File Number: «CaseNumber»
«FORM»-«CAT»-«SUBJ»

OMB No: 1240-0046
Expiration Date: XX-XX-XXXX

U.S. DEPARTMENT OF LABOR

«SenderAddress»
Phone: «SenderPhone»

August 1, 2014~~May 12, 2011~~

Date of Injury: «DtInjury»
Employee: «ClaimantFullName»

«ToAddress»

Dear «Salutation»:

This Office is in receipt of a request for the services of an attendant. For the purpose of making a decision as to whether payment for services of an attendant can be authorized, additional information is needed from you as well as your treating physician. Along with this letter, you will find two enclosures. The first is a list of questions to which you are asked to respond. The second is a questionnaire for completion by your physician.

Payments are to be billed by and paid directly to the professional providing attendant services. Such services are to be rendered by a home health aide, licensed practical nurse or similarly trained individual.

Please be advised that 20 CFR 10.314 allows payment for services of an attendant where medical documentation supports that you require assistance to care for basic personal care needs. The Federal Employees' Compensation Act allows no provision for payment of tasks such as cooking, laundry, housekeeping, shopping, or yard work.

Sincerely,

«SignatureName»
«SignatureTitle»

«CCAddresses»

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

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Employee: «ClaimantFullName»

Case Number: «CaseNumber»

Please respond to the following questions.

1. State why you believe you require the services of an attendant. Identify the specific activities with which you require assistance. How does your condition render you incapable of performing these activities on your own?

2. Give the approximate amount of time you believe an attendant will be required. (State your answer in number of hours per day and number of days per week.)

3. If you wish to have a specific individual provide attendant services, state the name and address of that person. Indicate what qualifies that person to be an attendant and cite any credentials that person has. If that person is a family member, state his/her relationship to you.

4. Are you currently in receipt of attendant services? If so, state how long you have had attendant services. Indicate how much your attendant is paid per month. If not paid in cash or if only partially paid in cash, indicate what the reasonable monthly value of the services rendered by your attendant is?

I hereby certify that the information given by me and in connection with this questionnaire is true and correct to the best of my knowledge and belief.

Signed _____ Date _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution or civil action, and may, under appropriate criminal provisions, be punished by fine or imprisonment, or both.

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Employee: «ClaimantFullName»
Case Number: «CaseNumber»

Note to treating physician: Additional information is needed to determine whether the disability of the federal employee you are treating warrants the services of an attendant. Please complete the enclosed questionnaire and return it promptly to this Office. If you need more space, use a separate sheet of paper and number your answers to correspond with the questions.

1. When did you most recently examine the employee named above? _____
What were the findings upon examination? _____
_____

2. Explain why you believe the employee's condition warrants the services of an attendant._____
_____

3. How long do you believe the employee will require the services of an attendant?
_____
_____

4. Is the employee living at home? Yes or No. (Please circle)

5. Is the employee living in an institution? Yes or No. (Please circle). If no, give the name and address of the institution:_____
_____
_____

6. If the employee now has the services of an attendant, what is the name and relationship of the attendant to the employee (if related)?
_____

7. Is the employee able to: (Check one box after each item)

	Unassisted	Assisted	Not at All
(a) Travel?	( )	( )	( )
(b) Walk?	( )	( )	( )
(c) Feed himself/herself?	( )	( )	( )
(d) Dress himself/herself?	( )	( )	( )
(e) Bathe himself/herself?	( )	( )	( )

	Unassisted	Assisted	Not at All
(f) Get out of bed? (If so, state number of hours per day_____)	( )	( )	( )
(g) Get out of doors? (If so, state to what extent:_____)	( )	( )	( )
(h) Take exercise? (If so, state to what extent:_____)	( )	( )	( )

If the answer to any of the above items is 'Not at All', please give detailed reasons.

_____

_____

7. If the employee now has the services of an attendant, identify the actual duties performed by the attendant:

_____

_____

_____

8. Outline all other facts with reference to the employee's behavior or activity which are pertinent to the need for an attendant:

_____

_____

9. I certify that all statements in response to the questions asked on this form are true, complete and correct to the best of my knowledge. I further understand that any knowingly false statement, misrepresentation or concealment of fact may subject me to felony criminal prosecution.

(Signature) _____ (Date) _____

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~~**Privacy Act Statement**~~

~~The Privacy Act of 1974 as amended (5 U. S.C. 552a) and the Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.), authorizes collection of this information. The purpose of this form is to determine authorization and payment for services of an attendant where it is medically documented that an injured worker requires assistance to care for personal needs such as bathing, dressing, eating, etc. Completion of this form is voluntary (5 U.S.C. 8101, et seq.), however, failure to provide the information may result in the delay of processing of the claim or payment or benefits, or may result in an unfavorable decision or reduced levels of benefits. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus."~~

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C. 8101, et seq. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0046. Note: Please do not return the requested information to the address shown just above. Rather, send it to the address shown on the letterhead.

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