SEPTEMBER 11TH VICTIM COMPENSATION FUND
ELIGIBILITY AND COMPENSATION FORM
FOR PERSONAL INJURY CLAIMANTS

COMPENSATION FORM
(PARTS V-X)

PART V. CLAIMANT'S MEDICAL EXPENSE LOSS OR OTHER OUT-OF-POCKET EXPENSE LOSS (IF APPLICABLE)

Please complete this Part only if you are claiming past or future medical expenses or other out-of-pocket losses.

A. Medical Expenses or Other Expenses Loss Previously Incurred.

- Does the Claimant seek compensation for incurred medical expenses that have not been reimbursed and that are directly related to the treatment of the condition(s) listed in Part III? Yes/No.

    - If yes, what is the nature and amount of these medical expenses? Expenses can include rehabilitation treatment, vocational training, home modification, prescription drugs, assisted living and other such expenses. Please itemize the type of medical service identified and the amount of expenses incurred for each type of medical service. You must submit documentation of any claimed medical expenses loss – for example, invoices or receipts from the health provider showing payments received.

Type of Medical Expenses	Amount
	$
	$
	$
	$
	$
	$
	$
TOTAL	$

- Does the Claimant seek compensation for incurred other (non-medical) out-of-pocket expenses directly attributable to the Claimant's injury/condition from the September 11, 2001 terrorist attacks or debris removal? Yes/No.

    - If no, proceed to Section B.

- If yes, please describe other out-of-pocket expense losses – i.e., expenses directly related to the condition for which the Claimant seeks compensation.

  _____
  _____
  _____

B. Future Medical Expenses

- Does the Claimant seek compensation for future medical expenses directly related to the treatment of the condition(s) listed in Part III?

  - If yes,

    (1) If the Claimant is receiving treatment for the condition claimed through the WTC Health Program, please provide information regarding that treatment, the cost of the treatment and the anticipated future need for that treatment after the WTC Health Program concludes.

    (2) If the Claimant is *not* receiving treatment for the condition claimed through the WTC Health Program, please describe:

Anticipated Future Medical Needs	**Anticipated Expenses**

Note: Claimant will be required to submit information from a treating physician as to the Claimant's prognosis and anticipated ongoing medical treatment.

- Does the Claimant seek compensation for future other (non-medical) out-of-pocket expenses directly attributable to the Claimant's injury/condition from the September 11, 2001 terrorist attacks or debris removal? Yes/No.

  - If yes, please describe other out-of-pocket expense losses – i.e., expenses directly related to the condition for which the Claimant seeks compensation.

    _____
    _____
    _____

C. Health Insurance Information

You must complete this Section C if you are claiming past or future medical expense loss.

- Does/did the Claimant have any insurance, health care or disability benefits under which the injured Claimant is/was covered for any period in which he/she is claiming medical expenses? Yes/No

    - If yes, please provide documentation of any reimbursement and/or coverage provided to Claimant for the condition that the Claimant seeks compensation for from the VCF. If reimbursement and/or coverage was denied by any health insurer or other benefit provider, please submit documentation of the denial.

- If the Claimant is seeking future medical expenses, please identify the Claimant's current coverage and/or eligibility in the chart below:

Insurance Type	Name of Carrier and Contact Information	Group or Individual	Policy or ID# if applicable
Major Medical		Group ☐ Individual ☐	
Union Benefits		Group ☐ Individual ☐	
Medicare			
Medicaid			
Disability Income Insurance		Group ☐ Individual ☐	
Workers Compensation			
Other (please describe)			
Other (please describe)			
Other (please describe)			
Other (please describe)			

PART VI. – CLAIMANT'S LOSS OF EARNINGS TO DATE/LOSS OF REPLACEMENT SERVICES TO DATE (IF APPLICABLE)

*Please complete this Part **only** if you are claiming past loss of earnings or past replacement services loss as a direct result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal.*

A. Loss of Earnings to Date (If Applicable)

- Is the Claimant claiming loss of earnings to date as a direct result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal? Yes/No
    - If no, proceed to Section B below.
    - If yes,
        - (1) Describe the amount of time the Claimant missed work as a result of the injury or condition (i.e. work missed for which the Claimant was not or will not be compensated).

