

VETERANS LAW

Military Trauma

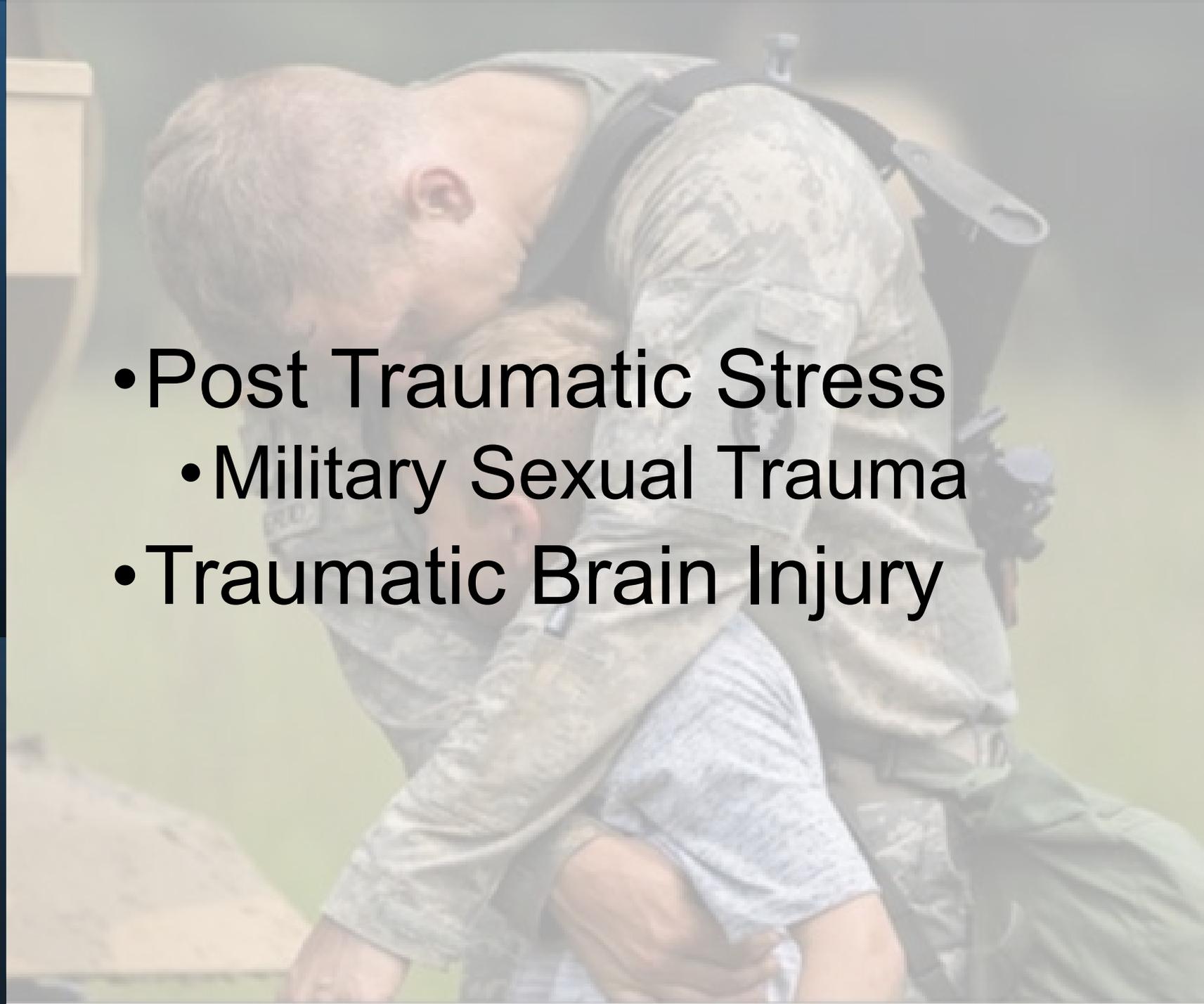


“To fulfill President Lincoln's promise to care for those who have served in our nation's military and for their families, caregivers, and survivors.”



Military Trauma

- Post Traumatic Stress
 - Military Sexual Trauma
- Traumatic Brain Injury





Post Traumatic Stress



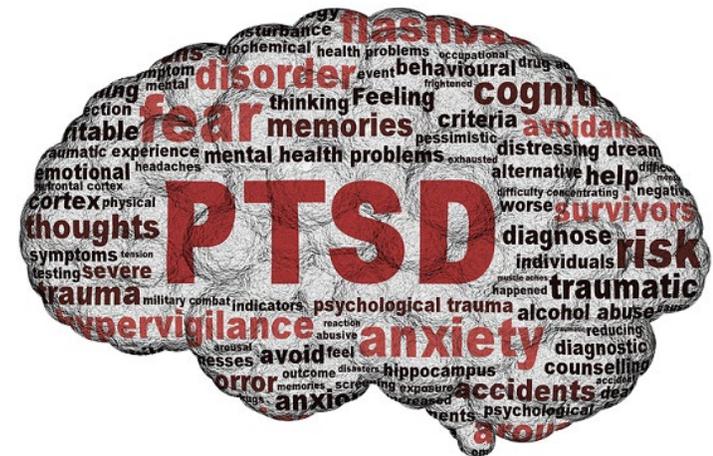
NOT ALL
WOUNDS
ARE
VISIBLE





Post Traumatic Stress

- “Soldier’s Heart” ; “Shell Shock” ; “Battle Fatigue”
- 1980 - PTSD added to **DSM-III** based on research of Vietnam veterans, Holocaust survivors, and sexual trauma victims
- PTSD linked to other health issues – heart disease, autoimmune disorders (think secondary disabilities)
- PTSD alters the brain’s chemistry
- Why **Underreported**:
 - Warrior Culture
 - Loss of Job / Promotion
 - Loss of Security Clearance
 - Embarrassed





