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WHAT EVERY VETERAN SHOULD KNOW

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Camp Lejeune Justice Act: Post-Deadline Check-In (October)

Camp Lejeune Justice Act claims stem from long-term drinking-water contamination at Marine Corps Base Camp Lejeune, giving former residents, workers, and families a path to seek compensation through the Navy and, if needed, federal court. While the filing window closed on August 10, 2024, the story is active now: the Navy is validating existing claims, issuing Elective Option settlement offers with firm 60-day decision clocks, and cases are advancing on the Eastern District of North Carolina's fall docket.

Where settlements stand: the Department of Justice (DOJ) and Department of the Navy are still using the Elective Option (EO) to resolve a defined set of claims faster than trial. EO offers are based on a grid that ties payment to (1) one of nine qualifying injuries and (2) documented time on base (30–364 days; 1–5 years; >5 years). Tier-1 illnesses (kidney cancer, liver cancer, non-Hodgkin lymphoma, leukemias, bladder cancer) range from $150k–$450k; Tier-2 illnesses (multiple myeloma, Parkinson's disease, Stage 4–5 chronic kidney disease/ESRD, systemic sclerosis/scleroderma) range from $100k–$400k, with an additional $100k when the qualifying injury caused or contributed to death (EO max $550k). EO payments are not offset against VA benefits. DOJ's Jan. 21, 2025 FAQ update also clarified estate-claim details and payment paperwork.

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Why documentation is the bottleneck: to qualify for the EO (or to move any claim forward), claimants must substantiate 30+ days at Camp Lejeune (1953–1987) and provide signed/certified medical records of a qualifying diagnosis within the EO's onset/latency parameters. The Navy's portal and validation page outline acceptable proofs (service/employment or other contemporaneous records for presence; originals or certified medical records for diagnosis). DOJ/Navy say they will first mine government records; if gaps remain, they request additional documentation from the claimant. U.S. Navy Department of Justice

What to expect this fall: cases already in court proceed under EDNC's consolidated management orders (bench trials rather than juries per earlier rulings), while DOJ continues parallel settlement screening for suits filed before the EO was announced (the "DOJ-EO" track for Group A filings). If you're awaiting an EO decision, note that offers typically expire 60 days after issuance, and reconsideration requires timely, new substantiating evidence (e.g., longer verified time on base). Claim status and secure messaging run through the Navy's CLJA Claims Portal.

You can review more details at the Navy CLJA site (deadline, documentation, portal); DOJ Public Guidance and Jan. 21, 2025 EO FAQ (injury tiers, payment grid, offsets, estate guidance).

Survivor Claims After PACT Act Expansions: Tying Cause of Death to New Presumptives

VA expanded presumptions in January 2025, adding urinary bladder, ureter, and related genitourinary cancers (effective Jan. 2, 2025) and acute/chronic leukemias, multiple myelomas, myelodysplastic syndromes, and myelofibrosis (effective Jan. 10, 2025). These join the broader PACT Act list for toxic exposure cohorts and matter for survivors seeking Dependency and Indemnity Compensation (DIC) when a Veteran's death occurred before these conditions were presumptive.

How the standard works: VA grants service connection for cause of death when a service-connected condition is the principal cause or a contributory cause under 38 C.F.R. § 3.312. When a condition becomes presumptive, the survivor does not need to re-prove exposure-causation for that disease if the Veteran meets the service/location criteria—but the record must still show that the presumptive disease caused or contributed to death.

Why older death certificates are tricky: many certificates list immediate mechanisms (e.g., pneumonia, sepsis, cardiac arrest) rather than the underlying malignancy or systemic illness now on the presumptive list. The evidence task is to map the underlying presumptive disease to the death pathway—e.g., oncology notes showing refractory leukemia with treatment complications leading to infection, or records showing bladder/ureter cancer with metastasis culminating in multi-organ failure. Survivors can rely on the medical file (hospital discharge summaries, pathology, hospice notes) to demonstrate contributory causation consistent with § 3.312.

