Overpayment Recovery Questionnaire

Reset Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Name of Overpaid Person	Claim No.	OMB No.: 1215-0144 Expires:
Name of Claimant		

EVERYONE MUST COMPLETE PART I, PART II, AND PART V, COMPLETE THE FOLLOWING PARTS ONLY IF MARKED: ☐ **PARTIII** ☐ **PART IV**

Part I - Possession of Overpayment (to be completed by all applicants for waiver)

1. Do you have any of the incorrectly paid checks or payments in your possession?

   ☐ Yes ☐ No

   If "Yes", show the total amount: $_____. (These funds should be returned to the U.S. Department of Labor immediately).

2. Since you were notified of the overpayment, have you transferred by loan, gift, sale, etc. any property or cash? ☐ Yes ☐ No

   If "Yes", explain:

Part II - REFUND QUESTIONNAIRE

(To be completed by the person for whom repayment of the overpayment would cause undue hardship)

3. List your monthly income (Including any income of your spouse or any dependent relative living in the household with you) from:	Monthly Income
Social Security Benefits	$
Supplemental Security Income Payment	$
State or Local Welfare Payment. Specify:	$
Other benefits, such as Veterans Administration, Civil Service, Unemployment, Black Lung, FECA, Railroad, Private Pension, etc. Specify:	$
Earnings (take-home wages and average net earnings from self-employment). Specify:	$
Other income, such as dividends, interest, rentals, roomers or boarders, etc. Specify:	$
Total Monthly income	$

4. Do you support, either fully or in part, anyone other than yourself? ☐ Yes ☐ No

If "Yes", give the following information about each person you support:

Name	Address	Age	Relationship To You (If None, Enter "None")

5. List the usual expenses of your household on a monthly basis	Monthly Payment
Rent or Mortgage, including Property Tax	$
Food	$
Clothing	$
Utilities (electricity, gas, fuel, telephone, water)	$
Other expenses (Such as: Miscellaneous household expenses, medical and dental care (not covered by insurance), automobile expenses or other transportation costs, personal necessities.)	$

Other Debts Being Paid By Monthly Installments

Creditor	Amount Owed	Monthly Payment
		$
		$
	Total Monthly Expenses	$

6. Not counting your home, family automobile, or household furnishings, do you or your spouse own any valuable property or real estate? ☐ Yes ☐ No

If "Yes", specify and give current market value. If mortgage, show amount of mortgage.

7. List below any funds you have (including those of your spouse, if you live with your spouse):

a. Cash on hand	$
b. Checking account balance	$
c. Savings account balance	$
d. Current value of any stocks and bonds	$
e. Value of other personal property and other funds	$
TOTAL	$

f. Name of stocks and bonds you have (use separate sheet if space is insufficient).	g. Name and address of financial institution (s)

PART III - WITHOUT FAULT STATEMENT

8. Explain fully why you thought the incorrect payment was due you and why the overpayment was not your fault:

9. Did you report the change in circumstances which affected your monthly payment? ☐ Yes ☐ No ☐ There was no change
If "Yes", when did you report? (Give date):

If "No", why didn't you report?

10. When were the conditions under which you could receive payments first explained to you?

11. Do you NOW fully understand reporting responsibilities? ☐ Yes ☐ No If "No", explain:

PART IV - REPRESENTATIVE PAYMENT MADE
(to be completed ONLY by a representative payee)

12. Give the name and present address of the person for whom you received payment:

13. Were the incorrect payments used for this person? ☐ Yes ☐ No

Explain:

PART V

14. Remarks (optional):

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Federal Coal Mine, EEOICPA and FECA Acts commits a crime punishable under Federal and/or State law. I affirm that all information I have given in this document is true.

(Signature of Overpaid Person or Representative Payee)

(Date - Month, day, year)

(Telephone Number)

Mailing Address (Number and Street, Apt. No., P.O. Box, Rural Route)

City and State	ZIP Code	County (if any) in which you now live:

Privacy Act Statement

Collection of this information by OWCP is authorized by section 8129(b) of the Federal Employees' Compensation Act (5 USC 8129(b)), section 413(b) of the Black Lung Benefits Act (30 USC 923(b)) and section 7385j-2 of the Energy Employees Occupational Illness Compensation Program Act (42 USC 7385j-2). The information provided will be used to determine the extent to which overpayments of benefits will be recovered and is fully protected by the Privacy Act of 1974, as amended (5 USC 552a) under the following systems of records: DOL/GOVT-1, DOL/ESA-6, DOL/ESA-30 and DOL/ESA-49, published in the Federal Register, Vol. 67, page 16816, April 8, 2002, or as updated and republished. This information may be disclosed to private collection agencies under contract with the Departments of Labor, Justice or Treasury, or to the Department of Justice for litigation purposes. Additional disclosures may be made through the routine uses for information contained in the referenced systems of records.

Public Burden Statement

Under the Paperwork Reduction Act, persons are not required to respond to a collection of information unless such collection displays a valid OMB control number. Completion and submission of this form is voluntary; however, failure to provide the information may result in the denial of a request to waive recovery of the overpayment. We estimate that it will take an average of 60 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Director, U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.**