Why Post Traumatic Stress

- Witnessing Traumatic Event/Death
- Threat of Death
- Causing Death
- Survivor's Guilt
- Perceived Threat
- Difficult Living Conditions
- NBC Threat
- Sexual Assault/Harassment
- Life and Family Disruptions





Why Post Traumatic Stress Iraq & Afghanistan

- Were attacked – fear of death
- Saw buddy wounded
- Hand-to-hand combat
- Caused death of enemy
- Caused death of non-combatant
- Saw bodies/remains
- Knew someone injured or killed





Post Deployment

- ***“Signature wound”*** of OIF and OEF – 2.6 million deployed
 - OEF – 11% with PTSD
 - OIF – 17% with PTSD
 - Typically manifests itself as we age
- **But...**
 - Vietnam – 30%
 - Gulf War – 21%
 - General US Population – 8.7%





NVLSP

Post Deployment Iraq & Afghanistan

- Highest number of OTH discharges
 - Drugs and Alcohol Abuse
 - Fights / Domestic Abuse
 - Anger Management
 - AWOL / Desertion
- Social Isolation
 - Decline of VSOs
 - IAVA
 - Social Media



IRAQ AND AFGHANISTAN
VETERANS OF AMERICA

Iraq & Afghanistan

- Asymmetrical and Urban Combat
 - Policing civilian areas
 - Suicide bombers
 - IEDs
 - Door to door searches for high value targets





Bad Paper Trends

- “Bad Paper” Discharges: Rate Increasing
 - WW II Era: 1.7%
 - Vietnam Era: 2.8%
 - Gulf War Era: 6.5%
 - Over 125K (33K deployed to Iraq & Afghanistan)
- Service Differences
 - USMC - 10 times more likely to get a bad paper discharge than Air Force



Discharge Upgrades

DoD Policy – Mental Health

- **Hagel Memo** (Sep 2014) – Boards must give “liberal consideration” to upgrade requests based on PTSD
- **Carson Memo** (Feb 2016) – Expands Hagle Memo to include TBI
- **Kurta Memo** (Aug 2017) – Further expands Hagel Memo to include **all mental health conditions**, including PTSD, TBI, MST. Adds **substance abuse** (self medicating) due to a mental health condition.
 - **Four questions for Boards to consider**



Discharge Upgrades

DoD Policy – Mental Health

- **Kurta Questions:**

1. Did the applicant have a condition or experience that may excuse or mitigate the discharge?
2. Did the condition/experience occur during military service?
3. Does the condition or experience excuse or mitigate the discharge?
4. Does the condition / experience outweigh the reasons for the discharge?



Discharge Upgrades

DoD Policy – Mental Health

- So, what does “liberal consideration” mean?
 - Focus on mental health conditions linked to service
 - Recognizes that mental health inherently affects behavior and choices
 - Misconduct can result from mental health conditions and can be evidence of a mental health condition
- Settlements: DRBs to review less than Honorable discharges of service members deployed to Iraq and/or Afghanistan (2001-2021)(2001-2023 USAF) and suffers from PTSD or TBI
 - *Manker v. Del Toro* (2021) – Navy / USMC (and Reserves)
 - *Kennedy v. McCarthy* (2021) – Army (Reserves and ANG)
 - *Johnson v. Kendall* (2023) – USAF, Space Force (Reserves and ANG)



Evaluating Your Client Post Deployment Signs

- Anger/Aggression/Violence
- Sleep Disturbances (Nightmares)
- Anxiety
- Emotional Numbing
- Substance Abuse/Self-Medicating
- High Risk Behaviors –
 - Actions to duplicate the “high” of combat



**VETERAN
ADRENALINE
THERAPY**

Saturday, September 16

Location:
Glen Helen Raceway
18585 Verdmont Ranch Rd
San Bernardino, CA 92407

About a one-hour drive from Temecula, CA.
Time: 0830 – 1600 (8:30 am to 4:00 pm)



Evaluating Your Client Post Deployment Signs

- Impulse Control Difficulties / Carry Weapon to be Safe
- Hyper-Arousal/Bad Memories/Hyper-Startle
- Social Isolation/Withdrawal
- Suicide (at a rate of 20+ per day)



