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. How long is the child's disability expected to continue? _____

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

7. 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. _____

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

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

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

11. 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. Last four digits of 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
Collection and Use of Personal Information

5 U.S.C. § 8901 authorizes us to collect this information. The information you provide will be used to determine whether your adult disabled child is eligible for health care benefits under the Federal Employee Health Benefits Program (FEHB) beyond age 22.

The information you furnish on this form is voluntary. However, failure to provide the requested information will result in automatic termination of benefits at age 22.

We rarely use the information you supply for any purpose other than for determining your adult disabled child's eligibility for health care benefits under the FEHB beyond age 22. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

2. To facilitate audit, or investigative activities necessary to assure the integrity of the FEHB program; and,

3. To the Department of Justice when representing the Social Security Administration in litigation.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Systems of Records Notice 60-0238 (Pay, Leave, and Attendance Records). The Notice, additional information about this form, and any other information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at your local Social Security 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. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** 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.**