What counts as the right building blocks: (1) qualifying service/exposure under the PACT Act framework; (2) a diagnosis that now carries a presumption; and (3) medical documentation that links that disease to the death—directly (principal cause) or indirectly (contributory).

VA's survivor benefits page explains DIC basics, and VA's PACT Act pages outline the expanded presumptives and exposure cohorts. The application remains VA Form 21P-534EZ.

Bottom line for October: the January 2025 expansions open a lane for survivors whose loved one died before these conditions were added.

The claim still needs a clear medical throughline between the now-presumptive disease and death, but you no longer have to litigate general causation for those diseases if the service/exposure criteria are met.

Nevada Veterans Home Faces Whistleblower Lawsuit Over Resident Safety and Retaliation Claims

A group of former employees has sued the Nevada Department of Veterans Services (NDVS), alleging the agency and several officials retaliated against staff who raised concerns and put residents at risk at the state-run veterans nursing home in Southern Nevada. The civil complaint, filed in Clark County, began with one plaintiff—former Boulder City administrator Eli Quiñones—and was expanded in January to include three additional ex-employees and a contractor. The plaintiffs are seeking a jury trial and damages for lost benefits and emotional harm.

According to the lawsuit, leaders at NDVS and the Southern Nevada State Veterans Home carried out sham internal investigations that led to unlawful terminations, pressed staff to engage in improper practices ranging from timekeeping to the handling of controlled substances, and failed to hold supervisors accountable. The filing names former NDVS director Fred Wagar, who was removed from his post last year by the governor, and Corine Watson, the home's director of nursing. In June, the state moved to partially dismiss certain claims against the officials in their official capacities; the plaintiffs agreed, allowing those allegations to continue against the individuals personally while narrowing the case against the state.

The complaint describes a series of incidents the plaintiffs say compromised care at the 180-bed facility, which serves veterans, their spouses, and Gold Star parents. One allegation asserts that leadership refused to implement COVID-19 testing for staff and residents, leading to a November 2022 outbreak and three resident deaths. Other allegations include inadequate oversight of wound care, a failure to report a suspected patient abuse incident through required channels, and changes to how discontinued narcotics were stored—changes the plaintiffs say increased the chance of error. In another instance, a plaintiff says she was placed under investigation after declining to violate electronic medical record rules and was barred from the facility for about four months, during which her mother was a resident.

NDVS declined to comment on the pending litigation. A Nevada State Police inquiry into the agency's operations and the leadership of the Southern Nevada home began last year; the department did not respond to questions about the status of that investigation. Watson did not respond to a request for comment; Wagar referred inquiries to NDVS.

The case remains active in Clark County District Court, with the core allegations—retaliation, unsafe practices, and wrongful termination—moving forward against the officials in their individual capacities.

Gulf War Illness: What the Latest Research Says and How VA Benefits Treat It

Gulf War Illness (GWI) is a chronic, multisystem condition affecting roughly a quarter to a third of the 1990–1991 Gulf War cohort.

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Symptoms cluster across fatigue, pain, cognitive problems ("brain fog," slowed processing), sleep disturbance, headaches, GI issues, and more. Estimates vary by case definition, but large cohort and advisory-committee summaries consistently place prevalence near one-third of the ~700,000 who served.

What current research is finding. Recent work continues to strengthen biologic explanations rather than "it's all stress." A June 2025 neuroscience editorial synthesizes human and animal studies pointing to persistent brain dysfunction with neuroinflammation, glial/immune activation, and cholinergic disruption—mechanisms that track with the cognitive and mood symptoms veterans report. Gene–environment findings also keep advancing: a 2024 multi-site case-control study reported PON1 genotype–exposure interactions—for example, stronger associations between GWI and possible nerve-agent alarms or skin pesticide use in specific PON1 variants, particularly when pyridostigmine bromide pills were taken in theater. That pattern fits long-standing concerns about mixed neurotoxicant exposures (nerve agents, pesticides, oil-well fire byproducts) rather than a single cause.

