INCAPACITATION PAY MONTHLY CLAIM FORM

For use of this form, see DA PAM 135-381; the proponent agency is DCS, G-1.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 3013, Secretary of the Army; 37 U.S.C. 204, Entitlement, AR 135-381, Incapacitation of Reserve Component Soldiers and EO 9397 *(SSN)*

PRINCIPAL PURPOSE: This information will be used to determine eligibility for incapacitation pay.

ROUTINE USES: None. The "Blanket Routine Uses" set forth at the beginning of the Army's Compilations of System of Records Notices apply to this system.

DISCLOSURE: Voluntary. However, failure to provide all the requested information may delay or prevent the payment of compensation.

SECTION I - CLAIM STATEMENT *(Completed by Soldier - PLEASE PRINT)*

1. LAST NAME	2. FIRST NAME	3. MIDDLE INITIAL	4. SSN

5. RANK	6. DUTY MOS/AOC	7. UNIT OF ASSIGNMENT	8. UNIT PHONE NUMBER

9. DATE OF INJURY/ ILLNESS/DISEASE *(YYYYMMDD)*	10. MO/YR OF CLAIM

11. EXACT DATES OF INCAPACITATION *(DAYS I WAS UNABLE TO WORK DURING THIS CALENDAR MONTH):*

a. FROM *(YYYYMMDD)*	b. TO *(YYYYMMDD)*

12. I verify that during the claim period indicated in block 11, I lost the following amount of income due to the injury/illness/disease incurred or aggravated on the date noted in block 9: $

13. During the claim period identified in Block 11, I received the following non-military income from other sources *(including all wages, salaries, tips, income protection plans, vacation or sick pay, unemployment compensation, if NONE, so state)* . Attach copies of pay stubs or other documentation reflecting total amount(s) received $

	YES	NO
14a. I was employed *(civilian job)* on date of injury/illness/disease indicate in block 9: *(Include copy of previous year's W-2 or federal income tax forms with claim)*	☐	☐
b. I was covered by an Income Protection Plan and elected to use it: *(Check one)*	☐	☐
c. I am receiving VA Disability Compensation for the same disabling condition: *(Check one)*	☐	☐
d. I am receiving Supplemental Income from an Income Protection Plan. *(Check one)*	☐	☐
e. I am receiving professional fees or compensation for personal services rendered: *(Check one)*	☐	☐

15. NAME OF CIVILIAN COMPANY/EMPLOYER *(To include self employment)*	16. STREET ADDRESS/CITY/STATE/ZIP

17. "As the individual making this claim, I understand that I am responsible for the accuracy of the information in Section I and Section II, and that any false statements or omissions in connection with this claim may subject me to prosecution and possible fines and/or imprisonment."

a. SOLDIER'S SIGNATURE	b. DATE *(YYYYMMDD)*

SECTION II - EMPLOYER'S VERIFICATION

18. EMPLOYER 1

a. I verify that the above-named reserve Soldier is a *(check one)* current ☐ former ☐ employee of this company/organization and that he/she was not able to work during the dates shown in block 11.

b. Had this individual been able to work during the dates identified in block 11, he/she would have earned: $ _____ *(amount lost)*

c. The individual named above is covered by an employee Income Protection Plan. YES ☐ NO ☐

(If YES, and he/she elected to use it, indicate amount received from this plan): $ _____

LAST NAME	FIRST NAME	MIDDLE INITIAL	SSN

SECTION II - EMPLOYER'S VERIFICATION *(Continued)*

d. I understand that this information is being used by the claimant as the basis of a claim against the United States government. I further understand that knowingly and willfully assisting a claimant making a false claim or false statement in connection with a claim is a criminal offense under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment.

e. EMPLOYER'S REPRESENTATIVE *(Name, title, business address)*	f. PHONE NUMBER	h. EMAIL ADDRESS
	g. FAX NUMBER	i. SIGNATURE/DATE

19. EMPLOYER 2 *(If applicable)*

a. I verify that the above-named reserve Soldier is a *(check one)* current ☐ former ☐ employee of this company/organization and that he/she was not able to work during the dates listed in block 11 of this form.

b. Had this individual been able to work during the dates above, he/she would have earned: $ _____ *(amount lost)*

c. Is the individual named above covered by an employee Income Protection Plan? YES ☐ NO ☐

(If YES, and elected to use it, indicate amount he/she received from this plan): $ _____

d. I understand that this information is being used by the claimant as the basis of a claim against the United States government. I further understand that knowingly and willfully assisting a claimant making a false claim or statement in connection with a claim is a criminal offense under Federal and State laws which may subject the parties to a substantial fine and/or lengthy improvement.

