U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

REPRESENTATIVE PAYEE REPORT

OMB No.: 1240-0020
Expires: xx-xx-xxxx

INSTRUCTIONS

All representative payees are required to account annually. This is your Representative Payee Report. **You must complete and return the report** whether you are the beneficiary's relative, friend, or court-appointed guardian, or you are an official of a bank or a public or private agency or institution. You should keep a record of the amount of benefits you received and how you used them because the report will be reviewed by the U.S. Department of Labor and is subject to verification. You will be notified if verification is required. DO NOT submit receipts, canceled checks, etc., with this report. If you need help completing the report, please contact the office listed above by mail or telephone. This report must be completed and returned within 30 days in order to obtain or retain benefits .

YOUR JOB AS A REPRESENTATIVE PAYEE

Your job as a representative payee is to use the Black Lung benefits you receive for the personal care and well-being of the beneficiary. you must keep yourself informed of the beneficiary's needs so you can decide how the benefits should be used. **You must** notify the U.S. Department of Labor when the beneficiary changes residence or if you no longer exercise responsibility for the care and welfare of the beneficiary. **You must** report the beneficiary's death, marriage, adoption, employment, or release from a hospital or institution. **You must** also report the beneficiary's receipt of any State Workers' Compensation Benefits and changes in school attendance or disability status, if the person for whom you receive benefits is a student or disabled.

NOTICE

Whoever, having received a payment for the use and benefit of another person, knowingly and willfully uses such payment for other than the use and benefit of the person for whom it is received, is subject to a fine, imprisonment or both.

PAPERWORK/PRIVACY ACT NOTICE

The following statement is made in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a). This report is authorized by law (30 USC 922 section 20 CFR 725.513). Your cooperation is needed to insure that Black Lung benefits are being received in the correct amount and that the beneficiary's needs are being met. Failure to provide all or part of this information could prevent an accurate and timely decision as to your continued suitability as representative payee. The information you furnish on this form may be routinely disclosed without your consent to another person or Government agency for purposes such as (1) to comply with Federal laws requiring the release of information from our records; or (2) to conduct research and audit activities needed to assure the continuing integrity and improvement of the U.S. Department of Labor representative payee program. Other routine disclosures of this information are listed in the Federal Register, which will be made available upon request.

PUBLIC BURDEN STATEMENT

We estimate that it will take an average of 90 minutes per response 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 these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the, U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Reset Print

REPRESENTATIVE PAYEE REPORT

This report is for the period from: _____ to _____

Identifying Information Department of Labor Only

Name and address of representative payee:

City
State Zip

Name and address of beneficiary:

City
State Zip
Claim Number:

1a. Show below all places where the beneficiary lived during the report period shown above. (Check appropriate box and supply information.)

☐ With you ☐ With a relative (answer 1b.) ☐ With an unrelated person (answer 1b.)

☐ in a public institution: hospital, home for aged, nursing home, etc. (answer 1b.)

1b. Give the name and address of each person with whom the beneficiary lived.

	Date of residence: from	to
City State Zip		
City State Zip		

2. How did you find out what the beneficiary's needs were, if the beneficiary did not live with you?

3. Do you maintain contact with the beneficiary by:

Same household ☐ Yes ☐ No | Visit ☐ Yes ☐ No | Telephone ☐ Yes ☐ No | Letter ☐ Yes ☐ No

4. Funds on hand from Black Lung benefits at beginning of this report period. if you have filed a previous U.S. Department of Labor Black Lung Representative Payee accounting report, this amount should be the same as the figure shown on your last report (item #9) as remaining balance . . . . . $

5. Total Black Lung benefits received during this reporting period . . . . . $

6. Total Black lung funds available during this reporting period . . . . . $
(item #4 plus item #5.)

7. How available Black Lung funds were used during this reporting period:

a. Amount used for beneficiary's food and shelter . . . . . $
(Show in "REMARKS" section of this report the name and address of the person or entity receiving your food and shelter payments.)

b. Amount used for beneficiary's clothing . . . . . $

c. Amount used for beneficiary's medical and dental care . . . . . $

d. Amount used for personal needs of beneficiary . . . . . $

e. Amount used for support of beneficiary's dependents . . . . . $

f. Amount used for other items: (show purpose for which funds were used in "REMARKS" section of this report). . . . . $

8. Total amount used during this reporting period: (Add 7a. through 7f.) . . . . . $

9. Balance remaining at end of this period: (Item 6 minus 8.) . . . . . $

10. How is balance in item #9 held, saved, or invested?

	AMOUNT	TITLE/OWNERSHIP*
Cash	$	
Checking account	$	
insured savings account	$	
U. S. Savings Bonds	$	
other (Specify)	$	

• Specify who's name(s) appear on each account, i.e., "Your name for beneficiary", "Beneficiary's name by your name'', "Your name on-behalf-of (OBO) beneficiary", etc.

NOTE: Benefits shall be held in an account which shows that the money belongs to the beneficiary. If you are not sure whether the account you have established shows this ownership, you should consult your bank and, if necessary, change the account title appropriately.

11. If all benefits listed in item #6 of this report were held, saved, or invested, please explain how beneficiary's needs were met.

12. During this period, did the beneficiary have any income other than U.S. Department of Labor Black Lung benefits?

☐ Yes ☐ No

If yes, list sources of other income:

SOURCE	AMOUNT	FREQUENCY OF PAYMENT

13. Have you ever been convicted of a felony? ☐ Yes ☐ No if yes, explain below, in remarks section.

REMARKS:

The penalty upon conviction for the misuse of benefits by a representative payee is a fine and/or imprisonment for up to five (5) years for the first offense, pursuant to Public Law 98-450. A second offense is punishable by up to five (5) years of imprisonment and/or a fine not exceeding $25,000. The court may also order restitution.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN ON THIS FORM IS TRUE.

SIGNATURE OF PAYEE (If signed by mark (X), two witnesses must sign below)		TELEPHONE NUMBER (include area code)	
RELATIONSHIP TO BENEFICIARY OR TITLE	DATE	BUSINESS	HOME

WITNESS SIGNATURES ARE REQUIRED ONLY IF THE PAYEE'S SIGNATURE ABOVE HAS BEEN SIGNED BY MARK (X)

SIGNATURE OF WITNESS	DATE	SIGNATURE OF WITNESS	DATE