VOLUNTARY DEMOGRAPHIC SURVEY FOR OFFICE OF WORKERS' COMPENSATION PROGRAMS (OWCP) CLAIMANTS

U.S. Department of Labor
Office of Workers' Compensation Programs
OMB Control Number: XXXX-XXXX
Expiration Date: XX/XX/XXXX

U.S. Department of Labor's (DOL) Office of Workers' Compensation Programs (OWCP) is collecting demographic information to improve program accessibility and inclusion. OWCP is committed to finding ways to promote equity for all, including people who have been historically marginalized or adversely affected by inequality. ***Your participation in this survey is optional and will not impact your claim.*** *Your demographic information will be kept separate from your claim file and will not be shared with or used by the OWCP staff in making decisions about your claim.*

1. CLAIMANT INFORMATION

Identify the OWCP Claimant for whom this information is being reported.

First Name of Claimant: _____ **Last Name of Claimant:** _____

Case Identification (ID) Number associated with the Claimant: _____

CERTIFICATION: *I hereby certify that, to the best of my knowledge, the provided information is true and accurate.*

Signature of person completing survey:_____ **Date:**_____

(Must be the OWCP Claimant or their designated Authorized Representative or Attorney in Fact)

2. DEMOGRAPHIC INFORMATION ABOUT CLAIMANT

Race and Ethnicity

What is your Race or Ethnicity? (Select all that apply. Note, you may report more than one group.)

- ☐ White
- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander

Sexual Orientation

Which of the following best represents how you think of yourself? (Select one.)

- ☐ Gay or Lesbian
- ☐ Straight, that is not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term:_____
- ☐ I don't know

Gender Identity

What sex were you assigned at birth, on your original birth certificate? (Select one.)

- ☐ Female
- ☐ Male

How do you currently describe yourself? (Select all that apply.)

- ☐ Woman
- ☐ Man
- ☐ Transgender
- ☐ I use a different term:_____

Primary Language

How well do you speak English? (Select one.)

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

Do you speak a language other than English at home?

☐ Yes ☐ No

If yes, what is this language?

- ☐ Spanish ☐ French (including Patois, Cajun, Creole, Haitian)
- ☐ Chinese ☐ Tagalog ☐ Vietnamese ☐ Arabic ☐ Korean
- ☐ Russian ☐ German ☐ Hindi ☐ Portuguese
- ☐ Other language not listed:_____

Disability Status

Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐ Yes ☐ No
Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	☐ Yes ☐ No
Do you have serious difficulty walking or climbing stairs?	☐ Yes ☐ No
Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	☐ Yes ☐ No

Survey Disclaimer: This survey is for claimants who have filed a claim with OWCP's Division of Coal Mine Workers' Compensation (DCMWC or Black Lung). Participation in this survey is strictly voluntary. OWCP's collection of this survey information is separate and distinct from your claim adjudication process. Information collected from this survey will not be used in determining your claim or be associated with your claim file.

INSTRUCTIONS

Section 1—Claimant Information

- **First Name of Claimant and Last Name of Claimant:** Provide the first and last name of the claimant for whom demographic information is being provided.
- **Case Identification (ID) Number:** Provide the Case ID Number for the above claimant. Case ID Numbers are listed on OWCP claim correspondence or can be obtained by contacting the OWCP office handling the claim. Case ID Numbers will only be used to verify that information is associated with an OWCP claim and this survey information will not be added to your case file records.
- **Certification and Signature:** The person completing the survey must provide their signature certifying that the information provided is true and accurate. If you are completing the survey on behalf of a claimant, you must be designated in the case file record as the claimant's Authorized Representative or possess legal authority to serve as the claimant's Attorney in Fact or guardian.

Section 2—Demographic Information About Claimant

Provide the answer that best represents your personal understanding. Some responses may allow for multiple selections. Selection may be marked with an (X) or check mark (✓). You may choose to provide a response to all or some of the questions depending on your willingness to provide the requested demographic information.

Submitting the Completed Survey:

DCMWC/Black Lung claimants may mail the completed survey to:
U.S. Department of Labor OWCP/DCMWC
P.O. Box 8307
London, KY 40742-8307

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) OWCP of the U.S. Department of Labor receives and maintains personal information on claimants. (2) Information received by this collection will be used to improve program accessibility and inclusion. (3) Information may be used to compile statistics to determine whether OWCP benefits are being provided in an equitable manner to people who have been historically marginalized or adversely affected by inequality. (4) This collection of information is not mandatory, and failure to disclose the requested information will not delay or impact any claim for OWCP benefits.

PUBLIC BURDEN STATEMENT

The OMB control number for this collection is XXXX-XXXX and expires on XX/XX/XXXX. According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless such collection displays a valid OMB control number. The obligation to respond to this collection is voluntary. We estimate it takes about 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information to the U.S. Department of Labor, 200 Constitution Ave., NW, Room xx, Washington, D.C. 20210 and reference OMB Control Number XXXX-XXXX.

Note: Do not return the completed survey to this address for comments.