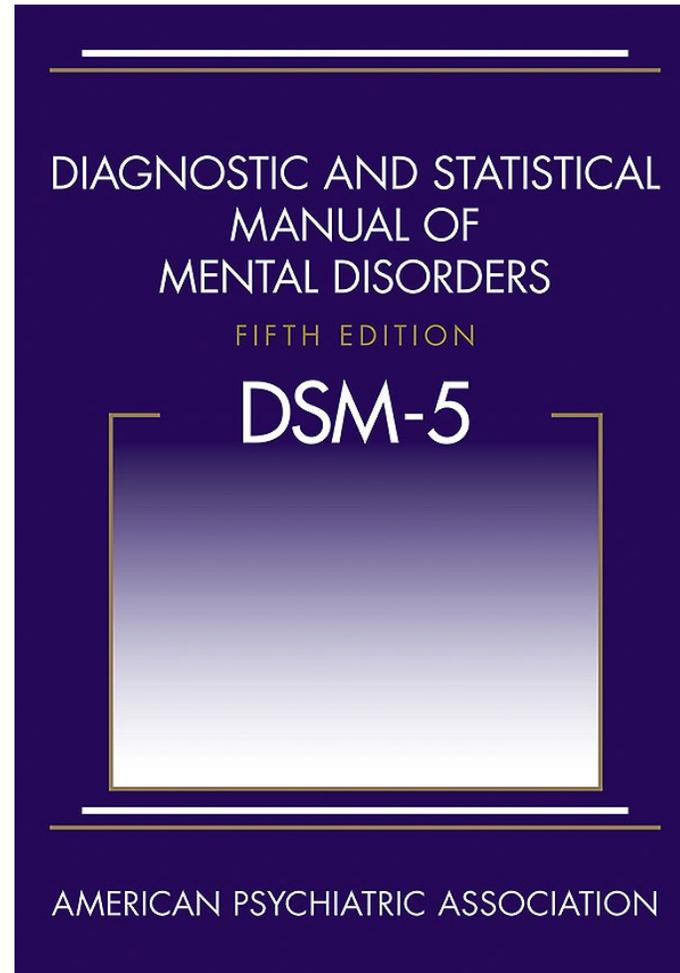


PTSD Claims

- **38 CFR 3.304(f)**
 - **Requires Current Diagnosis**
 - Medical evidence
 - **In-Service Stressor**
 - Credible supporting evidence
 - **Nexus established by medical evidence** between symptoms and in-service stressor



PTSD Claims: Current Diagnosis





PTSD Claims: Current Diagnosis

- Competent Medical Evidence of a Diagnosis
- **Only** the following can provide an initial diagnosis of PTSD:
 - Board Certified **Psychiatrist**;
 - **Psychiatrist** who has successfully completed an accredited psychiatry residency and who is appropriately credential and privileged;
 - **Licensed Doctorate-Level Psychologist**;
 - **Non-Licensed Doctoral Level Psychologist** working toward licensure under close supervision by a board certified or board eligible psychiatrist or licensed doctoral level psychologist;
 - **Psychiatry resident** under close supervision by a board-certified or board eligible psychiatrist or licensed doctoral level psychologist;
 - **Psychologist resident** under close supervision by a board eligible psychiatrist or a licensed doctoral level psychologist



Why “Acquired Psychiatric Disorder”

1. Catch-All Term to allow for any resulting diagnosis to be service connected;
2. It forces VA to develop for a more specific diagnosis;
3. It forces the VA examiner to find a relevant diagnosis;
4. It allows VA to consider the veteran’s symptoms without getting “caught up” on the diagnosis



PTSD Claims: Stressor

- In-Service Stressor
 - Combat
 - Does not need to be combat (crime/accident, etc.)
 - Stressor Statement – VA Form 21-0781 (Mar 24)





PTSD Claims Combat Stressor

38 CFR 3.304(f)(2)

If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is **consistent with the circumstances, conditions, or hardships of the veteran's service**, the **veteran's lay testimony alone** may establish the occurrence of the claimed in-service stressor.



PTSD Claims Combat Stressor





Combat as Stressor



- Lay evidence is enough for stressor if:
 - VA finds the veteran engaged in combat with the enemy;
 - Stressor is related to combat; and
 - Veteran submits a lay statement about occurrence of stressor in combat
 - Must be consistent with the veteran's service/type/ place
- Relaxed standard for combat veterans - 38 USC § 1154(b)
- Use service records – orders, decs, service ribbons, evals



PTSD Claims

Hostile Military or Terrorism

38 CFR 3.304(f)(3)

If a stressor claimed by a veteran is related to the **veteran's fear of hostile military or terrorist activity** and a **VA psychiatrist or psychologist, or a psychiatrist or psychologist** with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of posttraumatic stress disorder and that the veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is **consistent with the places, types, and circumstances of the veteran's service**, the **veteran's lay testimony alone** may establish the occurrence of the claimed in-service stressor....



PTSD Claims

Hostile Military or Terrorism

38 CFR 3.304(f)(3)

... For purposes of this paragraph, “fear of hostile military or terrorist activity” means that a **veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the veteran or others**, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.



PTSD Claims

Hostile Military or Terrorism

1. Stressor is related to a veteran's fear of hostile military or terrorist activities;
2. Stressor is consistent with places, types, and circumstances of the veteran's military service;
3. VA employed or contracted doctor (psychologist or psychiatrist) must confirm that the stressor is adequate and that the symptoms are related to the stressor; and
4. No clear and convincing evidence to the contrary



PTSD Claims

Hostile Military or Terrorism

Stressor is related to a veteran's fear of hostile military or terrorist activities



Iranian Missile Attack on US Base



Terrorist Attack on Khobar Towers



PTSD Claims

Hostile Military or Terrorism

Stressor is related to a veteran's fear of hostile military or terrorist activities



