REQUEST AND CERTIFICATION FOR INCAPACITATION PAY

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.

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

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended. These records of information contained therein, may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b) as follows: Information may be provided to the Department of Veterans Affairs for the purpose of determining the service members entitlement to benefits. Note: This system of records contains individually identifiable health information. The DoD Health Information Privacy Regulation (DoD 6025.18-R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most such health information. DoD 6025.18-R may place additional procedural requirements on the uses and disclosures of such information beyond those found in the Privacy Act of 1974 or mentioned in this system of records notice.

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

SECTION I - MEMBER INFORMATION AND CLAIM STATEMENT

1. NAME	2. GRADE/RANK
3. ORGANIZATION	4. UNIT POC
5. UNIT POC EMAIL ADDRESS (.MIL)	6. UNIT PHONE NUMBER
7. HOME OF RECORD *(Include Zip Code)*	
8. DATE OF ILD INCIDENT *(YYYYMMDD)*	9. ILD DETERMINATION ☐ FORMAL ☐ INFORMAL
10. EXACT DATES OF INCAPACITATION *(Not to exceed on calendar month):* a. FROM *(YYYYMMDD)* b. TO *(YYYYMMDD)*	11. CIVILIAN JOB TITLE

12. CIVILIAN JOB TITLE

a. I HAVE EARNED _____ DURING THE CLAIM MONTH b. I HAVE LOST _____ DURING THE CLAIM MONTH

c. I HAVE PERFORMED MILITARY DUTY DURING THIS CLAIM PERIOD ☐ NO ☐ YES, DUTY TYPE _____

13. EMPLOYER INFORMATION

a. COMPANY NAME AND POC	b. TELEPHONE NUMBER	c. FAX TELEPHONE NUMBER
d. COMPANY ADDRESS (*Include Zip Code)*	e. POC EMAIL ADDRESS	

By signing below, I fully understand and agree to the following:

1. That in signing this form, I hereby voluntarily grant permission, in relevant part IAE the Privacy Act, 37 USC 204 and 10 USC 3013 to provide the government with information regarding my nonmilitary "earned income" and employment status and all medical information related to the injury, illness, or disease identified above for the purpose of substantiating the claim.
2. I swear or affirm under penalty of perjury that this information is true and accurate. I understand that filing a false claim is punishable under Article 7 of the Uniform Code of Military Justice and Title 18, Section 1001 of the United States Code. Filing a false claim for incapacitation pay or in connection with obtaining health care at a military medical facility could lead to my conviction of a felony, confinement in a federal prison for up to 5 years, a fine of $10,000 and/or discharge from military service.
3. Military duties are the duties of a Soldiers office and grade and not necessarily the skill or special qualification held prior to the ILD condition. Military duties may be assigned within the limitations of an approved medical profile (DA Form 3349, Physical Profile).

14. MEMBER CERTIFICATION

a. NAME AND GRADE/RANK	b. EMAIL ADDRESS	
c. TELEPHONE NUMBER	d. SIGNATURE	e. DATE *(YYYYMMDD)*

SECTION II - UNIT COMMANDER VERIFICATION

15. I have reviewed the ILD finding and request for incapacitation pay. The Soldier was counseled as provided in the request.

RECOMMENDATION: ☐ APPROVAL ☐ DISAPPROVAL

a. NAME AND GRADE/RANK	b. EMAIL ADDRESS	
c. TELEPHONE NUMBER	d. SIGNATURE	e. DATE *(YYYYMMDD)*

SECTION III - MILITARY MEDICAL PROVIDER

16. MILITARY MEDICAL PROVIDER DETERMINATION OF INCAPACITATION

a. ATTENDING PHYSICIAN (Last, Name, First, MI)	b. PRACTICE NAME AND ADDRESS (Incl Zip Code)	c. TELEPHONE NUMBER
CHECK ONE ☐ Civilian Provider ☐ Military Provider		
d. PERIOD COVERED BY DA FORM 3349	e. DOES PROFILE COVER LENGTH OF CLAIM? ☐ YES ☐ NO	☐ TEMPORARY ☐ PERMANENT

f. MEDICAL TREATMENT PLAN INCLUDED: ☐ YES ☐ NO

g. LIST IDENTIFIED LIMITATIONS (MILITARY OR NON-MILITARY)

h. DIAGNOSIS:

i. PROGNOSIS:

j. MEDICAL DOCUMENTATION PROVIDED NO CLEAR EVIDENCE TO SUPPORT INABILITY TO PERFORM DUTY (MILITARY OR NON-MILITARY)

