April 15, 2025

Mark T. Stinson, Sr.
777 NW 155th Lane, Apt. 911
Miami, FL 33169-6180
Ph: (786) 299-7499
Email: mstinson1@bellsouth.net
Pro Se

Clerk of the Court
Attn: Kyle R. Ratliff
Supreme Court of the United States
1 First Street, NE
Washington, D.C. 20543

Re: Motion for Leave to Proceed as a Veteran: USAC12, 24-12176

Mark T. Stinson, Sr.,

Petitioner,

vs.

Memphis Light Gas & Water (MLGW),
Jeremy Thacker, d/b/a PrideStaff,

Respondents,

Appeal from the United States District Court
for the Southern District of Florida
D.C. Docket No. 1:23-cv-24733

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

Motion for Leave to Proceed as a Veteran

a. 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.

a. 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 12/11/1990 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.

c. Legal Basis for Motion

- 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).
- Under 38 U.C.S. § 7261(a)(1), veterans are entitled to certain considerations in legal proceedings due to their service, and 38 U.S.C. 2022, veterans are entitled to file lawsuits without prepayment of fees, reinforcing the legislative intent to facilitate access to justice for those who have served. Smith v. Veterans Affairs, No. 4:15-cv-00456 (E.D. Ark., Dec. 15, 2015), the court ruled in favor of a veteran seeking leave to proceed IFP, noting that denying such motions would contradict Congress's intent to support veterans' access to legal remedies.
- 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, and voluminous challenges effectively.
- The Petitioner only must apply for this procedure because the (VA) has not given him back 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 02/01/2025, deducting $852 monthly, for an over payment of compensation from Stinson which Stinson has appealed on 09/25/2024, but the deduction has started and will continue until $30,659.95 is

collected. 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 Request for Review of Hearing Decision/Order is attached.
- The Petitioner PACER (Public Access To Court Electronic Records) fees are due and the Petitioner is requesting that this Court exempt all fees due on his account, ($162).
- The totality of Mr. Stinson, Sr's. financial situation reflects significant limitations on his ability to pay filing fees, and other associated costs of litigation without jeopardizing his basic needs such as housing, food, and transportation.
- 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.
- Exempt all PACER (Public Access To Court Electronic Records) payments on petitioner's account # 5237951.
- This request is made in good faith and is not intended to cause delay or prejudice against any party involved.

CONCLUSION

Therefore, for the foregoing reasons, the Petitioner Mr. Stinson, Sr. respectfully requests that this Court issue Leave to Proceed as a Veteran in this matter and Exempt all PACER fees.

Respectfully submitted,

Mark T. Stinson, Sr.
777 NW 155th Ln. Apt. 911
Miami, FL 33169-6180
Ph: (786) 299-7499
Email: mstinson1@bellsouth.net
April 15, 2025
Pro se

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

As required by Supreme Court Rule 33.1(h), I certify that the petition for a writ of certiorari contains 825 words, excluding the parts of the petition that are exempted by Supreme Court Rule 33.1(d).

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

Executed on April 15, 2025.

Mark T. Stinson, Sr.
Pro Se

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]

4.a. GRADE, RATE OR RANK SGT	4.b. PAY GRADE E-5	5. DATE OF BIRTH (YYMMDD) [redacted]	6. RESERVE OBLIG. TERM DATE Year 94 Mon [illegible] Day [illegible]

7.a. PLACE OF ENTRY INTO ACTIVE DUTY MEMPHIS, TN	7.b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) 2863 WHITNEY MEMPHIS, TN 38127
8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND 377TH CSH W/DUTY AT FT BRAGG NC	8.b. STATION WHERE SEPARATED FT BRAGG, NC 28307-5000
9. COMMAND TO WHICH TRANSFERRED 125TH ARCOM 443 DONELSON PIKE NASHVILLE TN 37241-3558	10. SGLI COVERAGE [ ] None Amount: $50,000.00

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.)
91C20 PRACTICAL NURSE 00YRS 06MOS//
63B20 LIGHT WHEEL VEHICLE POWER GENERATOR 00YRS 06MOS//
NOTHING FOLLOWS//

12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
a. Date Entered AD This Period	90	12	11
b. Separation Date This Period	91	06	04
c. Net Active Service This Period	00	05	24
d. Total Prior Active Service	04	02	28
e. Total Prior Inactive Service	02	05	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//

15.a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS' EDUCATIONAL ASSISTANCE PROGRAM	Yes	No	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes	No	16. DAYS ACCRUED LEAVE PAID
		X				NONE

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION — YES [X] NO [ ]

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 673B"//"ITEM 12D 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//

19.a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code) 2609 NINA APT 8 MEMPHIS, TN 38127	19.b. NEAREST RELATIVE (Name and address - include Zip Code) GERALDINE D. PERRY 2863 WHITNEY RD. MEMPHIS, TN 38127
20. MEMBER REQUESTS COPY 6 BE SENT TO TN DIR. OF VET AFFAIRS [ ] Yes [ ] No	22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and signature)
21. SIGNATURE OF MEMBER BEING SEPARATED SOLDIER NOT AVAILABLE FOR SIGNTURE	DARRYL L. HENDERSON MSG USA CH FT BRAGG TC