Pentagon Attack on 9/11



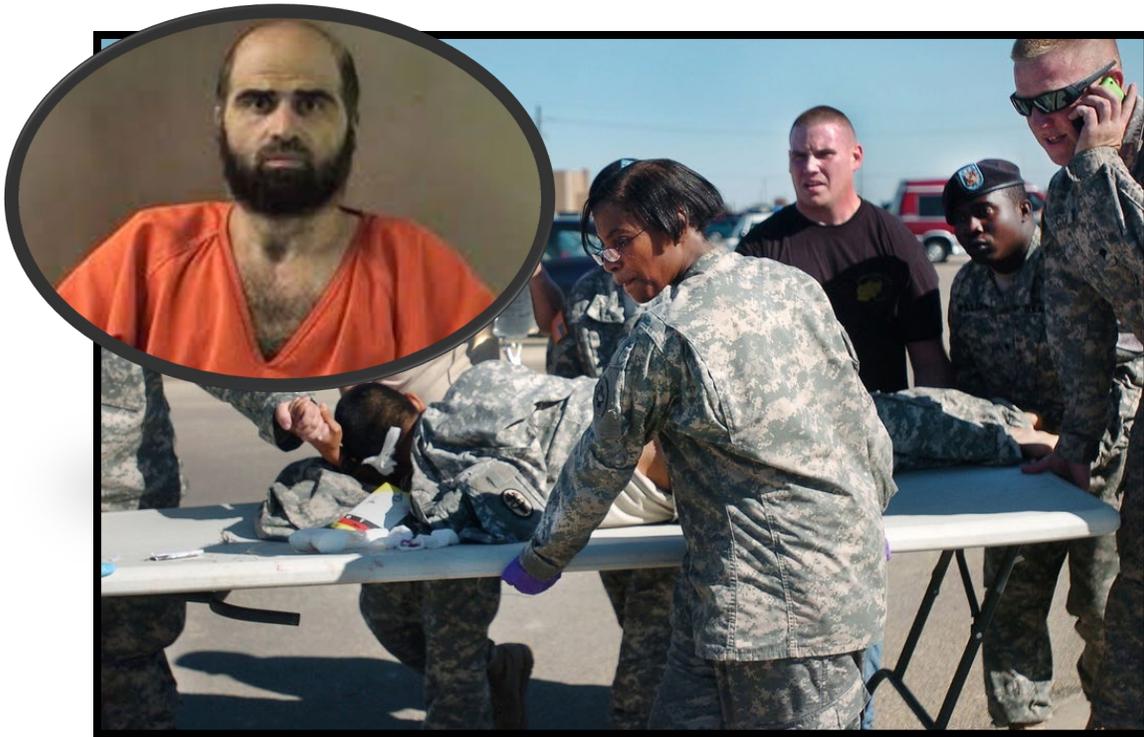
OKC Bombing



PTSD Claims

Hostile Military or Terrorism

Stressor is related to a veteran's fear of hostile military or terrorist activities



Fort Hood Attack



Fort Stewart Attack – 2025



PTSD Claims Other Stressor

If neither combat nor hostile military/terrorist activity was the cause of the stressor, competent evidence of the in-service event must be established by the veteran and/or VA.

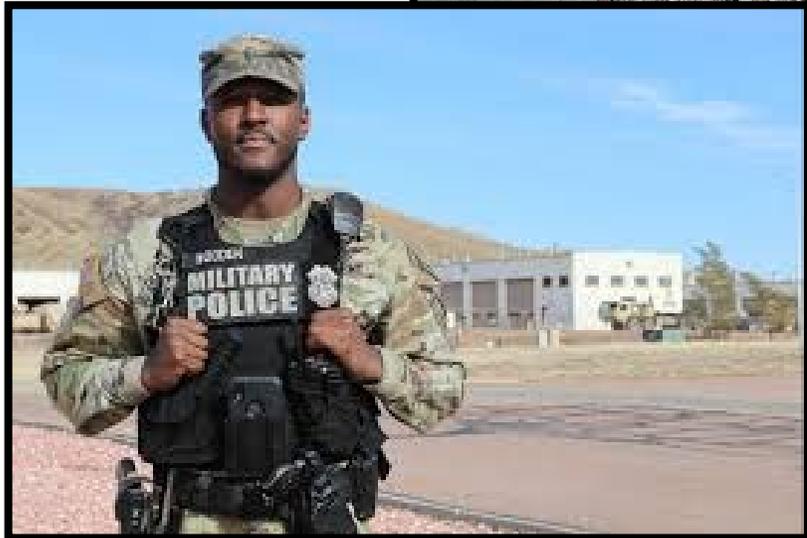
- What types of events might cause the stressor that results in PTSD?



NVLSP

PTSD Claims Other Stressors

What types of events might cause the stressor that results in PTSD?





Proving PTSD Claims

- Evidence of Non-Combat Stressor:
 - Police Reports
 - News Articles
 - Contemporaneous Statements
 - Medical Records
 - Lay Statements
 - Photos
 - Diary Entries / Letters
 - Etc...





NVLSP

| GENERAL RATING FORMULA FOR MENTAL DISORDERS | RATING |
|---|--------|
| Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name. | 100 |
| Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships. | 70 |
| Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships. | 50 |
| Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events). | 30 |
| Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication. | 10 |
| A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication. | 0 |



PTSD Claims Sexual Stressors

What other types of events might cause the stressor that results in PTSD? **Sexual Assault / Harassment**





Military Sexual Trauma (MST)





Military Sexual Trauma (MST)

MST is defined by Title 38 USC 1166 as “a physical assault of a sexual nature, battery or a sexual nature, or sexual harassment during active military, naval, air, or space service.”



“MST”

- Department of Defense Fiscal Year 2024 Annual Report on Sexual Assault in the Military
 - 8195 Reported Sexual Assaults ↓
 - 5169 unrestricted reports
 - 3026 restricted reports
- Estimated 70% never reported
- 1.4 million visits to the VA for MST (FY21)
- 57,400 VA claims (FY24) ↑
 - 65% grant rate for MST (Female)
 - 56% grant rate for MST (Male)



NVLSP

MST

32 CFR § 103.6 (a)(2) - Restricted Reporting

This reporting option does not trigger an investigation. The command is notified that “an alleged sexual assault” occurred but is not given the victim's name or other personally identifying information.

Restricted Reporting allows Service members and military dependents who are adult sexual assault victims to confidentially disclose the assault to specified individuals (**SARC, SAPR VA, or healthcare personnel**) and receive healthcare treatment and the assignment of a SARC and SAPR VA.

- **Chaplain / Legal Assistance Attorney** – other privileges apply

Unrestricted Reporting – all others – investigation required



Military Sexual Trauma (MST)

- Personal Trauma: Harm by a person not considered part of an enemy force
 - Assault, battery, harassment, hazing
- **MST is subset of PTSD** – rape, sexual assault, sexual harassment
- **MST is the stressor, not a diagnosis**
 - Diagnosis = PTSD, Anxiety Disorder, Panic Disorders, Major Depressive Disorder





MST Claims

1. Current diagnosis;
 2. Credible supporting evidence that an in-service stressor occurred; and
 3. Nexus, established by medical evidence linking current symptoms to the in-service stressor
- Veteran's lay statement alone is not enough



But...