MEMBER WAS UNABLE TO PERFORM MILITARY DUTIES (TIER 1) FROM _____ TO _____

MEMBER WAS UNABLE TO PERFORM NON-MILITARY DUTIES (TIER 2) FROM _____ TO _____

k. MMP NAME AND GRADE/RANK	l. MMP EMAL ADDRESS/TELEPHONE NUMBER

m. MMP UNIT	n. SIGNATURE	o. DATE

SECTION IV - CLAIM CERTIFICATION

17. Was any duty performed during claim period? ☐ NO ☐ YES, DUTY TYPE _____

18. Was member employed during claim period? ☐ NO ☐ YES

a. Gross amount nonmilitary income during claim period: _____

b. Total amount of lost nonmilitary income during claim period: _____

19. Financial Documentation to support claim (list): _____

20. Previous Pad INCAP Requests ☐ NO ☐ YES, Total Number of Months _____

a. NAME AND GRADE/RANK		b. EMAIL ADDRESS (.MIL)
c. TELEPHONE NUMBER	d. SIGNATURE	e. DATE

SECTION V - APPROVAL AUTHORITY

21. INCAP PAY PERIOD ☐ APPROVED ☐ DISAPPROVAL

a. NAME AND GRADE/RANK		b. EMAIL ADDRESS (.MIL)
c. TELEPHONE NUMBER	d. SIGNATURE	e. DATE

22. WAS CLAIM RECONSIDERED? ☐ YES ☐ NO

REMARKS

SECTION VI - APPELLATE AUTHORITY

23. INCAP PAY PERIOD ☐ APPROVED ☐ DISAPPROVAL

a. NAME AND GRADE/RANK		b. EMAIL ADDRESS (.MIL)
c. TELEPHONE NUMBER	d. SIGNATURE	e. DATE

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INSTRUCTION SHEET

All entries explained below are for electronic completion, except those specifically noted. If a computer is not available, print in black or blue-black ink ensuring a legible image on all copies.

ITEM 1. Enter fill last name, first name and middle initial.

ITEM 2. Enter grade and rank at time of incapacitation period.

ITEM 3. Enter the Soldier's current organization. Include UIC.

ITEM 4. Enter the Unit POC Name and Rank.

ITEM 5. Enter the Unit POC military issued email address.

ITEM 6. Enter the Unit POC phone number. Include extension, if applicable.

ITEM 7. Enter home of record (HOR) at time of incapacitation period. Include zip code.

ITEM 8. Enter the date of line of duty incident. Must match date on findings memo.

ITEM 9. Line of duty findings on approved ILOD memo. Indicate whether Formal or Informal.

ITEM 10. Enter dates being requested. Do not cross calendar months; not to exceed one (1) calendar month.

ITEM 11. Enter job title at time of incapacitation period.

ITEM 12a. Enter total amount of nonmilitary income earned during the claim period.

ITEM 12b. Enter total amount of nonmilitary income lost during the claim period.

ITEM 12c. Indicated whether or not military duty was performed during the claim period. This includes duty for pay or retirement points.

ITEM 13a-e. Enter information for employer at time of incapacitation period..

ITEM 14a-e. Certifies acknowledgement of Statement of Understanding. Date MUST BE the last day of the claim or later.

ITEM 15a-e. Unit Commander will recommend approval or denial of application. MUST BE the last day of the claim or later.

ITEM 16a-o. To be completed by the Incapacitation Review Board Military Medical Provider.

ITEM 17. Verification of duty performance.

ITEM 18a-b. Verification of employment.

ITEM 19. List of financial documentation submitted..

ITEM 20. Indicate whether Incapacitation Pay was previously requested and the total number of months.

ITEM 20a-e. To be completed by IRB Authority. DA Form 577 must be filed with USARC.

ITEM 21. To be completed by the appropriate Approval Authority.

ITEM 22. To be completed by the appropriate Approval Authority, if reconsideration is submitted before an appeal..

ITEM 23. To be completed by the Appellate Authority, if an appeal is submitted.