e. EMPLOYER'S REPRESENTATIVE *(Name, title, business address)*	f. PHONE NUMBER	h. EMAIL ADDRESS
	g. FAX NUMBER	i. SIGNATURE

SECTION III - COMMANDER'S VERIFICATION

20. UNIT OF ASSIGNMENT	21. UNIT ADDRESS *(CITY, STATE, ZIP CODE)*
22. UIC	23. SOLDIER'S DUTY MOS/AOC

24. SUPPORTING MILITARY MEDICAL TREATMENT FACILITY OR COMMAND AND ADDRESS

25. DETERMINED UNFIT FOR MILITARY DUTY: I, _____ *(Soldier's Name)* , have not performed or been paid for duty after being determined unfit to perform military duty. _____ *(Soldier's Signature)*.

26. COMMANDER'S NAME/RANK/SIGNATURE/DATE	☐ RECOMMEND APPROVAL ☐ RECOMMEND DISAPPROVAL *(See Attached)*

27. I have reviewed the approved line of duty investigation *(IAW AR 600-8-4)* which is attached *(Commander's Initials):*

SECTION IV - REVIEW / APPROVAL

28. JFHQ/USARC/RRC/MSC	29. POINT OF CONTACT *(Name, title, email address, Fax number)*	30. PHONE NUMBER

31. ☐ APPROVED ☐ DISAPPROVED	32. NAME/RANK/TITLE/SIGNATURE/DATE *(Approving Authority)*

33. REMARKS

INCAPACITATION PAY MONTHLY CLAIM FORM
INSTRUCTION SHEET

SECTION I - CLAIM STATEMENT

1. Self-explanatory.

2. Self-explanatory.

3. Self-explanatory.

4. Self-explanatory.

5. Rank -PVT, SPC, SGT, 1LT, CW2, CPT, COL

6. Duty MOS/AOC - 91B, 13B, 42D/66H, 70B.

7. Self-explanatory.

8. Self-explanatory.

9. Date of Injury/Illness/Disease *(YYYYMMDD).*

10. Month/Year of Claim *(MM/YY or Claim)* - 11/98, 12/98 or 03/00.

11. Exact Dates of Incapacitation - Do not cross calendar months when completing this form. This first date of incapacitation will be the date the government physician determines the Soldier unfit for military duty or demonstrates a loss of nonmilitary income. Subsequent the Incapacitation Pay Monthly Claim Form will reflect the entire month, i.e., 1 Sep 99 to 30 Sep 99 or 1 Oct 99 to 31 Oct 99 or the end of the incapacitation claim.

12. Amount of income, from civilian job, which you would have earned if you had not been injured. This must be during the claim period indicated on the Incapacitation Pay Monthly Claim Form. NOTE: Full months of incapacitation pay and allowances are based on a calculation of 30 days per month, regardless of the actual days per month.

13. Amount of reportable income from other sources that you received during the incapacitation period reflected in Block II.

14.a. Indicate whether you were employed *(check Yes)* or unemployed *(check No).*

14.b. Self-explanatory.

14. c. You must indicate whether or not you are receiving VA Disability Compensation for the same condition. If you are, the amount of the compensation will be deducted from your incapacitation entitlements.

14. d. Indicate whether receiving Supplemental Income from an Income Protection Plan. If you are, that amount will be deducted.

14. e. Indicate whether receiving professional fees or compensation for other personal services rendered. If you are, that amount will be deducted.

15. Self-explanatory.

16. Self-explanatory.

17. Your signature indicates all previous statements are true and accurate and that you may be subject to prosecution for making false claims.

SECTION II - EMPLOYER'S VERIFICATION

18. EMPLOYER 1

a. Self-explanatory.

b. Amount this employee would have earned if he/she were able to work.

c. Self-explanatory.

d. Self-explanatory.

e. f., g., h., i. Self-explanatory.

19. EMPLOYER 2

a., b., c., d., e., f., g., h., i. Same as 18.a THRU e above.

SECTION III - COMMANDER'S VERIFICATION

20. Self-explanatory.

21. Self-explanatory.

22. Unit Identification code *(UIC)*.

23. Same as block 6.

24. Self-explanatory.

25. Self-explanatory.

26. Self-explanatory.

27. Commander's Initials.

SECTION IV - REVIEW/APPROVAL

28. Higher headquarters or approving authority *(JFHQ/USARC/RRC/MSC).*

29. Point of contact within STARC/USARC/RRC/MSC.

30. Self-explanatory.

31. Self-explanatory.

32. Self-explanatory.

33. Self-explanatory.