

Section/Heading	Subheading	Modal?	Question	Field Type	Answer Choices (If applicable)	Required/Not Required	Instructional Text
Applicant Type	<i>In what way are you authorized?</i>		In what way are you authorized to complete this application on behalf of the Public Safety Officer's Employing Agency?	Radio	Employee of the Agency/National Stakeholder/Other (please describe)	Required	
			Describe "other" here:	Text Box	NA	Only required if "other" was chosen in the previous question.	
Enter the Public Safety Officer's information							
			Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr., Other(please describe)	Not Required	
			Describe "other" here	Text Box	NA	Required (if "other" is chosen)	
			Public Safety Officer First Name	Text Box	NA	Required	
			Public Safety Officer Middle Name	Text Box	NA	Not Required	
			Public Safety Officer Last Name	Text Box	NA	Required	
			Public Safety Officer Suffix	Text Box	NA	Not Required	
			Public Safety Officer Job Title	Text Box	NA	Required	
			Public Safety Officer Social Security Number (Enter in this format: 555-55-5555)	Text Box	NA	Required	
			Public Safety Officer Date of Birth	Text Box/Date	NA	Required	
			Public Safety Officer Date of Injury	Text Box/Date Picker	NA	Required	
			Public Safety Officer Date of Death	Text Box/Date Picker	NA	Required	
Enter information about the Public Safety Officer and Employing Agency							
			Public Safety Officer Type:	Radio	Law Enforcement Officer, Firefighter, Rescue Squad or Ambulance Crew Member, Emergency Management or Civil Defense Member, Other (please describe)	Required	
			Describe "other" here:	Text Box	NA	Only required if "other" was chosen in the previous question.	
			Jurisdiction Type:	Radio	1 - Local Unit of Government (City, County, Township), 2 - State Government, 3 - Tribal Government, 4 - Federal Government, 5 - Volunteer Fire Department, 6 - Nonprofit entity serving the public: (Fire Services, Rescue Activities, Emergency Medical Services), 7 - Other (please describe)	Required	

		Describe "other" here:	Text Box	NA	Only required if "other" was chosen in the previous question.
		Was the Officer serving in a volunteer capacity at the time of injury?	Radio	Yes/No	Required
		Was the Officer serving as a contractor at the time of injury?	Radio	Yes/No	Required
Enter the Employing Agency's information					
	<i>Employing Agency Contact Information</i>	Name of Employing Agency, Organization or Unit:	Text Box	NA	Required
		Employing Agency Address Line 1:	Text Box	NA	Required
		Employing Agency Address Line 2:	Text Box	NA	Not Required
		Employing Agency City:	Text Box	NA	Required
		Employing Agency State:	Dropdown	Alabama (AL) Alaska (AK) Arizona (AZ)	Required
		Describe "other" here:	Text Box	NA	Only required if "other" chosen in the previous question.
		Employing Agency Zip/Postal Code:	Text Box	NA	Required
		Employing Agency Country	Text Box	NA	Not Required
		Employing Agency Phone Number	Text Box	NA	Required
		Employing Agency Alternate Phone Number	Text Box	NA	Not Required
	<i>Agency Head Contact Information</i>	Agency Head Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr., Other(please describe)	Not Required
		Agency Head Prefix Other	Text Box	NA	Only required if other chosen as an answer to the previous question
		Agency Head First Name	Text Box	NA	Required
		Agency Head Last Name	Text Box	NA	Required
		Agency Head Suffix	Text Box	NA	Not Required
		Agency Head Job Title	Text Box	NA	Required
		Agency Head Email Address	Text Box	NA	Required
		The address of the Agency Head is the same as the Agency Point of Contact.	Check Box	NA	Not Required
		Agency Head Address Line 1	Text Box	NA	Required
		Agency Head Address Line 2	Text Box	NA	Not Required
		Agency Head City	Text Box	NA	Required
		Agency Head State	Dropdown	Alabama (AL) Alaska (AK) Arizona (AZ)	Required
		Describe "other" here:	Text Box	NA	Only required if "other" chosen in the previous question.
		Agency Head Zip/Postal Code	Text Box	NA	Required
		Agency Head Country	Text Box	NA	Not Required
		Agency Head Phone Number	Text Box	NA	Required
		Agency Head Alternate Phone Number	Text Box	NA	Not Required

