https://www.va.gov/disability/how-to-file-claim/evidence-needed/>.
- Evidence to support a claim for VA pension, DIC, or accrued benefits: <https://www.va.gov/resources/evidence-to-support-va-pension-dic-or-accrued-benefits-claims/>.

I CERTIFY THAT I HAVE REVIEWED THE NOTICE OF EVIDENCE THAT RELATES TO MY CLAIM.

- ☒ YES ☐ NO (If you check "No," VA will send the 5103 notice to you via mail.)

SECTION VII: OPTION FOR VETERANS BENEFITS ADMINISTRATION (VBA) TO NOTIFY VETERANS HEALTH ADMINISTRATION (VHA) ABOUT CERTAIN UPCOMING EVENT(S) DURING THE CLAIM AND OR APPEAL PROCESS

IMPORTANT: For information on VHA health care services, visit www.va.gov/health-care/about-va-health-benefits. To learn more about VHA health care services available related to military sexual trauma (MST), you can contact a VHA MST Coordinator. A list is available at www.mentalhealth.va.gov/msthome/vha-mst-coordinators.asp or you can contact your local VA medical facility and ask to speak to the MST Coordinator.

24. If you are filing a claim for compensation for a condition due to a personal traumatic event(s) involving MST and you are registered and/or enrolled for VHA health care, you have the option for VBA to electronically notify VHA about certain upcoming event(s) during your claim and/or appeal process. These event(s) are any scheduled compensation and pension (C&P) examination, hearing before the Board of Veterans' Appeals, and any decision notification. When notified, VHA will place an indicator in your medical record to alert VA health care providers that these event(s) are scheduled to occur. Notifications to VHA would only indicate the type of event(s) and potential time frame, not any details specific to your claim. The indicator in your medical record would not identify your claim as MST-related, but at this time, only claimants filing MST-related claims are provided this notification option. For this reason, providers may know that the indicator is in relation to an MST-related claim. The decision to consent, not consent, or revoke prior consent into the automatic notification system will not affect the status or outcome of your claim. A response is not required. If you do not respond, VBA will not send electronic notifications to VHA, nor will the outcome of your claim be impacted. If you would like VBA to send these electronic notifications to VHA, please indicate your consent by selecting a check box below.

- ☒ A. I CONSENT TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (Note: I understand that an indicator for these event(s) will appear in my VHA medical record.)
- ☐ B. I DO NOT CONSENT TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (Note: I understand that an indicator for these event(s) will not appear in my VHA medical record.)
- ☐ C. I REVOKE PRIOR CONSENT TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (Note: I understand that in the future, notice of these event(s) will no longer appear in my VHA medical record.)
- ☐ D. NOT APPLICABLE AND/OR NOT ENROLLED OR REGISTERED IN VHA HEALTH CARE

Note: You have the option to modify your previous selection at any time. Mail your correspondence to: **Department of Veterans Affairs, Compensation Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION VIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

25A. VETERAN/CLAIMANT'S SIGNATURE



25B. DATE SIGNED (MM/DD/YYYY)

1 0 - 1 1 - 2 0 2 4

SECTION IX: WITNESSES TO SIGNATURE

(Note: Only use this section if the veteran/claimant used an "X" in Item 25A)

26A. SIGNATURE OF THE FIRST WITNESS

26B. PRINTED NAME AND ADDRESS OF FIRST WITNESS

Name:

Address:

27A. SIGNATURE OF THE SECOND WITNESS

27B. PRINTED NAME AND ADDRESS OF SECOND WITNESS

Name:

Address:

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (Note: Required only if Item 25A is blank.)

NOTE 1: An alternate signer signature **will not** be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

NOTE 2: For insurance appeals, either VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, VA Form 21-22A, *Appointment of Individual as Claimant's Representative*, OR VA Form 21P-555, *Certificate of Legal Capacity to Receive and Disburse Benefits and Fee Authorization*, needs to be of record to allow an alternate signer to sign on behalf of the claimant.