          _____

          _____
        - (2) Describe any loss of earnings and/or other benefits from work already missed as a result of the Claimant's injury (i.e. work missed for which the Claimant was not or will not be compensated). You will need to submit documentation regarding uncompensated absences from work as a result of injury sustained as a result of the September 11th air crashes or debris removal.

          _____

          _____

B. Replacement Services Loss to Date (If Applicable)

Replacement services loss represents the value of household services the Claimant provided to the household prior to the physical injury. Please refer to the Instructions for information on whether and to what extent the VCF will consider replacement services loss in calculating economic loss.

- Does the Claimant claim any replacement services loss to date? Yes/No.
    - If no, proceed to Section C below.
    - If yes,

Claimant's SSN or National ID # _____

- (1) Identify the specific household services that the Claimant has not been able to perform as a result of his/her injury or condition

  _____

  _____

- (2) If the Claimant has obtained outside assistance to perform the household services that the Claimant previously provided, please state the related costs incurred to date. You will need to submit documentation regarding any replacement services costs.

  _____

  _____

PART VII. – CLAIM OF LOST FUTURE EARNINGS/CLAIM OF LOST FUTURE REPLACEMENT SERVICES (IF APPLICABLE)

*Please complete this Part **only** if you are suffering an ongoing disability/injury and are seeking compensation for loss of future earnings and/or loss of future replacement services.*

A. Medical Condition – Disability

- Does the Claimant claim permanent disability or temporary disability as a result of your claimed injury or condition that will result in a loss of future earnings? Yes/No.
    - If no, proceed to Section B below.
    - If yes,
        - Is the disability or incapacity partial or total?

          Partial ☐ Total ☐
        - Is the disability or incapacity temporary or permanent?

          Temporary ☐ Permanent ☐
        - Has any government agency, insurer, or physician made a determination with respect to the Claimant's disability? Yes/No.
            - If yes, what entity issued the determination?

              DROP DOWN LIST

              State workers' compensation board. Please specify state._____
              Social Security Administration
              Department of Veterans Affairs
              Department of Labor
              State Government Entity (e.g. FDNY)
              Municipal Government
              Insurance company. Please identify: _____
              Physician. Please specify name and address: _____
              _____
              _____
            - Please submit any determination regarding the Claimant's capacity to work in the future.
            -

B. Loss of Future Earnings

- Does the Claimant claim a loss of future earning capacity as a result of the disability claimed above? Yes/No.
  - If no, proceed to Section D below.
  - If yes,
    - (1) Describe specifically how the Claimant's disability will affect future earning capacity, including expected duration and related compensation that will be lost.

      _____

      _____

C. Claimant's Employment History and Compensation/Benefits Information

Please complete the following information separately for Claimant's current employment (if currently employed) and for any previous employment (i.e., different employer or different position/job title) for the period beginning three calendar years prior to the decrease in the Claimant's earnings capacity as a result of the Claimant's disability and up to the year this claim is being filed. For example, if claimant was unable to continue working full time in his or her job after May 2008, please provide history starting in 2005. If self-employed for all or part of this period, please indicate that below where asked and provide the information requested. (If you are submitting a hard copy claim form please make copies of this Section C and submit multiple copies of this section for each separate employment).

Note: **The VCF will need to receive documentation demonstrating the amounts and details of Claimant's compensation and benefits during this period.**

- Compensation includes base salary and wages as well as other sources of earned income such as commissions, bonuses, incentive pay, etc. Please note that passive sources of income, such as income from rental properties or investments, are <u>not</u> compensation for purposes of the VCF. Also note, that any compensation award for loss of future earnings will be based on certain employment benefits provided to the Claimant by his/her employer. Please see the Document Checklist and Instructions for further information.
- The Special Master recognizes that collecting this information may be a difficult task and will seek to work with the Claimant's employer to obtain and confirm compensation and benefits and make sure they have been calculated correctly.
- You also must submit copies of all tax return information (including W-2 forms and other attachments) for the period beginning three years prior to the decrease in the Claimant's earnings capacity as a result of the Claimant's disability and up to the year the claim is being filed.