	<i>Employing Agency Point of Contact Information</i>	Agency Point of Contact Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr., Other(please describe)	Not Required	
		Agency Point of Contact Prefix Other	Text Box	NA	Only required if other chosen as an answer to the previous question	
		Agency Point of Contact First Name	Text Box	NA	Required	
		Agency Point of Contact Last Name	Text Box	NA	Required	
		Agency Point of Contact Suffix	Text Box	NA	Not Required	
		Agency Point of Contact Job Title	Text Box	NA	Required	
		Agency Point of Contact Email Address	Text Box	NA	Required	
		The address of the Agency Point of Contact is the same as the Employing Agency.	Check Box	NA	Not Required	
		Agency Point of Contact Address Line 1	Text Box	NA	Required	
		Agency Point of Contact Address Line 2	Text Box	NA	Not Required	
		Agency Point of Contact City	Text Box	NA	Required	
		Agency Point of Contact State	Dropdown	Alabama (AL) Alaska (AK) Arizona (AZ) Arkansas (AR)	Required	
		Describe "other" here:	Text Box	NA	Only required if "other" chosen in the previous question.	
		Agency Point of Contact Zip/Postal Code	Text Box	NA	Required	
		Agency Point of Contact Country	Text Box	NA	Not Required	
		Agency Point of Contact Phone Number	Text Box	NA	Required	
		Agency Point of Contact Alternate Phone Number	Text Box	NA	Not Required	
Officer Injury Profile						
		Cause of Injury: (Check all that apply)	Checkbox	Bullets Explosives Sharp Instruments/ Blunt Objects Physical Blows	Required	
		Describe "other" here:	Text Box	NA	Only required if "other" chosen as an answer for the previous question.	
		Was this injury related to the events of September 11, 2001?	Radio	Yes/No	Required	
		At the time of injury, was the Officer:	Radio	On-duty, Off-duty, Other (please describe)	Required	
		Describe "other" here:	Text Box	NA	Only required if "other" is chosen as the answer to the previous question.	
Statement of Circumstances						
		Select this option if you would prefer to upload a Statement of Circumstances as a document instead of entering a new record below. If selected, you will be prompted to upload your document in the Required Documents section.	Checkbox - "I will upload a Statement of Circumstances"	NA	Not Required	
		Describe the circumstances of the Public Safety Officer's injury. Please provide details about what happened, as well as when, where, and how the incident occurred, and whether or not the Public Safety Officer was on duty.	Text Box	NA	Required	

Public Safety Officer's 24 Hour Activity Report							
Hyperlink			Click to upload the 24 Hour Activity Report	Checkbox - "Upload 24 Hour Activity Report"	NA	Not Required	
			Provide a statement accounting for the 24 hour period prior to the onset of the Officer's heart attack, stroke or vascular rupture. Note the hours within this period that the Officer was on duty, and give detailed information on all of the Officer's on-duty actions during that time.	Text Box	NA	Required	
		"Add 24hr Activity" modal					
			Date Activity Began				
			Approximate Time Activity Began	Text Field, AM/PM Radio	Text + AM/PM	Required	
			Approximate Time Activity Ended	Text Field, AM/PM Radio	Text + AM/PM	Required	
			Detailed Description of Activity	Text Box	NA	Required	
Potential Limitations on Payment							
			Was there any indication that the Officer was performing duties in a grossly negligent manner at the time of the injury?	Radio	Yes/No	Required	
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.	
			Was there any indication that the Officer's injury was caused by an intention to bring about the injury or death?	Radio	Yes/No	Required	
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.	
			Was there any indication that the Officer's injury was caused by intentional misconduct?	Radio	Yes/No	Required	
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.	
			Was there any indication that the Officer was voluntarily intoxicated at the time of injury?	Radio	Yes/No	Required	
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.	
Other Benefits							

			Has a claim for benefits been filed under any of the following: (Check all that apply)	Checkbox	State Line of Duty Death Benefits Workers' Compensation Federal Employees Compensation Act D.C. Retirement and Disability Act of September 1, 1916 September 11th Victim Compensation Fund Other (please describe) None of the Above (please describe)	Required	
			Describe "other" or "none of the above" here:	Text Box	NA	Only required if other or none of the above was chosen in the previous question	
			Has a final determination been issued for any of the following: (Check all that apply)	Checkbox	State Line of Duty Death Benefits	Required	
			Describe "other" or "none of the above" here:	Text Box	NA	Only required if other or none of the above was chosen in the previous question	
Hierarchy of Beneficiaries							
							<p>1) Officer's Surviving Spouse and Minor Child(ren) A Minor Child is defined as a Child of the Officer who was less than 18 years of age at the time of the Officer's fatal injury, or a Child who was between the ages of 19-22 at the time of the Officer's fatal injury in addition to being a full-time student at the time of the Officer's fatal injury. If the Officer has a Surviving Spouse and no Minor Children, the spouse receives 100% of the benefit; if the Officer has a Surviving Spouse and a Child or Children, the Spouse receives 50% of the benefit, while the Children receive the remaining 50% of the benefit in equal shares. If the Officer has no Surviving Spouse or Minor Children, the next eligible beneficiary on the benefits hierarchy would be the:</p> <p>2) PSOB Designee on file with the Agency at the time of the Officer's death The PSOB Designee on file with the Agency at the time of the Officer's death is the beneficiary for PSOB benefits that was specifically designated by the Officer prior to his or her fatal injury, if such a designation was made, and which was on file with the Agency at the time of the Officer's fatal injury. If there was such a designation, a copy of the written designation that was on file with the Officer's Agency at the time of his or her fatal injury must be provided. If the Officer has no Surviving Spouse or Minor Children, and had no PSOB Designee on file with the Agency at the time of his or her fatal injury, the next eligible beneficiary on the benefits hierarchy would be the:</p> <p>3) Life Insurance Designee on file with the Agency at the time of</p>
Provide information about any possible beneficiary who may be eligible for PSOB Benefits.							
			Number of Other Beneficiaries	Dropdown	0,1,2,3,4,5,6,7,8,9,10+	Required	
		"Add Beneficiary" modal					