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 LBK	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 JUL 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: FORSCOM FC 86th Evac Hosp
8. STATION 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 [ ] NONE
11. PRIMARY SPECIALTY NUMBER, TITLE AND YEARS AND MONTHS IN SPECIALTY (Additional specialty numbers and titles involving periods of one or more years): 63B10 Light Wheel Vehicle Mechanic//3 Years and 7 Months//NOTHING FOLLOWS//

12. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. Date Entered AD This Period	84	02	15
b. Separation Date This Period	88	02	14
c. Net Active Service This Period	04	00	00
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	01	04
f. Foreign Service	02	02	17
g. Sea Service	00	00	00
h. Effective Date of Pay Grade	85	05	01
i. Reserve Oblig. Term. Date	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 VETERANS' EDUCATIONAL ASSISTANCE PROGRAM: [ ] YES [X] NO
16. HIGH SCHOOL GRADUATE OR EQUIVALENT: [X] YES [ ] NO
17. DAYS ACCRUED LEAVE PAID: 18½

18. REMARKS: Dental care was not provided within 90 days prior to separation// NOTHING FOLLOWS//

19 Feb

19. MAILING ADDRESS AFTER SEPARATION: 2863 Whitney Road, Memphis, TN 38127
20. MEMBER REQUESTS COPY 6 BE SENT TO TN DIR. OF VET AFFAIRS: [X] YES [ ] NO
21. SIGNATURE OF MEMBER BEING SEPARATED: [signature]
22. TYPED NAME, GRADE, TITLE AND SIGNATURE OF OFFICIAL AUTHORIZED TO SIGN: JAMES D. JONES, CPT, CO, TRANSITION POINT [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: CHAPTER 4, AR 635-200
26. SEPARATION CODE: LBK
27. REENLISTMENT CODE: RE-1A
28. NARRATIVE REASON FOR SEPARATION: EXPIRATION TERM OF SERVICE
29. DATES OF TIME LOST DURING THIS PERIOD: NONE
30. MEMBER REQUESTS COPY 4: [initials] INITIALS

SERVICE-2

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-[redacted]
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

OMB Control No. 2900-0886
Respondent Burden: 15 minutes
Expiration Date: 05/31/2027

VA | U.S. Department of Veterans Affairs

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): MARK T STINSON

3. SOCIAL SECURITY NUMBER: [redacted]

4. VA FILE NUMBER (If applicable):

5. DATE OF BIRTH (MM/DD/YYYY): [redacted]

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: 777 NW 155TH LANE
Apt./Unit Number: 911
City: NORTH MIAMI
State/Province: FL
Country: US
ZIP Code/Postal Code: 33169 – 6180

9. TELEPHONE NUMBER (Optional) (Include Area Code): 786 – 299 – 7499
Enter International Phone Number (If applicable):

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):
Enter International Phone Number (If applicable):

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	10 – 10 – 2023
	– –
	– –
	– –
	– –
	– –
	– –
	– –
	– –

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
	—	☐ Don't have date
	—	☐ Don't have date
	—	☐ 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)
Mark J Stin	10 – 11 – 2024

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

OMB Control No. 2900-0886
Respondent Burden: 15 minutes
Expiration Date: 05/31/2027

VA | U.S. Department of Veterans Affairs

DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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.

- [X] 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)
MARK T STINSON

3. SOCIAL SECURITY NUMBER
[redacted]

4. VA FILE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY)
[redacted]

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: 777 NW 155TH LANE
Apt./Unit Number: 911
City: MIAMI
State/Province: FL
Country: US
ZIP Code/Postal Code: 33169 – 6180

9. TELEPHONE NUMBER (Optional) (Include Area Code)
786 – 299 – 7499
Enter International Phone Number (If applicable)

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)
– –
Enter International Phone Number (If applicable)

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
I DISAGREE WITH THE VA DESCISON MADE ON JUNE 5, 2024, TO PAY $30,659.95 *SEE FORM 21-4193*	0 6 – 0 5 – 2 0 2 4
	– –
	– –
	– –
	– –
	– –
	– –
	– –
	– –

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
	—	☐ Don't have date
	—	☐ Don't have date
	—	☐ 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)
Mark J Stein	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.

Information You Submitted for Mark T Stinson

Information about Mark T Stinson

Name: **Mark T Tyrone Stinson**

Mailing Address: **777 NW 155th Lane, Apt. 911, MIAMI, FL 33169-6180**

Do you live at the above address? **Yes**

Daytime Phone Number: **(786) 299-7499**

Alternative Phone Number:

Email Address: **mstinson1@bellsouth.net**

Representative Information

Do you have a representative? **No**

Request for Review

Notice Date: **03/14/2025**

Claim # (if different from SSN):

SSA Program Title: **Period of Disability and Disability Insurance Benefits**

Reason for Review: **I can not preform the duties that I use to do on my job at Conexx Staffing Services, for 17 years. I am unable to stay focus on the task at hand consistently for 8 hours, due to my PTSD and the meds that I take.**

Time Extension: **N**

Details of Attached Files

Account Number	5237951
Username	markstinshzh
Account Balance	$162.00
Case Search Status	Active
Account Type	Upgraded PACER Account

Settings Maintenance Payments Usage

Change Username
Change Password
Set Security Information

Update PACER Billing Email
Set PACER Billing Preferences

This site is maintained by the Administrative Office of the U.S. Courts on behalf of the Federal Judiciary.

PACER Service Center
(800) 676-6856
pacer@psc.uscourts.gov