DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard Reserve

MONTHLY INCAPACITATION CLAIM FORM (Member)

PRIVACY ACT STATEMENT

In accordance with 5 U.S.C. 522A (e)(3), the following information is provided to you when supplying personal information to the Coast Guard:
Authority: 37 U.S.C. 204 (g),(h),(i); 37 U.S.C. 206 (a)(3); 5 U.S.C. 301; 44 U.S.C. 3101; 10 U.S.C. 1071-1107; 14 U.S.C. 93(a)(17); 14 U.S.C 707(d) and 14 U. S.C. 632.
Principle Purpose: Develop automated information and determine eligibility for incapacitation claim.
Routine Uses: Same
Disclosure: Voluntary. However, failure to provide all the requested information will impede the payment of any incapacitation claim.

Information contained in this form, including any attachments, may be subject to the provisions of the Privacy Act of 1974 and Health Insurance Portability and Accountability Act (HIPAA) and shall only be reviewed or forwarded to personnel who are authorized and have a need to know. If you have received this information in error, notify the individual identified so appropriate action may be taken.

SECTION I - CLAIM STATEMENT *(Completed by Reservist - PLEASE PRINT)*

1a. Last Name	1b. First Name	1c. MI	2. Rank/Rate	3. EmplID

4. Date of injury/illness/disease incurred/aggravated in the line of duty *(DDMMMYY)*:

5. Dates of loss of earned income from non-military/self-employment due to the condition incurred/aggravated on the date in block 4: *(DDMMMYY)*

FROM: _____ TO: _____ *(Not to exceed 30 days)*

6. I was employed on the date that the condition(s) in block 4 were incurred/aggravated in the line of duty:

☐ NO ☐ YES If YES, who was the employer: _____

7. I received and/or lost the following earned income from my self-employment for the period of time specified in block 5. Attach copies of federal income tax forms or other documentation reflecting total amount(s) received and/or lost.	7a. Amount received (*Gross*)	7b. Amount lost (*Gross*)

8. Remarks:

9. As the individual making this claim, I understand I am responsible for the accuracy of the information in this form, and any false statements or omissions in connection with this claim may subject me to prosecution and possible fines and/or imprisonment.	_____ Initials
10. I authorize the release of my civilian pay records and medical information for the purpose of requesting incapacitation pay benefits. I understand that I must list all earned income from non-military/self-employment that I have received during the period in block 6 to include, but not limited to, salaries, wages, tips, commissions, professional fees, worker's compensation, income from income protection plan, vacation leave, sick leave, and insurance proceeds. Per DoDD1241.1, I may NOT receive dual compensation from the United States government.	_____ Initials

11a. Reservist's Signature	Reservist's Name	11b. Date *(DDMMMYY)*

DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard Reserve

MONTHLY INCAPACITATION CLAIM FORM (Employer)

1a. Last Name	1b. First Name	1c. MI	2. Rank/Rate	3. EMPLID

SECTION II - EMPLOYER VERIFICATION

12a. Employer's Name and Address	12b. Employer's POC Name	12c. Employer's POC Phone Number 12d. Employer's POC Email

13. Primary Job

14. Employment Status	15. Hours Normally Worked Per Week	16. Hourly Wage Rate or Annual Salary	17. Did the employee work during the period in block 5?
☐ Current ☐ Former			☐ No ☐ Yes

18. If NO, was the reason for the employee not returning to work due to the condition(s) which were incurred/aggravated on the date in block 4? If NO, explain why member did not return to work in Remarks block 20. ☐ No ☐ Yes

19. For the period of time specified in block 5, the employee received and/or lost the following earned income. Attached copies of pay stubs, W-2s, federal income tax forms or other documentation reflecting total amount(s) lost and/or received. EMPLOYER : PLEASE ATTACH MEMO WITH DATES EMPLOYEE WAS UNABLE TO WORK.	**Amount Lost (*gross*)**	**Amount Received (*gross*)**
a. Wages or salaries.		
b. Income Protection Plan.		
c. Professional fees or compensation for personal services rendered.		
d. Tips.		
e. Pay for sick leave.		
f. Pay for vacation time.		
g. Other earned income and description.		
TOTAL:		

20. Remarks

21. I understand that this information is being used by the claimant as the basis of a claim against the United States government. I further understand that knowingly and willfully assisting a claimant making a false claim or false statement in connection with a claim is a criminal offence under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment. _____ Initials