I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; OR, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; OR, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; OR, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; AND, that the claimant is under the age of 18; OR, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; OR, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

28A. ALTERNATE SIGNER'S SIGNATURE

28B. DATE SIGNED (MM/DD/YYYY)

- -

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE

(Note: This section does not apply to insurance claims)

I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature **will not** be accepted unless at the time of submission of this claim a valid VA Form 21-22, or VA Form 21-22a, indicating the appropriate POA is of record with VA.

29A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE

29B. DATE SIGNED (MM/DD/YYYY)

- -

29C. ACCREDITATION NUMBER

29D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known)

- -

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



The Florida Bar

651 East Jefferson Street
Tallahassee, FL 32399-2300

Joshua E. Doyle
Executive Director

850/561-5600
www.floridabar.org

February 14, 2025

Mr. Mark T. Stinson, Sr.
777 N.W. 155th Lane
Apartment #911
Miami, FL 33169

Re: Carol Avard; The Florida Bar File No. 2025-10,267(20A)

Dear Mr. Stinson:

We have carefully considered your inquiry/complaint with all of the information available and find no basis for further action by this office. Your inquiry/complaint involves a fee dispute. This office has no jurisdiction over fee disputes unless the amount demanded is clearly excessive, extortionate, or fraudulent. Your inquiry/complaint does not fall into any of those categories.

Further questions regarding fee disputes may be directed to the Fee Arbitration program assistant in our Tallahassee office at 850/561-3166, should you desire to arbitrate this matter.

The Florida Bar cannot give you legal advice, and our disposition of this inquiry/complaint has no effect on any legal remedy that you may have. If you have further concerns about any legal issue, please consult with legal counsel of your choice.

Our file on this matter is now closed. Pursuant to the Bar's records retention schedule, the computer record and file will be disposed of one year from the date of closing.

Sincerely,

Carlos A. Leon, Bar Counsel
Attorney Consumer Assistance Program
ACAP Hotline 866-352-0707

cc: Ms. Carol Avard

DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM

Page 4

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 20A through 20D) should **ONLY** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

20A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

☐ YES (If "Yes," complete Items 20B through 20D regarding your living situation)

☒ NO (If "No," skip to Item 21)

20B. WHICH OF THESE STATEMENTS BEST DESCRIBES YOUR LIVING SITUATION? (Select all that apply)

☐ I LIVE OR SLEEP IN A PLACE THAT IS NOT MEANT FOR REGULAR SLEEPING (e.g., a car, park, abandoned building, bus station, train station, airport or camp ground)

☐ I LIVE IN A SHELTER (e.g., a hotel or motel that is meant for temporary stays)

☐ I AM STAYING WITH A FRIEND OR FAMILY MEMBER, BECAUSE I AM UNABLE TO OWN A HOME RIGHT NOW

☐ IN THE NEXT 30 DAYS, I WILL HAVE TO LEAVE A FACILITY, LIKE A HOMELESS SHELTER

☐ IN THE NEXT 30 DAYS, I WILL LOSE MY HOME
Note: This selection includes any house, apartment, trailer, or other living space that you own, rent, or live in without paying rent, any hotels or motels that are meant for temporary stays, or a living space that you share with others.)

☐ NONE OF THESE SITUATIONS APPLY TO ME

Note: We understand that you may have other housing risks not listed here. If you feel comfortable sharing more about your situation, you can check "other" and specify in the space provided. Or you can check "other" and not include any details. We will use this information only to prioritize your request.

☐ OTHER (Specify)

20C. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

20D. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

SECTION IV: ISSUE(S) FOR SUPPLEMENTAL CLAIM

21. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU WOULD LIKE VA TO REVIEW AS PART OF YOUR SUPPLEMENTAL CLAIM (Note: Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's decision.)

