ELIGIBILITY QUESTIONNAIRE FOR HAVANA ACT PAYMENTS

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The public reporting burden for this collection of information is estimated to average 30 minutes per response, 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 the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.
PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITIES: The information sought is pursuant to the Further Consolidated Appropriations Act of 2020 and the HAVANA Act of 2021 (22 U.S.C. 2680b).

PURPOSE: The information collected on this form will assist the Department of Defense in determining whether a board-certified neurologist has verified that a patient under their care has been reviewed for the appropriate medical eligibility criteria for potential payment under the HAVANA Act.

ROUTINE USES: To the Department of State, as appropriate in evaluating whether an incident is an “other incident” for purposes of establishing a qualifying injury or should be so designated. Other incident is a new onset of physical manifestations that cannot otherwise be readily explained that is designated under 22 U.S.C. 2680b. More information on routine uses associated with this collection can be found at DHRA 23, Defense Civilian Human Resource Management System (DCHRMS), which can be accessed at **https://dpcld.defense.gov/Privacy/SORNs/**

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in a delay or denial of eligibility for payment authorized under the HAVANA Act.

Section I: Patient Demographics *(Patient Only)*

INSTRUCTIONS
This form is for current and former Department of Defense employees and dependents of current and former Department of Defense employees. Complete Section I and bring this form to a neurologist or physician board-certified by the American Board of Psychiatry and Neurology, American Board of Physical Medicine and Rehabilitation, American Osteopathic Board of Neurology and Psychiatry, or the American Osteopathic Board of Physical Medicine and Rehabilitation along with any other medical records that may assist with determining a qualifying injury. Individuals submitting this form for themselves please complete Blocks 1-12. Individuals submitting this form on behalf of the requester please complete Blocks 1-16 and provide proof of your relationship to the requester. Once complete, this form and any other required documentation should be sent to: **dodhra.mc-alex.dcpas.mbx.dod-havana-act@mail.mil** for processing.

1. Last Name	2. First Name	3. Date of Birth *(mm-dd-yyyy)*

4. Email Address	5. Phone Number
6. Employer	7. Employment Status
8. Location of Incident	9. Date of Incident (estimated *mm-yy*, if unknown)

10. Requested Benefit Level *(Select One)* ☐ Base ☐ Base Plus

☐ I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in Section I (Patient Demographics) is true and correct, and I understand that any falsification of information is punishable under the provisions of 18 U.S.C. § 1001 by a fine, imprisonment of not more than five years, or both, and that requesting or obtaining any record(s) under false pretense is punishable under the provisions of 5 U.S.C § 552a(i)(3) by a fine of not more than $5,000.

11. Signature of Individual Submitting Form	12. Date of Signature *(mm-dd-yyyy)*
13. Name of Individual Filing on Behalf of Requester	14. Relationship to Requester
15. Contact Phone Number	16. Contact Email Address

Section II: Qualifying Brain Injury Questionnaire *(Physician Only)*

INSTRUCTIONS
This section is only to be completed by a physician currently certified with the American Board of Psychiatry and Neurology (ABPN), the American Board of Physical Medicine and Rehabilitation (ABPMR), the American Osteopathic Board of Neurology and Psychiatry (AOBNP), or the American Osteopathic Board of Physical Medicine and Rehabilitation (AOBPMR), who has a history of providing medical care for this patient. Please review the following statements, any pertinent medical records, and provide your signature below. Once completed, scan this document and send as an attachment to **dodhra.mc-alex.dcpas.mbx.dod-havana-act@mail.mil**

DISCLAIMER: No SSN or classified information will be collected on this form.

1. ☐ Yes ☐ No	Did the individual experience an acute injury to the brain such as, but not limited to, a concussion, penetrating injury, or as the consequence of an event that leads to permanent alterations in brain function as demonstrated by confirming correlative findings on imaging studies (to include Computer Tomography scan (CT), or Magnetic Resonance Imaging scan (MRI), or Electroencephalogram (EEG)?
2. ☐ Yes ☐ No	Did the individual receive a medical diagnosis of a Traumatic Brain Injury (TBI) that required active medical treatment for 12 months or more?
3. ☐ Yes ☐ No	Did the individual experience an acute onset of new persistent, disabling neurologic symptoms as demonstrated by confirming correlative findings on imaging studies (to include CT or MRI), or EEG, or physical exam or other appropriate testing, and that required active medical treatment for 12 months or more?
4. ☐ Yes ☐ No	Did the injury occur on or after January 1, 2016?
5. ☐ Yes ☐ No	Do you have evidence or otherwise believe that the symptoms can be attributed to a pre-existing condition or other cause?
6. ☐ Yes ☐ No	Does the individual require a full-time caregiver for activities of daily living, as defined by the Katz Index of Independence of Daily Living?

The signature below attests that the certifying physician is currently certified with the ABPN, the ABPMR, the AOBNP, or the AOBPMR, and solemnly affirms that it is their clinical opinion based on their knowledge, education, and belief that the information above is correct.

Printed Name of Physician	Street Address, City, State and Zip Code
Signature of Physician	Date *(mm-dd-yyyy)*
Email Address	Phone Number

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) STATEMENT

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. For the provider completing this form, do not provide any genetic information when responding to this request for medical information. Genetic Information, as defined by GINA, includes the following: an individual's family medical history; the results of an individual's or family members' genetic tests; the fact that an individual or an individual's family member sought or received genetic services; and genetic information of a fetus carried by an individual, or an individual's family member, or an embryo lawfully held by an individual or family member receiving assistive reproductive services.