

**HAWAII ARMY NATIONAL GUARD  
DISABILITY COUNSELING STATEMENT  
IAW AR 600-8-4 (Line of Duty Policy, Procedures and Investigations)**

I, \_\_\_\_\_, understand to be eligible for continuance (Soldier's Rank/Name) of pay and allowances while disabled from an injury/aggravation/illness/disease sustained on \_\_\_\_\_ DATE \_\_\_\_\_ and if found to have incurred in line of duty by the approving authority:

**1. When seeking required follow-on medical care**

- a. \_\_\_\_\_ I must promptly notify my unit when in need of any medical or hospital care required as the result of this line of duty injury/illness.
- b. \_\_\_\_\_ I cannot seek private medical or hospital care without first requesting and receiving approval from my unit (the request will be processed by my unit for final approval through State Headquarters to NGB-ARP-H IAW AR 135-381).
- c. \_\_\_\_\_ I must report for any medical appointment scheduled by my unit or by the doctor treating my condition.
- d. \_\_\_\_\_ I must cooperate fully with the medical personnel providing treatment and follow their course of treatment.
- e. \_\_\_\_\_ I must furnish to my unit, upon completion of each of my medical appointments, documentation on the results of that appointment.

**2. When filing and in support of my claim for Incapacitation Pay and Entitlements, in accordance with AR 135-381:**

- a. \_\_\_\_\_ I must provide copies of my pay stubs if I work or receive sick or vacation pay. This statement will include amount received from each income protection plan/policy.
- b. \_\_\_\_\_ If I am employed during this period, I must provide the following: Soldier's Claim Form – Employed.
  - (1) Provide copies of my pay stubs.
  - (2) Provide a statement as to whether I have one or more income protection plans and the amount of funds received from each, on a daily or monthly basis.
- c. \_\_\_\_\_ If I am self-employed during this period I must provide the following: Soldier's Claim Form – Self-Employed.
  - (1) Provide a statement of income.
  - (2) Provide a statement as to whether I have one or more income protection plans and the amount of funds received from each, on a daily or monthly basis.

(3) Provide a copy of my latest Internal Revenue Service tax forms to include Schedule C and all attachments.

d. \_\_\_\_\_ If I am unemployed, I will provide a statement indicating I have not earned any income from any source. (Soldier's Claim Form – Unemployed)

(1) Provide a statement from the State of Hawaii, Department of Labor – Unemployment Insurance Division certifying your unemployment claim.

(2) Provide proof of disbursement of unemployment insurance income.

e. \_\_\_\_\_ Any money received by me from an insurance company (Third Party Claim) will be reported through channels to the State Judge Advocate.

f. \_\_\_\_\_ I cannot expect any incapacitation benefits until my unit has received the approved Line of Duty. This may be six weeks after the investigation is initiated and forwarded from my unit. Questions regarding this Line of Duty will be addressed through my chain of command.

g. \_\_\_\_\_ I understand I am not on active duty while incapacitated. I will not accrue leave nor receive active duty retirement points for the duration of this period and will not receive ADT/IDT/AT pay with incapacitation benefits.

h. \_\_\_\_\_ I authorize and request the Veteran's Administration, my civilian physician, the civilian hospital, or any other facility providing care release any and all medical records, examinations, treatments/treatment plans, and summaries associated with the date referenced above to my State Adjutant General.

i. \_\_\_\_\_ I understand that failure to fulfill the above requirements may result in termination of my entitlements to pay and allowances and medical care for this disability.

j. \_\_\_\_\_ I acknowledge that the penalty for willfully making a false claim is a maximum fine of \$10,000; imprisonment for 5 years, or both. (Section 287.1001, Title 18, USC)

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Soldier's Signature

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Date

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Rank/Name of Counselor

Distribution:

Original – Unit

Copy – Individual

Copy – INCAP Pay Request