

Countermeasures Injury Compensation Program (CICP)
Certification of Status for Death Benefit – Standard Calculation

Case Number: _____

This Certification will assist the Countermeasures Injury Compensation Program (CICP) in determining benefits. Please complete the statement below that applies to your case, and print and sign your name below. Please read all options before making a selection(s).

If a dependent has more than one legal guardian, only one guardian must complete and sign this form. If there are multiple dependents, a separate Certification must be completed and signed for each dependent by one guardian.

Option 1

I certify that _____
(deceased injured countermeasure recipient's name)

did not receive a disability or death benefit under the Public Safety Officers' Benefit (PSOB) Program.

Option 2

I certify that _____
(deceased injured countermeasure recipient's name)

did receive a disability or death benefit under the PSOB Program.

(Please explain why deceased injured countermeasure recipient was covered under the PSOB Program.)

Option 3

I certify that _____
(deceased injured countermeasure recipient's name)

was covered under the PSOB Program and no benefit was or will be provided.

Under the PSOB Program, the survivors of the deceased injured countermeasure recipient are eligible for a death benefit? Yes No

If yes, has it been paid yet? Yes No

If yes, how much has been paid? _____

I am the legal guardian of a dependent less than age 18 of the deceased injured countermeasure recipient who is eligible for death benefits from the Countermeasures Injury Compensation Program. By signing this form, I hereby certify that I have read the information provided about the standard calculation and the alternative calculation and have chosen to receive the death benefit under the standard calculation in place of the alternative calculation.

By signing this form, I hereby certify that the information provided in this Certification is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Certification, including subsequent information and documentation submitted in connection with this Certification, may result in any remedy, including civil remedies, available by law to the United States. I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final benefits decision.

Name of Legal Guardian (Please print)

Name of dependent (if applicable)

Signature of Legal Guardian

Date

OR

Name of Requester (Please print)

Name of Representative (if applicable)

Signature of Requester or Representative

Date

number. The OMB control number for this information collection is 0915-0334 and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09-15-0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average 3.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.