Treatment research (what's being tested). The DoD's Gulf War Illness Research Program (GWIRP) continues to fund clinical and translational trials aimed at symptom relief and disease mechanisms (neuroinflammation, mitochondrial and immune dysfunction). Examples include randomized trials of coenzyme Q10 showing symptom/function signals in small cohorts; exploratory work on intranasal insulin for cognition; and emerging preclinical/early clinical efforts targeting neuroimmune pathways (e.g., cannabidiol investigated in 2024 for cognitive/mood and pain phenotypes). While no single therapy is definitive, the pipeline is active and growing.

How VA benefits view GWI. You do not have to prove a specific toxin exposure to pursue disability compensation tied to Gulf War service. Under 38 C.F.R. § 3.317, VA may grant service connection for a "qualifying chronic disability" in a Persian Gulf veteran when symptoms are (1) chronic (≥6 months), (2) at least 10% disabling by the deadline, and (3) medically unexplained (a MUCMI, such as chronic fatigue syndrome, fibromyalgia, or functional GI disorders) or an undiagnosed illness. The current manifestation deadline in regulation is December 31, 2026. Covered service is defined as duty in the Southwest Asia theater of operations (Iraq, Kuwait, Saudi Arabia, Bahrain, Qatar, UAE, Oman, the Gulf/Arabian seas and adjoining airspace). VA's symptom list explicitly spans neurologic, neuropsychological, respiratory, sleep, cardiovascular, GI, skin, weight-change and menstrual symptoms, reflecting the multi-system nature of GWI.

Health care & specialized evaluation. VA offers a Gulf War Registry health exam (exposure/medical history, labs, physical) and access to the War Related Illness and Injury Study Center (WRIISC) network for complex deployment exposure cases. These services are clinical—not benefits determinations—but they help build a coherent record and care plan. The science is converging on biological mechanisms—neuroinflammation, immune and cholinergic dysregulation—with gene–environment interactions that make certain exposure combinations riskier for some Veterans. On the benefits side, § 3.317 remains the central pathway: if you have qualifying Southwest Asia service and chronic multi-symptom illness or undiagnosed symptoms to a compensable level by Dec 31, 2026, you may qualify without proving the exact toxin.

Agent Orange Aftershocks: Hypertension & MGUS are Now Presumptive— What That Unlocks for Secondaries and Survivor DIC

As of this year, VA's official Agent Orange presumptive list explicitly includes hypertension and monoclonal gammopathy of undetermined significance (MGUS). That matters beyond first-line service connection: both diagnoses can serve as the starting point for secondary conditions and, in some cases, survivor Dependency and Indemnity Compensation (DIC).

Why these two additions matter. Hypertension is common and clinically powerful—it drives cerebrovascular events (ischemic stroke, hemorrhagic stroke), chronic kidney disease, and certain heart failure phenotypes. MGUS is often asymptomatic, but it can evolve into multiple myeloma or cause organ-specific damage (for example, monoclonal gammopathy of renal significance or amyloid cardiomyopathy). Now that both are presumptive for qualifying Vietnam-era herbicide exposure, veterans no longer have to litigate the Agent Orange link for those root conditions; the task shifts to documenting downstream consequences and showing proximate causation or aggravation for secondaries.

