RATEMYVSO FIELD GUIDE

BEFORE YOU FILE

MENTAL HEALTH CLAIM CHECKLIST

Build a record that connects diagnosis, service, symptoms, and functional impairment

USE THIS AS A GAP CHECK, NOT A GUARANTEE

Mark what is already in the file. An unchecked box identifies something to review, not an automatic reason to delay filing.

Ready Review

01 FOUNDATION — CONFIRM THE CURRENT DISABILITY

DSM

- [ ] **A current diagnosis is documented**
  A qualified clinician identifies the mental-health condition under the applicable DSM-5 requirements
- [ ] **The diagnostic history is collected**
  Include prior diagnoses, changed labels, differential diagnoses, and relevant testing
- [ ] **Current treatment records are included**
  Therapy, medication, hospital care, crisis care, response, and side effects
- [ ] **Other medical causes or overlapping conditions are addressed**
  TBI, substance use, sleep disorders, pain, medications, and neurological conditions when relevant

CHECKPOINT: A diagnosis establishes the condition. It does not establish service connection or determine the percentage by itself.

02 LEGAL THEORY — IDENTIFY THE PATHWAY YOU ARE CLAIMING

PATH

- ○ **DIRECT**
  The current condition is linked to symptoms, events, injuries, or circumstances during service.
- ○ **SECONDARY CAUSATION**
  An already service-connected condition or its treatment caused the mental-health condition.
- ○ **SECONDARY AGGRAVATION**
  An already service-connected condition increased the severity of an existing mental-health condition.
- ○ **TRAUMATIC EVENT**
  A PTSD, personal-assault, or MST pathway may require specialized stressor or alternative-evidence development.

- [ ] **The claimed pathway is named consistently**
  Use the same theory in the application, statement, and medical opinion
- [ ] **The timeline supports the selected theory**
  Reconcile service, onset, diagnoses, treatment, medications, and later changes

03 MEDICAL LINK — MAKE THE NEXUS OPINION ANSWER THE RIGHT QUESTION

LINK

- [ ] **The provider reviewed the relevant history**
  Service records, treatment, diagnostic changes, lay evidence, and the claimed primary disability
- [ ] **The opinion explains the medical connection**
  It applies medical reasoning to this veteran's history instead of offering only a conclusion
- [ ] **Causation and aggravation are addressed separately**
  A negative causation opinion does not answer whether a service-connected condition worsened the disability
- [ ] **Alternative explanations are discussed**
  Other diagnoses, post-service events, substance use, medical conditions, and medication effects when relevant
- [ ] **The conclusion uses the correct standard**
  The opinion clearly answers whether the relationship is at least as likely as not

04 IMPAIRMENT EVIDENCE — DOCUMENT WHAT THE CONDITION CHANGES

FILE

- [ ] **Work or school functioning**
  Attendance, reliability, productivity, concentration, discipline, accommodations, and job loss
- [ ] **Social functioning**
  Family relationships, friendships, conflict, trust, communication, and isolation
- [ ] **Daily functioning**
  Self-care, hygiene, meals, finances, transportation, appointments, and routine activities
- [ ] **Personal statement**
  Specific episodes, frequency, severity, duration, triggers, recovery, and resulting impairment
- [ ] **Family, friend, or coworker statements**
  Firsthand observations of changes in behavior and functioning
- [ ] **Safety and crisis evidence**
  Emergency care, hospitalization, safety planning, and need for assistance or supervision

WHOLE-SYMPTOM REVIEW: Include listed and unlisted manifestations. Explain how often they occur, how severe they are, how long they last, and what they change.

05 SUBMISSION AND EXAM — REVIEW THE FILE BEFORE IT LEAVES YOUR HANDS

GO

- [ ] **Names, dates, and onset statements are consistent**
  Explain legitimate differences rather than allowing apparent contradictions to control the analysis
- [ ] **Every referenced private record is attached or obtainable**
  Do not assume VA already has therapy notes, hospitalization records, or a private opinion
- [ ] **Diagnosis labels and overlapping symptoms are understood**
  Most overlapping mental-health manifestations are evaluated together under one rating formula
- [ ] **C&P examination preparation is complete**
  Know the history and describe ordinary functioning honestly without minimizing or maximizing
- [ ] **A prior denial is answered with new and relevant evidence**
  Address the specific missing element rather than merely resubmitting the same record

FINAL REVIEW

CAN SOMEONE NEW TO THE FILE ANSWER THESE THREE QUESTIONS?

1. WHAT IS THE CURRENT DIAGNOSIS?
2. WHY IS IT CONNECTED TO SERVICE?
3. HOW DOES IT AFFECT WORK AND SOCIAL FUNCTIONING?

If any answer is unclear, that is the part of the record to review.