- VA may not treat the absence of documentation of the MST in service records as negative evidence
 - *AZ v. Shinseki* (Fed Cir 2013)
 - MST is often not reported (estimate 81% not reported)
- Evidence from service records used
- Evidence from sources other than the veteran's service records may be used to corroborate the existence of an in-service personal assault stressor
 - *Molitor v. Shinseki* (CAVC 2017)



Evidence From Other Sources

38 CFR § 3.304(f)(5)

If a posttraumatic stress disorder claim is based on in-service personal assault, evidence from **sources other than the veteran's service records may corroborate the veteran's account** of the stressor incident.

Examples of such evidence include but are **not limited to**: records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy.

Evidence of behavior changes following the claimed assault is one type of relevant evidence that may be found in these sources.



Evidence From Other Sources

38 CFR § 3.304(f)(5)

Examples of behavior changes that may constitute credible evidence of the stressor include but are **not limited to**: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes.

VA will not deny a posttraumatic stress disorder claim that is based on in-service personal assault without first advising the claimant that evidence from sources other than the veteran's service records or evidence of behavior changes may constitute credible supporting evidence of the stressor and allowing him or her the opportunity to furnish this type of evidence or advise VA of potential sources of such evidence. VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred.



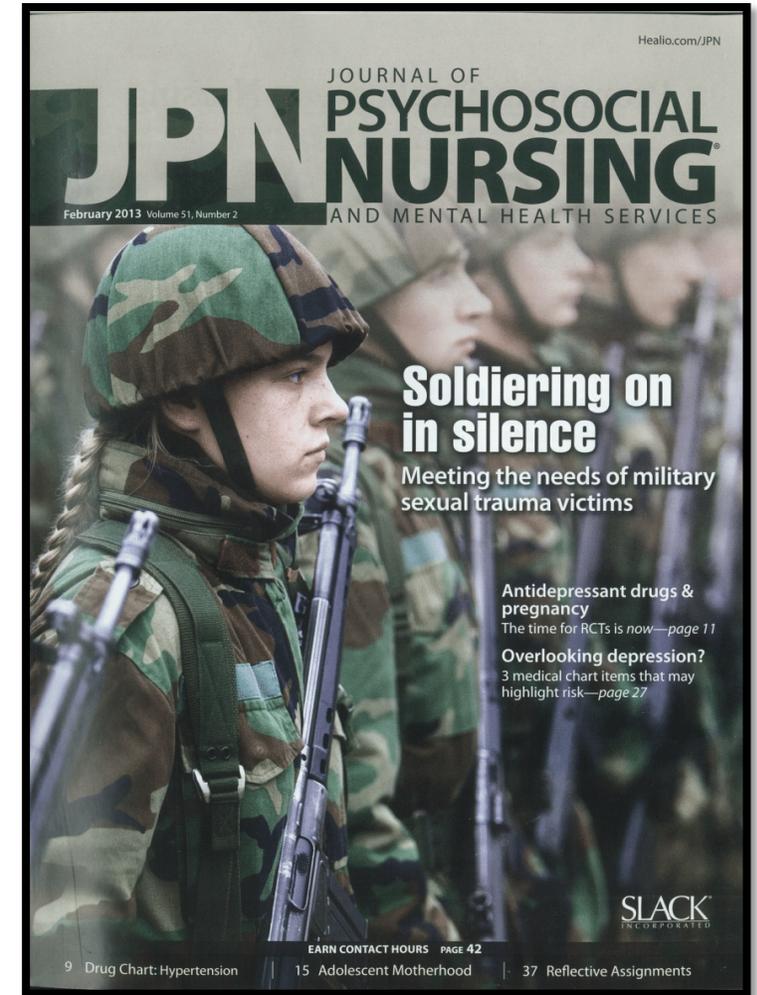
MST Claims – “Markers”

- Police records;
- Medical records;
- STD or pregnancy tests;
- Statements from family, friends, roommates, clergy;
- Evidence of behavioral changes...



MST Claims - Markers

- Evidence of behavioral changes:
 - Episodes of depression
 - Drug/alcohol use
 - Fights
 - Requests for transfer
 - Periods of AWOL
 - Unexplained economic changes
 - Deterioration of work performance





MST Claims: Medical Opinions

- For PTSD claims based on MST, after-the-fact opinions can corroborate claimed stressors and must be considered by the VA
 - *Menegassi v. Shinseki*, 638 F.3d 1379 (Fed. Cir. 2011)



MST Policy - Reminder

Kurta Memo (Aug 25, 2017)

- *“Standards of review should rightly consider the unique nature of these cases and afford each veteran a reasonable opportunity for relief **even if the sexual assault or harassment was unreported, or the was not diagnosed until years later.**”*
 - Includes mental health conditions, sexual assault, and sexual harassment
 - Policy applies to characterization, narrative reason, separation code and reenlistment code



VA Form 21-0781





PTSD Claims

- VA Form 21-0781 (Updated March 2024)
- Section I – Veteran Information
- Section II – Traumatic Event(s) Information
 - Combat, Personal Traumatic Event Not Involving MST, Personal Traumatic Event Involving MST, Other
 - Brief Description of the Traumatic Event/Location/Date
 - Combat Corpsman, Raped, Physically Assaulted, Witnessed Death, Processed Dead Bodies



PTSD Claims

- Section III – Additional Information Associated With The In-Service Traumatic Event
- Behavioral Changes:
 - Increased/decreased visits to healthcare provider/counselor
 - Request for change in duty assignment or job
 - Increased/decreased use of leave
 - Changes in performance
 - Episodes of depression/panic attacks, anxiety