If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in Item 21A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.

| 21A. SPECIFIC ISSUE(S) | 21B. DATE OF VA DECISION NOTICE |
|---|---------------------------------|
| I DISAGREE WITH THE VA DECISION MADE ON JUNE 5, 2024, TO PAY \$30,659.95 *SEE FORM 21-4193* | 0 6 - 0 5 - 2 0 2 4 |
| | - - |
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| | - - |

SECTION V: NEW AND RELEVANT EVIDENCE

IMPORTANT: To complete your application, you must submit new and relevant evidence to VA or tell us about new and relevant evidence that VA can assist you in gathering in support of your supplemental claim. If you have records in your possession, attach the records to this form. List your name and file number on each page. If you would like VA to obtain non-Federal records, review your decision notification letter or read the instructions for this section on Page 3 that lists the appropriate forms to complete and submit those forms to VA with this request form. **Note:** Unless your supplemental claim is based on a change in law, you'll need to submit supporting evidence that's new and relevant for your application to be complete. You can also identify evidence you'd like us to gather for you.

22A. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply)

- ☐ PRIVATE HEALTH CARE PROVIDER (including non-Federal records)
- ☐ VA VET CENTER
- ☐ COMMUNITY CARE (Paid for by VA)
- ☒ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)
- ☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)
- ☐ OTHER (Specify): _____

Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your private provider, (excluding community care (paid for by VA)) or VA Vet Center health records, VA requires your consent by completing VA Forms 21-4142, *Authorization to Disclose Information to VA*, and 21-4142a, *General Release for Medical Provider Information to VA*. VA forms are available at www.va.gov/vaforms.

Note: If treatment began from 2005 to present, you **do not** need to provide in Item 22C the date(s) of treatment.

| 22B. NAME AND LOCATION OF THE TREATMENT FACILITY | 22C. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY) | 22D. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT |
|--|--|--|
| | — | <input type="checkbox"/> Don't have date |
| | — | <input type="checkbox"/> Don't have date |
| | — | <input type="checkbox"/> Don't have date |

SECTION VI: 5103 NOTICE OF ACKNOWLEDGMENT

(This section applies to Compensation, Pension, DIC, and Accrued benefit claims only.)

Note: If we issued your decision within the past year, skip to Section VII

23. FOR SPECIFIC EVIDENCE YOU NEED TO PROVIDE WITH YOUR CLAIM, VISIT ONE OF THESE PAGES ON www.va.gov.

- Evidence to support a claim for Veterans Disability Compensation and related Compensation benefits: <https://www.va.gov/disability/how-to-file-claim/evidence-needed/>.
- Evidence to support a claim for VA pension, DIC, or accrued benefits: <https://www.va.gov/resources/evidence-to-support-va-pension-dic-or-accrued-benefits-claims/>.

I CERTIFY THAT I HAVE REVIEWED THE NOTICE OF EVIDENCE THAT RELATES TO MY CLAIM.

- ☒ YES ☐ NO (If you check "No," VA will send the 5103 notice to you via mail.)

SECTION VII: OPTION FOR VETERANS BENEFITS ADMINISTRATION (VBA) TO NOTIFY VETERANS HEALTH ADMINISTRATION (VHA) ABOUT CERTAIN UPCOMING EVENT(S) DURING THE CLAIM AND OR APPEAL PROCESS

IMPORTANT: For information on VHA health care services, visit www.va.gov/health-care/about-va-health-benefits. To learn more about VHA health care services available related to military sexual trauma (MST), you can contact a VHA MST Coordinator. A list is available at www.mentalhealth.va.gov/msthome/vha-mst-coordinators.asp or you can contact your local VA medical facility and ask to speak to the MST Coordinator.

24. If you are filing a claim for compensation for a condition due to a personal traumatic event(s) involving MST and you are registered and/or enrolled for VHA health care, you have the option for VBA to electronically notify VHA about certain upcoming event(s) during your claim and/or appeal process. These event(s) are any scheduled compensation and pension (C&P) examination, hearing before the Board of Veterans' Appeals, and any decision notification. When notified, VHA will place an indicator in your medical record to alert VA health care providers that these event(s) are scheduled to occur. Notifications to VHA would only indicate the type of event(s) and potential time frame, not any details specific to your claim. The indicator in your medical record would not identify your claim as MST-related, but at this time, only claimants filing MST-related claims are provided this notification option. For this reason, providers may know that the indicator is in relation to an MST-related claim. The decision to consent, not consent, or revoke prior consent into the automatic notification system will not affect the status or outcome of your claim. A response is not required. If you do not respond, VBA will not send electronic notifications to VHA, nor will the outcome of your claim be impacted. If you would like VBA to send these electronic notifications to VHA, please indicate your consent by selecting a check box below.

