U.S. Department of Commerce

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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: Chief Human Capital Officer, Office of Human Resources Management/Suite 50003, 1401 Constitution Avenue NW, Washington, DC 20230.

Section I: Patient Demographics (*Patient Only*)

INSTRUCTIONS:
This form is for current and former Department of Commerce employees and dependents of such current and former employees. 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*)

If you are completing this form on behalf of the person named above, you will be required to provide proof of your relationship. You will receive instructions for doing so after submission of this form.

10. Relationship to the claimant	11. Phone Number	12. Email Address

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 and has examined the patient in person. Please review the following statements, and any pertinent medical records, and provide your signature below. Once completed, email HAVAPP@doc.gov for further instructions to submit through our secure file system or via fax.

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, MRI), EEG, 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

The collection, maintenance, and disclosure of this information is governed by the Privacy Act of 1974 (5 U.S.C. § 552a).

AUTHORITY: The Department of Commerce requests the patient information solicited on this form to carry out the agency's responsibilities pursuant to 22 U.S.C. 2680b, as amended by the Helping American Victims Affected by Neurological Attacks (HAVANA) Act of 2021 (Pub. L. 117-46) and the Department's implementing regulations at part 3 to Subtitle A of Title 15, Code of Federal Regulations.

PURPOSE: The principal purpose for which the Department of Commerce will use the patient information solicited on this form is to assist the agency in determining the patient's medical eligibility for potential payment under the HAVANA Act, for which the assessment and diagnosis of a qualifying injury by a board-certified neurologist is required.

ROUTINE USES: In addition to those disclosures generally permitted under the Privacy Act of 1974, as amended, 5 U.S.C. § 552a(b), records maintained as part of this system of records – DEPT-32, Helping American Victims Afflicted by Neurological Attacks Act of 2021 (HAVANA Act) Records – may be routinely disclosed to the U.S. Department of State to verify prior employment; to the U.S. Department of Labor and/or the Social Security Administration to determine reemployment potential or disability status; to a state Board of Medicine, or any similar organization, to verify a certifying physician's medical license; and, to a certified physician attesting to an individual's eligibility when necessary to follow up regarding information provided on an individual's application. A complete set of routine disclosures is included in the system of records notice, published both in the Federal Register and on the Department's website at: www.commerce.gov/privacy.

VOLUNTARY DISCLOSURE: Disclosing the information requested on this form is voluntary; however, failure to provide such information will preclude the patient's eligibility for payment authorized under the HAVANA Act of 2021.