PTSD Claims

- Section III – Additional Information Associated With The In-Service Traumatic Event
- Behavioral Changes Continued:
 - Increased/decreased use of prescription medications
 - Increased/decreased use of non-prescription medications
 - Increased/decreased use of alcohol/drugs
 - Disciplinary/legal difficulties
 - Changes in eating habits



PTSD Claims

- Section III – Additional Information Associated With The In-Service Traumatic Event
- Behavioral Changes Continued:
 - Pregnancy tests
 - Tests for sexually transmitted infections
 - Economic or social behavioral changes
 - Changes in or breakup of significant relationship
 - Additional behavioral changes



PTSD Claims

- Section III – Additional Information Associated With The In-Service Traumatic Event
- Was an official report filed?
- Sources of Evidence: Rape crisis/domestic abuse center, health clinic, counseling center, family member, roommate, faculty, police reports, medical reports, chaplain/clergy, fellow service members, personal diaries/notes, other, none



PTSD Claims

- Section IV – Treatment Information
- Section V – Additional Remarks



NVLSP

GENERAL RATING FORMULA FOR MENTAL DISORDERS

RATING

Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.

100

Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships.

70

Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.

50

Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).

30

Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication.

10

A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.

0



Traumatic Brain Injury



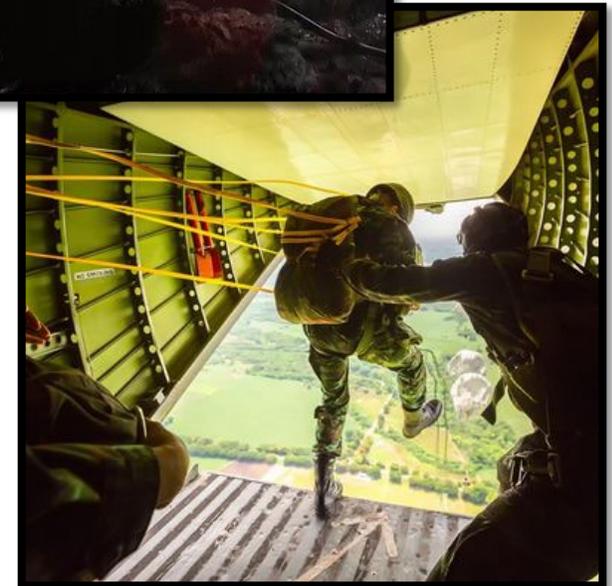


Traumatic Brain Injury

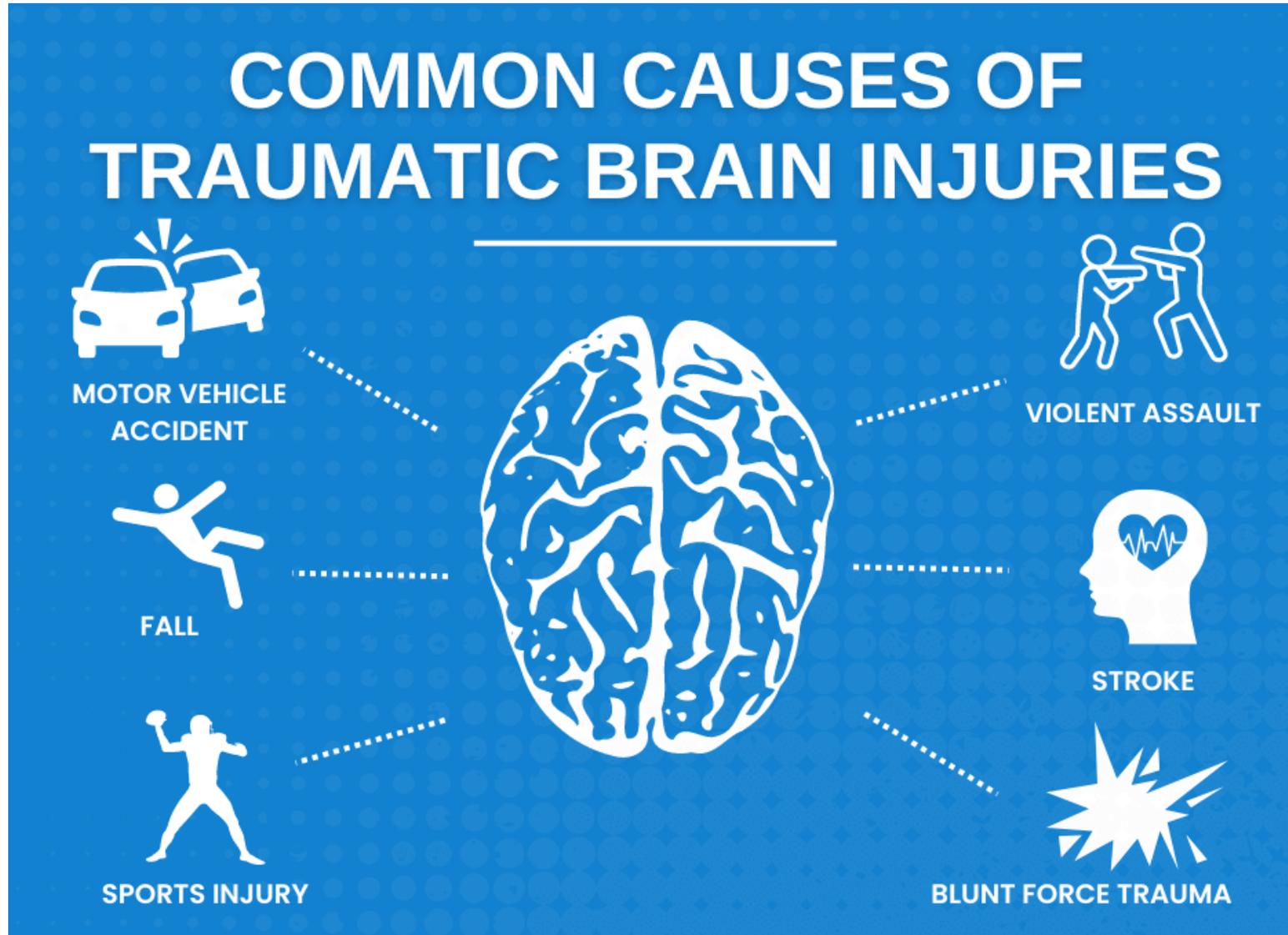
- A traumatically induced **structural injury and/or physiological disruption of brain function** as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs immediately following the event:
 - Any period of loss or decreased level of consciousness;
 - Any loss of memory for events immediately before or after injury;
 - Any alternation of mental state at the time of the injury (confusion, disorientation, slowed thinking); or
 - Neurological defects (weakness, loss of balance, change of vision, sensory loss, etc.)



