Form Approved
OMB No. 0960-XXXX

Certificate of Incapacity

PART A - TO BE COMPLETED BY EXAMINING PHYSICIAN

The Federal Employees Health Benefits Program covers adult children of an employee's family if they are incapable of self-support because of a physical or mental disability. These children are over the age of 22 whose disabilities existed before age 22. This provision of law has been construed as applying to only the most serious types of disabilities, and then, only if the disability can be expected to continue for at least one year and the child is incapable of self-support

Complete the following only if you have examined the person and consider the person to have such a disability.

1. Name of adult incapacitated child: _____

2. Diagnosis underlying the disability which makes the child incapable of self-support: _____

   _____

3. Date that this person's disability began: _____

4. At what age did the condition become so severe that it rendered the child unemployable and incapable of self-support? _____

   _____

5. Provide a brief history of the specific medical condition including pertinent findings from previous examinations, test results, treatments, and responses to treatment. _____

   _____

   _____

6. List the clinical findings from the most recent physical examination, including results from laboratory or imaging studies and psychological tests, if applicable. You may attach a legible copy of your most recent entry in your medical record instead if it supplies or supports the documentation. _____

   _____

   _____

7. Has there been a recent change in the individual's medical condition, including improvement or deterioration? Please explain. _____

   _____

   _____

8. List any special supervisory, physical assistance, or custodial care that the individual now requires. _____

9. List any treatments, rehabilitation programs, educational training or occupational accommodations that could help the child become self-supportive. _____

10. Additional comments: _____

I certify that the adult child listed on this certificate is incapable of self-support due to the above disability. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Doctor's Name: _____ Date: _____

Doctor's Signature: _____

Office Address: _____

Office Telephone Number: _____

PART B - TO BE COMPLETED BY EMPLOYEE

1. Employee's name and mailing address: _____

2. Employee's social security number: _____

3. Health benefit plan code: _____

4. Adult child's relationship to employee: _____

5. Child's date of birth: _____

6. Has the child been employed during the last twelve months? If so, provide name of employer, periods of employment, description of work performed, and total earnings: _____

7. If employed, was employment in a closely supervised environment such as a sheltered workshop? _____

8. List highest level of education of disabled child: _____

Privacy Act Statement

We are required by 5 U.S.C. § 8901 to ask you to give us the information on this form. The information is needed to determine whether your adult disabled child is eligible for health care benefits under the Federal Employee Health Benefits Program (FEHB) beyond age 22. Although the responses on this form are voluntary, failure to provide the requested information will result in automatic termination of the health care benefits at age 22.

The information obtained on this form is almost never used for any purpose other than that stated above. However, sometimes the law requires us to disclose the facts on this form without your consent. For example, it may also be disclosed to another government agency if federal law requires that we do so or to contractors, as necessary, to assist in the efficient administration of the FEHB Program.

Explanations about the reasons why information you provide us may be used or given out are available in servicing personnel offices. If you want to learn more about this, contact your local servicing personnel office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. **You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.** ***Send only comments relating to our time estimate to this address, not the completed form.***