Claimant's SSN or National ID # _____

Employment (complete separately for each job/position)

- Date Range: _____ to _____
- Job title/description: _____
- Please check the box that best describes your annual income (including all forms of income) *during the last year of full-time work*.

☐ Under $25,000
☐ $25,000-$50,000
☐ $50,001-$100,000
☐ $100,001-$150,000
☐ $150,001-$250,000
☐ Over $250,000

- ☐ Check here if unemployed
- ☐ Check here if self-employed
- ☐ Check here if not self-employed and provide the following information:

Employer Name: _____
Employer Address: _____
_____

Employer Phone number: _____
Employer Email: _____
Indicate how Claimant's base salary/wages are/were paid?

☐ Yearly ☐ Monthly ☐ Weekly
☐ Hourly ☐ Other. Specify._____

- Did Claimant receive other compensation including, but not limited to, incentive pay, bonuses, overtime, tips, commissions, shift differentials, longevity, and honoraria? Yes/No.

If yes, check any that apply:

☐ incentive pay ☐ bonuses
☐ overtime ☐ tips
☐ commissions ☐ longevity
☐ shift differentials ☐ honoraria
☐ other. Describe: _____

Note: For Claimants who were in the armed forces – You should include information on housing, subsistence, TAD, re-enlistment, and other compensation by each category. However, if you want the Special Master to rely on published compensation and benefit scales please check the box at the end of this statement. If you do so, there is no need to provide

information on this additional compensation, but please submit a copy of the Claimant's Military Leave and Earnings Statement indicating the pay level and benefit information.

☐ I wish to rely on published data regarding U.S. military compensation.

- Did Claimant receive health benefits?
  - ☐ Yes, throughout course of employment
  - ☐ Yes, for portion of employment. Please specify dates._____
  - ☐ No

    If yes, indicate who was covered:

    ☐ Claimant only
    or
    ☐ Claimant and One Dependent
    or
    ☐ Claimant and Family

- Did Claimant receive pension benefits?
  - ☐ Yes, throughout course of employment
  - ☐ Yes, for portion of employment. Please specify dates._____
  - ☐ No

    If yes, check one:

    ☐ Defined Benefit Plan (monthly pension payable at retirement
    Indicate Claimant's hire date at last employer: (_____/_____/____)

    ☐ Defined Contribution Plan (employer contribution each pay period)
    Indicate employer contribution as % of salary: _____%

- Did employer provide matching contribution to a 401(k) or 403(b)?
  - ☐ Yes, throughout course of employment
  - ☐ Yes, for portion of employment. Please specify dates._____
  - ☐ No

- Did employer provide a transportation subsidy or company car?
  - ☐ Yes, throughout course of employment/
  - ☐ Yes, for portion of employment. Please specify dates._____
  - ☐ No

    If car was provided, please specify % of personal use: _____%

- Did employer provide club dues or memberships?
  - ☐ Yes, throughout course of employment
  - ☐ Yes, for portion of employment. Please specify dates._____
  - ☐ No

    If yes, indicate whether:

    ☐ Yearly ☐ Monthly
    ☐ Weekly ☐ Hourly

☐ Other. Specify._____

- Did employer provide a housing allowance (Non-military) (military allowances should be included on page ___)?
  ☐ Yes, throughout course of employment
  ☐ Yes, for portion of employment. Please specify dates._____
  ☐ No

  If yes, indicate whether the allowance was:

  ☐ Yearly ☐ Monthly
  ☐ Weekly ☐ Hourly
  ☐ Other. Specify._____

  Check whether the allowance was:
  [ ] Permanent.
  [ ] Temporary. If temporary, when did it end? _____

- Did the employer provide other benefits?
  ☐ Yes, throughout course of employment
  ☐ Yes, for portion of employment. Please specify dates._____
  ☐ No.

  If yes,
  Describe: _____

  Indicate whether:

  ☐ Yearly ☐ Monthly
  ☐ Weekly ☐ Hourly
  ☐ Other. Specify._____

  Describe: _____

  Indicate whether:

  ☐ Yearly ☐ Monthly
  ☐ Weekly ☐ Hourly
  ☐ Other. Specify._____

D. Loss of Future Replacement Services

Replacement services loss represents the value of household services the Claimant provided to the household prior to the physical injury or condition. Please refer to the Instructions for more information on whether and to what extent the VCF will consider replacement services loss in calculating economic loss.

