U.S. Department of State

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ELIGIBILITY QUESTIONNAIRE FOR HAVANA ACT PAYMENTS

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 60 minutes per response, including the time required for searching existing data sources, gathering the necessary data, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: PRA Attorney, Office of the Legal Adviser/LM, Suite 4805, 2201 C Street NW, Washington DC 20520.

Section I: Patient Demographics (*Patient Only*)

INSTRUCTIONS
This form is for Department of State employees, separated Department of State employees, Department retirees, and dependents of such employees, separated employees, and retirees. Complete Section I and bring this form to your board-certified physician along with any other medical records that may assist with determining a qualifying injury.

1. Last Name	2. First Name	3. Date of Birth (*mm-dd-yyyy*)

4. Email Address	5. Phone Number
6. Employer	7. Employment Status
8. Location of Incident	9. Date of Incident (*estimated mm-yy, if unknown*)

Section II: Qualifying Brain Injury Questionnaire (*Physician Only*)

INSTRUCTIONS
This section is only to be completed by a physician currently certified with the American Board of Psychiatry and Neurology (ABPN), the American Board of Physical Medicine and Rehabilitation (ABPMR), the American Osteopathic Board of Neurology and Psychiatry (AOBNP), or the American Osteopathic Board of Physical Medicine and Rehabilitation (AOBPMR), who has a history of providing medical care for this patient.. Please review the following statements, any pertinent medical records, and provide your signature below. Once completed, fax this document only to 202-261-8186 or scan this document and send as an attachment to an email to: HABenefit@state.gov.

1. ☐ Yes ☐ No	Did the individual experience an acute injury to the brain such as, but not limited to, a concussion, penetrating injury, or as the consequence of an event that leads to permanent alterations in brain function as demonstrated by confirming correlative findings on imaging studies (to include Computer Tomography scan (CT), or Magnetic Resonance Imaging scan (MRI), or Electroencephalogram (EEG)?
2. ☐ Yes ☐ No	Did the individual receive a medical diagnosis of a Traumatic Brain Injury (TBI) that required active medical treatment for 12 months or more?
3. ☐ Yes ☐ No	Did the individual experience an acute onset of new persistent, disabling neurologic symptoms as demonstrated by confirming correlative findings on imaging studies (to include CT or MRI), or EEG, or physical exam or other appropriate testing, and that required active medical treatment for 12 months or more?
4. ☐ Yes ☐ No	Did the injury occur on or after January 1, 2016?
5. ☐ Yes ☐ No	Do you have evidence or otherwise believe that the symptoms can be attributed to a pre-existing condition?

Section II: Qualifying Brain Injury Questionnaire (*Physician Only*) - Continued

6. ☐ Yes ☐ No	Does the individual require a full-time caregiver for activities of daily living, as defined by the Katz Index of Independence of Daily Living?

The signature below attests that the certifying physician is currently certified with the ABPN, the ABPMR, the AOBNP, or the AOBPMR, and solemnly affirms that it is their clinical opinion based on their knowledge, education, and belief that the information above is correct.

Printed Name of Physician	Street Address, City, State and Zip Code
Signature of Physician	Date
Email Address	Phone Number

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) STATEMENT

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. For the provider completing this form, do not provide any genetic information when responding to this request for medical information. Genetic Information, as defined by GINA, includes the following: an individual's family medical history; the results of an individual's or family members' genetic tests; the fact that an individual or an individual's family member sought or received genetic services; and genetic information of a fetus carried by an individual, or an individual's family member, or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PRIVACY ACT NOTICE

AUTHORITIES: The information sought is pursuant to the Further Consolidated Appropriations Act of 2020 and the HAVANA Act of 2021 (22 U.S.C. 2680b).
PURPOSE: The information solicited from this form will assist the Department of State in determining whether a board-certified neurologist has verified a patient under their care has been reviewed for the appropriate medical eligibility criteria for potential payment under the HAVANA Act.
ROUTINE USES: The Department will not share this information externally. More information on the routine uses for the system can found in System of Records Notice STATE-31, Human Resources Records.
DISCLOSURE: Providing the information requested on this form is voluntary; however, failure to provide such information may preclude eligibility for payment authorized under the HAVANA Act of 2021.