	Death Report Beneficiaries						
			Relationship to Public Safety Officer	Radio	Surviving Spouse Surviving Spouse with Minor	Required	
			Describe "other" here	Text box	NA	Required (if "other" is chosen) as an answer to the previous question.	
			Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr., Other (please describe)	Not Required	
			Describe "other" here	Text Box	NA	Required (if "other" is chosen) as an answer to the previous question.	
			First Name	Text Box	NA	Required	
			Middle Name	Text Box	NA	Not Required	
			Last Name	Text Box	NA	Required	
			Suffix	Text Box	NA	Not Required	
			Phone Number	Text Box	NA	Not Required	
			Email Address	Text Box	NA	Not Required	
APPLICATION PREVIEW	Please Review and Confirm						The following is a summary of the information you have entered. Please review and make any necessary changes to this page before submitting your application.
Required Documents							Based on your responses, a customized checklist has been generated. The following required documents must be uploaded for the application to be considered complete. If you have any questions, please contact the PSOB Customer Resource Center at 1-888-744-6513 or AskPSOB@usdoj.gov.
			Association	Static Text Box	NA	Auto filled	
			Document Type	Static Text Box	NA	Auto filled	
			Date Uploaded	Static Text Box	NA	Auto filled	
			Instructions	Static Text Box	NA	Auto filled	All doc instructions are located in the "Required Documents and Inst
			Review Status	Static Text Box	NA	Auto filled	
			Add document clarifying notes if necessary.	Text Box	NA	Not Required	
			Missing Document Justification	Text Box	NA	Required only if a required document is not uploaded	
		Click Here to Add Other Documentation . (Modal)					
Missing Documents							Your application is missing one or more required documents needed to successfully submit your application. Please go to the previous screen to review the list of required documents, to upload all required documents or to provide an explanation of why a document is missing.

CERTIFICATION OF APPLICATION							<p>The information provided will be used by the Department of Justice to determine eligibility of an Applicant/Claimant for PSOB Program benefits. To verify eligibility for benefits, the information provided is subject to investigation and may be disclosed to federal, state, tribal, and local agencies to verify eligibility for benefits. If the Department of Justice receives adverse information regarding an Applicant's or Claimant's eligibility, an information of record may be disclosed as necessary to affected persons and federal, state, tribal, and local agencies, including those persons or agencies challenging eligibility.</p> <p>I certify that all of the information provided is correct and complete to the best of my knowledge. I know of no facts or circumstances that would render the person identified here as ineligible for the benefit. I understand that knowingly and willfully making a false or incomplete statement or failing to fully disclose pertinent information concerning this claim may be grounds for non-payment of benefits or for prosecution for a false statement under 18 U.S.C. § 1001.</p> <p>Checking the box below asserts that you have read and understand this Certification of Application, and will be treated as an electronic signature by or on behalf of the Agency.</p> <p>If you are ready to submit your application, click the "Next/Save" button. If you need to make changes to your application, click the "Previous" button.</p>
FINAL REVIEW FORM	Please Review and Confirm		Certification of Application	Checkbox	NA	Required	<p>This final review form serves as the version of the application you are about to submit. If you wish to make edits, return to the editable preview screen to do so.</p>
Application Part B Successfully Submitted							<p>A PSOB Death Benefits Application consists of two parts, Part A and Part B. Part A is completed by the Officer's beneficiary or Authorized Representative, Part B is completed by the Employing Agency. Parts A and B, and all required supporting documents must be provided before the application can be considered complete.</p> <p>A Customer Resource Specialist will review the application. If all required documents are provided, the application will be assigned a claim number and will move to the next stage of review.</p> <p>If the contact information you initially provided changes, please log into the PSOB portal to update your contact details.</p>