- Does the Claimant claim any future household services that the Claimant will be unable to perform as a result of the injury? Yes/No.

- If no, proceed to Section E below.
- If yes,
    - (1) Identify the specific household services that the Claimant will not be able to perform as a result of his/her injury or condition.

      _____

      _____

    - (2) Describe the value (on an hourly, monthly or annual basis) of replacement services that the Claimant will need to obtain in order to perform those tasks that the Claimant previously performed but can no longer perform as a result of his/her injury or condition.

      _____

      _____

PART VIII. – COLLATERAL SOURCE PAYMENTS

In this Part, please identify any compensation or benefits the Claimant received or is entitled to receive from other sources as a result of the terrorist–related aircraft crashes of September 11, 2001 or debris removal efforts. For example, if the Claimant has received insurance or a specific payment from an employer that is not part of the normal compensation, these might be considered "collateral source" payments. Under the Act, the Special Master is required to reduce the compensation award by the amount of collateral source compensation a Claimant has received or is entitled to receive as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. *Note*: Settlement payments from September 11th-related lawsuits are to be included in Part I.E. and do not need to be listed again in this Part.

A. Social Security and Workers' Compensation Programs

- Has the Claimant received or is the Claimant receiving any payments from the Social Security Administration or from workers' compensation programs as a result of the Claimant's injury? (Include uniformed service benefits similar to Social Security or worker's compensation). Yes/No.

  - If no, has the Claimant applied to receive payments from the Social Security Administration or from workers' compensation programs as a result of the Claimant's injury? Yes/No

    - If yes,

      - Identify program or benefit applied for: _____

      - Was the Claimant's application denied? Yes/No

      - Is the application pending? Yes/No Submit any pending applications

  - If yes, please identify and describe any payments that the Claimant has received or is receiving and submit rulings, orders, determinations, or correspondence from Social Security Administration or workers' compensation program.

    _____
    _____
    _____

Claimant's SSN or National ID # _____

B. Medical payments

- Has the Claimant received or is the Claimant receiving any medical payments as a result of the Claimant's injury? Yes/No
  - If no, proceed to Section C.
  - If yes,
    - Please identify and describe medical payments and submit documentation of such payments.

_____
_____
_____

C. Other payments

- Has the Claimant received any other payments as compensation for or in response to the injury (excluding charitable contributions)? Yes/No.
  - If yes, please identify and describe and submit any documentation of such payments.

_____
_____
_____

PART IX. – OTHER INFORMATION (OPTIONAL)

Please use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individualized circumstances of your claim and the calculation of the economic and non-economic loss as well as collateral offsets. You may also submit any additional documents not already requested that you believe might be relevant.

Claimant's SSN or National ID # _____

PART X. CERTIFICATION FOR COMPENSATION FORM

A – PRIVACY ACT NOTICE

The Department of Justice is authorized to collect this information by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by the James Zadroga 9/11 Health and Compensation Act of 2010, Title II of Public Law 111-347. The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for and the amount of compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Government only in accordance with the provisions of the Privacy Act.

I Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

B. –CERTIFICATION OF ACCURACY OF INFORMATION

I hereby certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I agree that any payment made by the VCF is expressly conditioned upon the truthfulness and accuracy of the information and documentation provided in support of the claim. Further, I understand that false statements or claims made in connection with this application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, and that suspicious claims will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this _____ day of _____, 201_.

Signature of Claimant or Authorized Representative(s) (e.g., legal guardian)

If not Claimant:

Print Name

Relationship to Claimant

Claimant's SSN or National ID # _____

OMB control number 1105-_ _ _ _

Claimant's SSN or National ID # _____

C. – PAPERWORK REDUCTION ACT NOTICE

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. The estimated average time to complete and file this application is [ ]. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-_ _ _ _ . (Do not mail your completed application to this address.)

Claimant's SSN or National ID # _____