Certificate of Incapacity

PART A - TO BE COMPLETED BY EXAMINING PHYSICIAN

The Federal Employees Health Benefits Program covers adult children of an employee's family if they are incapable of self-support because of a physical or mental disability. These children are over the age of 26 whose disabilities existed before age 26. This provision of law has been construed as applying to only the most serious types of disabilities, and then, only if the disability can be expected to continue for at least one year and the child is incapable of self-support.

Complete the following only if you have examined the person and consider the person to have such a disability.

1. Name of adult incapacitated child: _____

2. Diagnosis underlying the disability which makes the child incapable of self-support: _____

3. Date that this person's disability began: _____

4. At what age did the condition become so severe that it rendered the child unemployable and incapable of self-support? _____

5. How long is the child's disability expected to continue? _____

6. Provide a brief history of the specific medical condition including pertinent findings from previous examinations, test results, treatments, and responses to treatment. _____

7. List the clinical findings from the most recent physical examination, including results from laboratory or imaging studies and psychological tests, if applicable. You may attach a legible copy of your most recent entry in your medical record instead if it supplies or supports the documentation. _____

8. Has there been a recent change in the individual's medical condition, including improvement or deterioration? Please explain. _____

9. List any special supervisory, physical assistance, or custodial care that the individual now requires. _____

_____

_____

10. List any treatments, rehabilitation programs, educational training or occupational accommodations that could help the child become self-supportive. _____

_____

_____

11. Additional comments: _____

_____

I certify that the adult child listed on this certificate is incapable of self-support due to the above disability. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Doctor's Name: _____ Date: _____

Doctor's Signature: _____

Office Address: _____

Office Telephone Number: _____

PART B - TO BE COMPLETED BY EMPLOYEE

1. Employee's name and mailing address: _____

_____

2. Last four digits of employee's social security number: _____

3. Health benefit plan code: _____

4. Adult child's relationship to employee: _____

5. Child's date of birth: _____

6. Has the child been employed during the last twelve months? If so, provide name of employer, periods of employment, description of work performed, and total earnings: _____

_____

_____

_____

7. If employed, was employment in a closely supervised environment such as a sheltered workshop?

_____

8. List highest level of education of disabled child: _____

Privacy Act Statement
Collection and Use of Personal Information

Title 5 CFR 890.302(c) authorizes us to collect this information. We will use the information you provide to determine whether your adult disabled child is eligible for health care benefits under the Federal Health Benefits Program (FEHB) beyond age 26.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could result in automatic termination of benefits for your child at age 26.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in the Office of Personnel Management (OPM) System of Records Notices entitled, OPM/GOVT-1. Additional information about this and other system of records notices and our programs, is available on-line at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We can use the information from these matching programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*