CLAIM FOR HOME HEALTH CARE, NURSING HOME, OR ASSISTED LIVING BENEFITS UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Instructions	
To claim for home health care, nursing home or assisted living benefits, please indicate below which benefits you are claiming, provide the requested contact information for your treating physician, sign and date the bottom of this form and mail it to: DOL DEEOIC Central Mail Room Correspondence, P.O. Box 8306, London KY 40742-8306. DO NOT WRITE IN SHADED AREAS.	OMB Control No: 1240-0002 Expiration Date: XX/XX/20XX

Employee's Information	
Name (Last, First, Middle Initial)	**Social Security Number:** **XXX-XX- _ _ _ _**
Address (Street, Apt. #, P.O. Box)	**DEEOIC Case ID#:**
(City, State, Zip Code)	**Telephone Number(s)** Home: ( ) - Other: ( ) -

Type of Medical Benefit Claimed (Check appropriate box)

I hereby request Home Health Care, Nursing Home, or Assisted Living benefits that are directly related to my DEEOIC accepted condition(s) and ordered by my treating physician. I acknowledge it is my responsibility to ensure that all requested medical documentation is submitted in support of my claim for these benefits.

☐ **Home Health Care** ☐ **Assisted Living** ☐ **Nursing Home**

Treating Physician of Record	
Physician Name (Last, First, Middle Initial)	**Telephone Number(s):** Office: ( ) -
Address (Name of Facility, Street, Suite #, P.O. Box)	Other: ( ) -
(City, State, Zip Code)	**Note:** Your physician must be either an M.D. or D.O.

Employee Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain benefits provided under EEOICPA, or who knowingly accepts benefits to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both. Any change to the information provided on this form, once it is submitted, must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. **I authorize any physician or hospital (or any other person, institution, corporation or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.**

_____ _____
Employee Signature Date

Privacy Act Statement

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq*.) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be disclosed to physicians and other health care providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (4) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (5) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are required to respond to this collection to obtain EEOICPA benefits (20 CFR 30.403). 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 S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE-17A. **DO NOT SUBMIT THE COMPLETED FORM TO THIS ADDRESS.**