22a. Employer's Representative Signature	22b. Name	22c. Date *(DDMMMYY)*

DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard Reserve

MONTHLY INCAPACITATION CLAIM FORM (Command)

1a. Last Name	1b. First Name	1c. MI	2. Rank/Rate	3. EMPLID

SECTION III - COMMAND'S VERIFICATION

23a. Unit	23b. Unit POC	23c. Unit POC's Phone Number 23d. Unit POC's Email

24. Primary Duties

25. Supporting Military Treatment Facility *(MTF)*

26a. Did the member complete any active duty *(including ADT)* during the period in block 5? ☐ No ☐ Yes If YES, Dates:

26b. Did the member complete any IDT, RMP, or FHD during the period in block 5? ☐ No ☐ Yes If YES, Dates:

27. During the period specified in block 5, did the member miss any IDT or ADT due to the condition incurred/aggravated on the date in block 4? ☐ No ☐ Yes If YES, Dates Missed:

28. Has a Medical Evaluation Board *(MEB)* been completed? ☐ No ☐ Yes If YES, Date Completed:

29a. Date of the Line of Duty Determination *(DDMMMYY)*	29b. Was the condition incurred/aggravated on the date in block 4 in the line of duty and not the result of gross negligence or misconduct of the member? ☐ No ☐ Yes

30. Remarks

31. I have reviewed the information provided in this form. _____ Initials

32. I understand that this information is being used by the claimant as the basis of a claim against the United States government. I further understand that knowingly and willfully assisting a claimant making a false claim or false statement in connection with a claim is a criminal offence under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment. _____ Initials

33a. CO Signature/By Direction	33b. Name and Rank	33c. Date *(DDMMMYY)*

34a. District *(or equivalent)* Signature/By Direction	34b. Name and Rank	34c. Date *(DDMMMYY)*

DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard Reserve

MONTHLY INCAPACITATION CLAIM FORM (CG PSC-RPM)

1a. Last Name	1b. First Name	1c. MI	2. Rank/Rate	3. EMPLID

SECTION IV - CG PSC-RPM REVIEW/APPROVAL

35a. POC's Name and Rank	35b. POC's Phone Number	35c. POC's Email

36. Notice Of Eligibility *(NOE)* Dates *(DDMMMYY)*: TO: _____ FROM: _____

37. Does the member require incapacitation pay greater than six months?
If YES, must route to CG-131 for approval. ☐ No ☐ Yes

38. Per Coast Guard Pay Manual, COMDTINST M7220.29(series), Figure 12-1, the following rule applies to this claim for compensation:	Rule #:

39. Incapacitation claim for the period in block 5 is: *(check one)*

- ☐ APPROVED - Full pay and allowances less earned income as authorized under 37 U.S.C. 204 (g).
- ☐ APPROVED - Lost earned income *(not to exceed regular component's pay and allowances)* as authorized under 37 U.S.C. 204 (h).
- ☐ APPROVED - Compensation for missed IDT(s)/ADT as authorized under 37 U.S.C. 206 (a)(3).
- ☐ DISAPPROVED - If DISAPPROVED, explain in Remarks block 40.

40. Remarks

41a. CG PSC-RPM's Signature/By Direction	41b. Name and Rank	41c. Date *(DDMMMYY)*

SECTION V - CG-131 APPROVAL *(for incapacitation pay claims over 6 months)*

42a. POC's Name and Rank	42b. POC's Phone Number	42c. POC's Email

43. Continuation of incapacitation pay is warranted *(If NO, explain in Remarks block 44)*: ☐ No - Disapproved ☐ Yes - Approved

44. Remarks

45a. CG-131's Signature/By Direction	45b. Name and Rank	45c. Date *(DDMMMYY)*

SECTION VI - CG PPC PROCESSING

46a. POC's Name and Rank	46b. POC's Phone Number	46c. POC's Email

47a. Amount of Gross Base Paid	47b. Amt of Allowances Paid	47c. Total Paid	47d. Date Paid *(DDMMMYY)*

48. Remarks

49a. CG PPC's Signature/By Direction	49b. Name and Rank	49c. Date *(DDMMMYY)*

PPC: CONTACT CG PSC-RPM WHEN CLAIMS ARE PROCESSED