UNIT
HAWAI'I ARMY NATIONAL GUARD
ADDRESS
CITY, STATE, ZIP

(OFFICE SYMBOL) **DATE**

MEMORANDUM FOR Incapacitation Review Board Authority

SUBJECT: Recommendation to **APPROVE/DENY TIER (1 or 2)** Incapacitation (INCAP) Pay for **RANK, FIRST, MI.LAST NAME, (Last Four SSN)** for claim periods **YYYMMDD** to **YYYMMDD**

1. Request **(approval/denial)** of the attached application for Tier **(1/2)** INCAP Pay for claim periods **XX MMM YYYY** through **XX MMM YYYY.** This request ***(DOES/DOES NOT)*** exceed the six month statutory limit for INCAP pay.

2. This request is based on an in line of duty (ILD) determination for **(insert ILD condition)**, an **(injury, illness, or disease)** that occurred on **(date of ILD condition)** while on **(insert training ordertype or duty status). *** Address their duty performance and readiness status – has the SM attended BA since the injury, are they currently receiving care, is a fit for duty exam required/necessary. Address the Soldier's attendance history.*

3. *Address previous approved/paid INCAP periods.* ***RANK LAST NAME was previously approved and paid XX months of TIER X INCAP pay for claims XX MMM YYYY to XX MMM YYYY in the gross amount of $$$. ***Address any update to profile (temporary or permanent profile) or enrollment into IDES. Discuss issues with either ofthese processes.* ***SM received a permanent profile on XX MMM YYYY and is pending enrollment into the IDES.***

4. *Address requested TIER status. His inability to perform military duties: If Tier I:* ***Pursuant to his DA 3349 and due to their ILD condition, RANK LAST NAME was put on a six week convalesce period and is unable to perform any military duties from XX MMM YYYY through XX MMM YYYY. He/She is expected to return to duty on XX MMM YYYY and will be re-evaluated on XX MMM YYYY. ***If Tier II:* Address his demonstrated loss of earnedincome; discuss limitations, timeframe to recover, etc. ***Pursuant to their Medical Treatment Plan and employer documentation, RANK LAST NAME is unable to return to their civilian employment during this requested claimperiod. Their expected return to work date is XX MMM YYYY. They were earning $$$ a month and are currently losing $$$ a monthly due to their ILD condition. After a review of his DA 3349, they're able to perform military duties and will attend battle assembly or M-day activities.***

5. I have personally reviewed the circumstances surrounding this case and firmly believe it meets the criteria establishedby law for entitlement.

6. For additional information, please contact ***(insert appropriate POC) NAME, phone number Position Title,and Email.***

FOR THE ***(INSERT APPROPRIATE AUTHORITY LINE****if applicable****):***

4 Encls
1. LOD Determination
2. DA Forms 7574
3. Medical Documentation
4. Financial Documentation

(SIGNATURE BLOCK)