

COUNTERMEASURES INJURY COMPENSATION PROGRAM REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as ~~the COVID-19 2009 H1N1~~ vaccine, ~~Remdesivir~~ ~~Tamiflu®~~, ~~Relenza®~~, and ~~peramivir~~, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a direct result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. ~~Although the CICP needs all the medical documentation that supports the injury in order to process the request, requesters may submit only this Form in order to meet the filing deadline.~~ The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

~~Type of countermeasure~~ Countermeasure administered or used (e.g., ~~COVID-19 2009 H1N1~~ vaccine):

Date(s) of the countermeasure administration or use that may have caused the injury: _____

Geographic location in which the countermeasure was administered or used (e.g., city, State): _____

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Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"): _____

Indicate who administered the countermeasure? (e.g., doctor, hospital, clinic, local health department): _____

List the specific injury(s) that may have been caused by the countermeasure (e.g., -myocarditis, Anaphylaxis): _____

Date of onset of the injury(s): _____

Describe the injury(s) that may have resulted from the countermeasure (optional): _____

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

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SECTION B. SURVIVOR OF DECEASED INJURED COUNTERMEASURE RECIPIENT WHO MAY HAVE DIED AS A RESULT OF THE COVERED COUNTERMEASURE

All information in Section B refers only to the survivor(s) of the individual identified in Section A, who is/are requesting death benefits.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

The date the injured countermeasure recipient identified in Section A died: _____

In order to be considered for Program benefits, a survivor must be in one of the categories ~~listed~~described below (and described in the instructions). - Check the box that describes the person identified in Section B in relation to the individual identified in Section A.

- ☐ Spouse
☐ Eligible child (described in the instructions)
☐ ~~Dependent younger than the age of 18 (described in the instructions)~~
☐ Beneficiary named in most recently executed life insurance policy (and there are no survivors in the categories ~~list~~described above)
☐ Parent (and there are no survivors in the categories ~~list~~described above)
☐ ~~Legal guardian of a deceased minor (and there are no survivors in the categories listed above)~~
☐ Adult child (and there are no survivors in the categories ~~list~~described above)
☐ ~~Legal guardian of a deceased minor (and there are no survivors in the categories listed above)~~
☐ ~~Dependent younger than the age of 18~~

Check the first box below if the requester is a sole survivor or the second box if there are other survivors ~~described~~listed above.

☐ To the best of my knowledge, there are no other survivors who may be eligible for a CICP death benefit payment;
or

☐ There are other survivors who may be eligible for a CICP death benefits payment. -I am providing their names, contact information, and their relationship to the person we survived.- If this box is checked, list survivors.- Use additional sheet(s), if necessary. (Eligible survivor categories are listed above and described in the instructions.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Go to **Section C (Blue)** if you are also the executor or the administrator of the estate.

Form No: CACP-1

OMB Control Number: 0915-0334

Expiration Date: 1/31/2026

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

Last Updated: October 30, 2010

SECTION C. EXECUTOR OR ADMINISTRATOR OF THE ESTATE OF A DECEASED INJURED COUNTERMEASURE RECIPIENT

The Program may provide medical and/or lost employment income benefits to the estate of a deceased individual described in Section A, regardless of the cause of death. All information requested in Section C refers to the executor or administrator of the estate only.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or an adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal **representative**; ~~but representative but~~ may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All Information in Section D refers to the legal or personal representative.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Relationship to the person applying for Program benefits (e.g., parent, lawyer): _____

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

☐ Yes

☐ No

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. -If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

2) 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 decision.

3) (Check one):

- ☐ I have the legal capacity to receive Program payments; or
☐ I represent someone who does not have the legal capacity to receive Program payments and I am signing below.

Name (Print clearly): _____

Signature: _____ Date: _____

You can submit your Request Form and all the required documentation to the CICP [online at injurycompensation.hrsa.gov](https://www.hrsa.gov/cicp) (preferred), or by U.S. mail, a private courier service, or commercial carrier to:

U.S. Department of Health and Human Services
Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, ~~08N146B14W-188W-25A~~
Rockville, MD 20857

For Program information and to obtain an additional copy of this Form and the instructions for completing it, visit the CICP Web-site at www.hrsa.gov/cicp, call 1-855-266-2427 (1-855-266-CICP), or email: CICP@hrsa.gov. ~~Check the Program Web site to see if this Form can be submitted electronically.~~

PRIVACY ACT STATEMENT

Section 319F-4 of the Public Health Service Act (PHS Act), ~~Public Law 109-148~~ (42 U.S.C. 247d-6e), ~~and the Debt Collection Improvement Act of 1996~~ authorizes collection of this information. It will be used to determine your eligibility to receive benefits. This information will be disclosed to the U.S. Department of Health and Human Services and its consultants; and Federal, State, or local law enforcement agencies, if the Government becomes aware of a possible violation of civil or criminal law; and for certain medical research purposes when consistent with the purposes for which the Program was formed, i.e., to make determinations concerning alleged covered countermeasure injury associations and to provide compensation to individuals injured by covered countermeasures. Furnishing the information on this Form is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act, 5 USC Section 552a, as amended.

PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0334. Public reporting burden for this collection of information is estimated to average ~~115~~ hours per respondent annually, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, 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 10-33, Rockville, Maryland, 20857

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