Traumatic Brain Injury Causes



Traumatic Brain Injury Causes





Traumatic Brain Injury

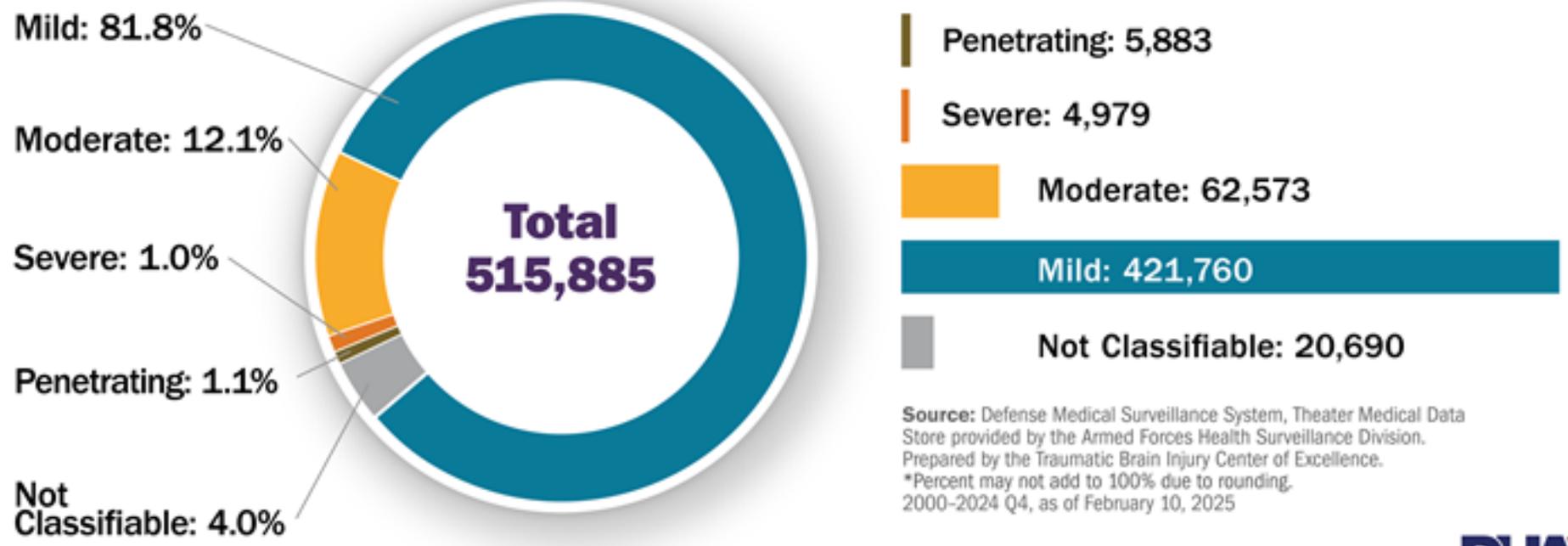
- VA requires **two components** to establish the existence of a TBI
 1. External force AND
 2. Identifiable manifestation of a brain injury immediately following the external force
- Advocates should inquire further about TBI when reviewing STRs and/or filing claims for cognitive impairment, vertigo, tinnitus, hearing loss, sleep impairment, endocrine dysfunction and headaches



Traumatic Brain Injury Signature Wound of OIF/OEF

DOD Numbers for Traumatic Brain Injury Worldwide

2000-2024 Q4



Source: Defense Medical Surveillance System, Theater Medical Data Store provided by the Armed Forces Health Surveillance Division. Prepared by the Traumatic Brain Injury Center of Excellence. *Percent may not add to 100% due to rounding. 2000-2024 Q4, as of February 10, 2025