Secondary condition strategy. If hypertension is service-connected on a presumptive basis, you can build secondary claims where the medical record shows the hypertension caused or aggravated another disability. Classic examples include post-stroke residuals (motor, speech, cognitive deficits), hypertensive chronic kidney disease (including dialysis/end-stage renal disease), and hypertensive heart disease/heart failure with preserved or reduced ejection fraction. For MGUS, secondaries turn on hematology and organ involvement: if MGUS progressed to multiple myeloma, the myeloma is itself on VA's long-standing Agent Orange list; if MGUS produced renal damage (e.g., biopsy-proven MGRS) or amyloidosis with cardiac or neurologic manifestations, those organs' disabilities can be claimed as secondary to the service-connected MGUS. The evidentiary through-line is the same in both paths: establish the presumptive diagnosis, then document the pathophysiology tying it to the downstream condition (with things like imaging, pathology, specialty notes, and longitudinal labs).

Survivor DIC after the PACT Act expansions. For survivors, the standard hasn't changed: VA grants service connection for the cause of death when a service-connected condition was the principal cause or a contributory cause under 38 C.F.R. § 3.312. What's new is that hypertension and MGUS can now be the service-connected predicate for that analysis. If a veteran's 2015 death certificate lists "pneumonia" or "cardiac arrest," but the chart shows refractory hypertension culminating in hemorrhagic stroke—or MGUS evolving to myeloma with complications leading to multi-organ failure—you can map that medical story to § 3.312 and argue principal or contributory causation even though the certificate predated the new presumptions. The record synopsis (hospital discharge summaries, oncology/hematology notes, pathology, hospice paperwork) is often more probative than the one-line certificate.

Effective-date realities (what to expect, not legal advice). PACT Act presumptives—including hypertension and MGUS—carry special effective date rules. VA has publicly stated that claims (or intents to file) submitted within the first-year window from enactment could receive benefits backdated to August 10, 2022; outside that window, dates generally track the claim or intent date. Also important: VA guidance indicates the Nehmer consent decree's unique retroactivity rules do not apply to presumptions created on or after August 10, 2022 (which includes hypertension and MGUS). Survivors and representatives should anchor expectations and documentation accordingly.

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What this means for current planning. For living veterans, it is straightforward: confirm presumptive eligibility for hypertension or MGUS, then build clean, specialty-driven narratives for any downstream disabilities (stroke residuals; CKD/ESRD; heart failure; myeloma or organ-specific MGUS complications). For survivor DIC, revisit older deaths where hypertension or a plasma cell disorder was present but not recognized as service-connected at the time, and reconstruct the causal chain using the medical file rather than relying on the brief wording of the death certificate. The addition of hypertension and MGUS to VA's Agent Orange list is not just a checkbox change. It opens new paths to establish secondaries and, when the record supports it, to recognize a service-linked cause of death.

What To Know About Burn Pit Effects Beyond the Lungs

The science is catching up to what many post-9/11 veterans have described for years: prolonged time at bases with open burn pits tracks not only with respiratory and cardiac disease, but also with neurological and mental health outcomes. A large cohort study led by NIH, DoD, and VA covering roughly 440,000 Army and Air Force veterans deployed between 2001 and 2011 found a clear dose–response pattern: the longer someone lived near burn pit smoke, the higher their odds of later diagnoses such as severe stress reactions, depression and mood disorders, intracranial injury/TBI, sleep disorders, and increased suicide mortality. Reporting on the analysis highlights concrete thresholds: about four months of proximity (around 129 days) correlated with ~27% higher severe-stress symptoms and ~37% higher intracranial-injury risk; around 16 months (≈474 days) corresponded to ~68% and ~124%, respectively. Sleep disorder diagnoses rose ~18% at four months and ~35% at sixteen months. The authors stress association not proof of causation but the overlap with exposure duration is hard to ignore.

This line of research expands the conversation beyond the lungs. Prior VA-funded work already tied burn pit exposure to higher rates of respiratory and cardiovascular problems; the new data extend the view to brain and behavioral health, suggesting that the complex chemical mix from uncontrolled combustion may have neurobehavioral effects over time.