- ☒ A. I CONSENT TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (Note: I understand that an indicator for these event(s) will appear in my VHA medical record.)
- ☐ B. I DO NOT CONSENT TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (Note: I understand that an indicator for these event(s) will not appear in my VHA medical record.)
- ☐ C. I REVOKE PRIOR CONSENT TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (Note: I understand that in the future, notice of these event(s) will no longer appear in my VHA medical record.)
- ☐ D. NOT APPLICABLE AND/OR NOT ENROLLED OR REGISTERED IN VHA HEALTH CARE

Note: You have the option to modify your previous selection at any time. Mail your correspondence to: Department of Veterans Affairs, Compensation Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.

SECTION VIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

25A. VETERAN/CLAIMANT'S SIGNATURE



25B. DATE SIGNED (MM/DD/YYYY)

0 9 - 2 5 - 2 0 2 4

SECTION IX: WITNESSES TO SIGNATURE

(Note: Only use this section if the veteran/claimant used an "X" in Item 25A)

26A. SIGNATURE OF THE FIRST WITNESS

26B. PRINTED NAME AND ADDRESS OF FIRST WITNESS

Name:

Address:

27A. SIGNATURE OF THE SECOND WITNESS

27B. PRINTED NAME AND ADDRESS OF SECOND WITNESS

Name:

Address:

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (Note: Required only if Item 25A is blank.)

NOTE 1: An alternate signer signature will not be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

NOTE 2: For insurance appeals, either VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, VA Form 21-22A, *Appointment of Individual as Claimant's Representative*, OR VA Form 21P-555, *Certificate of Legal Capacity to Receive and Disburse Benefits and Fee Authorization*, needs to be of record to allow an alternate signer to sign on behalf of the claimant.

I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; OR, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; OR, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; OR, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; AND, that the claimant is under the age of 18; OR, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; OR, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

28A. ALTERNATE SIGNER'S SIGNATURE

28B. DATE SIGNED (MM/DD/YYYY)

- -

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE

(Note: This section does not apply to insurance claims)

I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature will not be accepted unless at the time of submission of this claim a valid VA Form 21-22, or VA Form 21-22a, indicating the appropriate POA is of record with VA.

29A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE

29B. DATE SIGNED (MM/DD/YYYY)

- -

29C. ACCREDITATION NUMBER

29D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED
(If known)

- -

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



Marvin A. Bienvenu, Jr.
Michael E. Montesi¹

Cecil G. Keltner (1919-2012)
Rocco Gatti, Jr. (1922-2008)

Eugene E. Piccirilli
Charles H. Richardson, III
W. David Cheek¹
James B. Stephens, II¹
J. Phillip Kerley²
Bradford J. Spitzer²
Of Counsel:
D. Reid Wamble¹
Mississippi Office

GATTI, KELTNER, BIENVENU & MONTESI, PLC
Attorneys at Law
www.gkbn.com

219 Adams Avenue
Memphis, TN 38103
(901) 526-2126
(888) 526-2126
Fax (901) 577-5424

Office Administrator
Michelle Rourke

Social Security Consultants:
C. Greg Cates, Esq., ADR

¹ Licensed in MS

² Licensed in TN & AR

³ Licensed in TN, MS & AR

FAX MESSAGE SENT 8/30/2022 7:59 am

To: SSA
Company: Social Security Administration
Voice Phone: (855) 782-9155

FAX: 833-950-3789

FAX From: Jennifer Rogers
Sender's Phone: 901-577-4006
Sender's E-mail:

FAX: 901-577-5576

Our File No: 75475

Our Client: MARK STINSON [REDACTED]

Enclosed is Form SSA-1695 in the case of Mark Stinson. Once you have entered the appropriate data into SSA's computer system, please send us a letter acknowledging receipt of the SSA-1695 in accordance with the requirements of POMS GN 039010.042A.1, Step 3.

Thank you, Jennifer Rogers

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