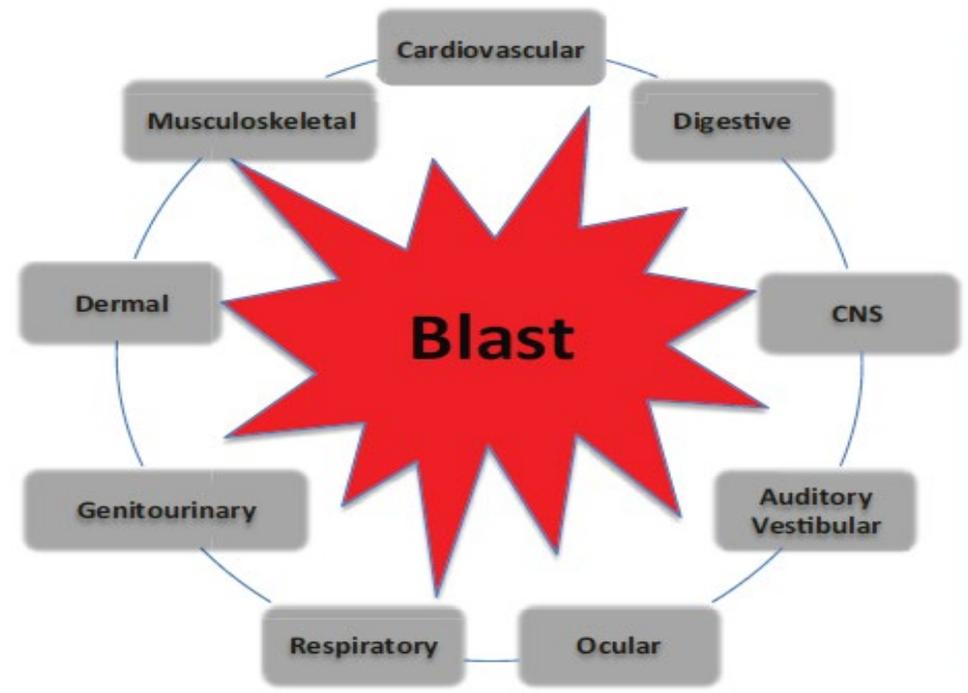




Traumatic Brain Injury Signature Wound of OIF/OEF

Acute blast: Vulnerable organs/systems

Long-term Secondary Effects



Modified from www.readengage.com



Traumatic Brain Injury Exams

- TBI Worksheets – 26 symptoms evaluated
- Can be diagnosed only by:
 - Psychiatrist, Neurologist, Neurosurgeon, Physiatriist (Rehab)
 - NOT a psychologist or neuro-psychologist



Traumatic Brain Injury

- Must use **specific** Diagnostic Codes when applicable
 - Seizures, Headaches
- Use Diagnostic Code 8045 for **residuals of TBI not otherwise independently rated**
 - No pyramiding





Traumatic Brain Injury

- Rating the residuals of a TBI (Facets of Cognitive Impairment)
 - Veteran's impairment is assessed as a 0, 1, 2, 3, or "Total" in 10 separate categories
 - 0 = no impairment
 - 1 = mild impairment
 - 2 = moderate impairment
 - 3 = moderate severe impairment
 - "Total" = very severe



Traumatic Brain Injury

- Categories – each gets an impairment assessment:
 1. Executive Function (memory, attention, goal setting, planning, etc.)
 2. Judgment
 3. Social Interaction
 4. Orientation (time, situation, place)
 5. Motor Activity (previous learned movements and tasks)
 6. Visual / Spatial Orientation
 7. Neuro-based Effects (mood, irritability, aggression, impulsivity)
 8. Communications
 9. Consciousness (coma = total)
 10. Subjective Symptoms (impact with daily living, employment, self care)



NVLSP

Traumatic Brain Injury

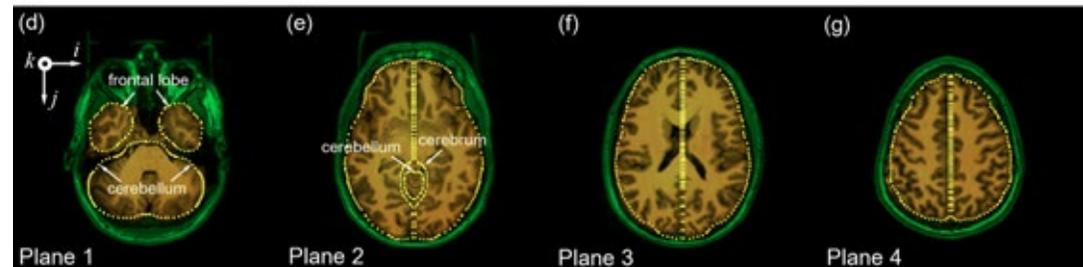
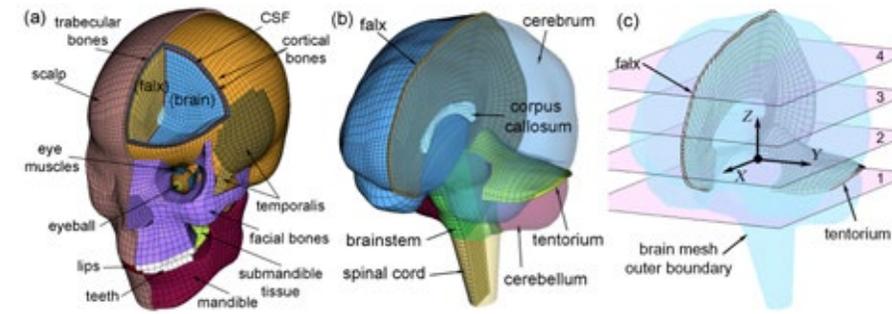
Evaluation of Cognitive Impairment and Subjective Symptoms

The table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified” contains 10 important facets of TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, labeled “total.” However, not every facet has every level of severity.... **Assign a 100-percent evaluation if “total” is the level of evaluation for one or more facets. If no facet is evaluated as “total,” assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent.** For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet.



Traumatic Brain Injury

- Rating will be Zero, 10%, 40%, 70%, or 100%
- Pre-stabilized Ratings
 - 100% until stabilized if unemployable
 - 50% if employable





Traumatic Brain Injury

- TBI Presumptions: If TBI is “**severe,**” certain diseases are presumed connected to the TBI
 - Parkinson's
 - Seizures
 - Dementia / Alzheimer's
 - Depression – manifests w/i 3 years of moderate/severe TBI or 1 year of a mild TBI
 - Hormone deficiencies – manifests within 1-year of TBI
- If not presumed – can still direct service connect



SMC (T) Eligibility

- To receive **SMC(T)**, Veteran must:
 - Needs regular A&A **for the residuals of TBI**
 - Is not eligible for a higher level of A&A under SMC (R-2); and
 - Would need hospitalization, nursing home care, or other residential institutional care w/out in-home A&A
- For Vets who meet all the above requirements, SMC (T) pays the **highest possible amount** of monthly VA benefits - \$\$