How to document the record now (to support direct or secondary claims)

For claims and care, the rule of the road is evidence. Start with exposure documentation that captures where and how long you were stationed near open burn pits. VA's Airborne Hazards and Open Burn Pit Registry lets eligible veterans record deployments and symptoms; it's useful for clinical context and research tracking even though it isn't required for care or benefits. VA also conducts a toxic exposure screening for enrolled patients under the PACT Act; make sure those results live in your chart.

Next, line up diagnoses and a clear medical timeline. Mental health conditions, sleep disorders, cognitive complaints, and head-injury sequelae are not currently presumptive outcomes of burn pit exposure, so you'll need a direct nexus showing causality (provider opinion that it's "at least as likely as not" related to service exposures) or a secondary nexus (the condition is proximately due to or aggravated by an already service-connected disability,

such as chronic respiratory disease that disrupts sleep/oxygenation and worsens mood or cognition). Keep deployment histories, specialty notes (neurology, psychiatry, sleep), and longitudinal test results together so a clinician can connect the dots in plain language for VBA review. (PACT Act still eases the path for many primary toxic-exposure conditions and ensures you're screened and treated, even when a presumption doesn't apply to the specific secondary you're claiming.)

Finally, preserve the timeline. The recent study's core insight is cumulative exposure, so details like duty location, dates, and estimated days near burn pit emissions matter. Unit records, orders, deployment rosters, and notes can corroborate those durations when medical experts prepare opinions. VA's public health pages outline who is eligible for the registry and how to pursue care if you're concerned about airborne hazard exposures.

Bottom line for October: evidence keeps broadening the picture of burn pit harm to include the brain and behavior particularly as exposure time increases. If your post-deployment story includes sleep problems, cognitive changes, mood symptoms, head-injury issues, or a combination of the above, make sure your exposure history and your diagnoses are both fully documented so clinicians can evaluate direct or secondary links under current VA rules.

October Is National Disability Employment Awareness Month (NDEAM)

October highlights hiring and retaining talent force with disabilities including service-connected injuries. The month addresses three high-impact tools: the Work Opportunity Tax Credit (WOTC), VA's VR&E employment tracks, and practical accommodations that keep good hires.

WOTC (veteran hires): Federal credit generally up to 40% of first-year wages; some veteran categories allow up to $9,600 in credit. Employers must file IRS Form 8850 with the state workforce agency within 28 days of the hire. Authorized through Dec 31, 2025; not available for rehires.

VR&E (Chapter 31): Pairs eligible veterans with counselors to build and fund an employment plan. **Rapid Access to Employment:** Helps those ready to work now (job search, placement, résumés). **Employment Through Long-Term Services:** Supports retraining, credentials, internships/OJT, and assistive tech. **Eligibility:** Service-connected disability and employment handicap.

Reasonable accommodations (make jobs stick): Through the ADA "interactive process," adjust how/where work is done without lowering standards.

Examples: TBI/cognitive: written checklists, reduced distraction space, extra training time. **PTSD:** flexible breaks/scheduling, quieter workstation, clear written feedback. **Mobility impairments:** accessible routes/parking, adjustable desks, evacuation plans. Most accommodations cost little many cost $0 and improve retention. The Job Accommodation Network (JAN) offers free, practical guidance.

Bottom line: NDEAM is a great moment to pair tax credits, VR&E prep, and smart accommodations so veteran hiring turns into long-term success for both the employer and employees.

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Pension-Poaching Alert: Protect Your VA Benefits

Open-enrollment time tends to bring a spike in scams targeting older veterans and surviving spouses. **Red flags:** promises to "guarantee" VA Pension/Aid & Attendance, pressure to move assets into annuities or trusts to "get eligible," requests to sign over benefits, or upfront/percentage fees for filing. Only VA-accredited VSOs, attorneys, and claims agents can assist and VA never charges to apply.

If approached, pause and verify accreditation, refuse products you don't understand, and don't pay anyone a cut of your benefit. For legit guidance, call your county VSO or state veterans agency. Suspected scams? Report to your state Attorney General and the FTC.

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