U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, D.C. 20210

Dear Claimant,

Our records indicate that you recently submitted an initial claim for home health care to the Division of Energy Employees Occupational Illness Compensation (DEEOIC). We are very interested in receiving feedback on your experience with DEEOIC. Your participation in the enclosed Customer Experience and Equity Surveys will help us improve the claimant/customer experience.

We appreciate your assistance in helping us determine what is working and what may be improved. The following survey is confidential. Please return this survey using the enclosed postage paid envelope by 12/31/2022.

Thank you for your participation.

Stakeholder Engagement
Branch of Outreach and Technical Assistance
Division of Energy Employees Occupational Illness Compensation

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U.S. Department of Labor

Office of Workers' Compensation Programs
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Over →

CUSTOMER EXPERIENCE SURVEY

Please agree or disagree with the following statements by circling a numerical response:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
The process leading up to receiving a decision on my initial home health care claim increased my trust in the Division of Energy Employees Occupational Illness Compensation (DEEOIC).	5	4	3	2	1	n/a
I am satisfied with the service I received from DEEOIC related to my home health care claim.	5	4	3	2	1	n/a
My questions about home health care have been answered throughout the process.	5	4	3	2	1	n/a
It was easy to complete what I needed to do to receive a decision on my home health care claim.	5	4	3	2	1	n/a
It took a reasonable amount of time to receive a decision on my home health care claim.	5	4	3	2	1	n/a
I understood what was being asked of me throughout the process.	5	4	3	2	1	n/a
The employees I interacted with were helpful.	5	4	3	2	1	n/a

Do you have additional feedback related to your experience filing for home health care?

Would you like to speak with our Customer Experience Team regarding your experience filing your initial home health care authorization?

Yes ☐ No ☐

If yes, please provide your name and telephone number:

Name:______________________________

Phone:______________________________

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The OMB control number for this collection is 1225-0093 and expires on 02/29/2024. According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless such collection displays a valid OMB control number. The obligation to respond to this collection is voluntary. We estimate it takes about 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information. Please send comments regarding the burden estimate or any other aspect of this collection of information to the U.S. Department of Labor, *DEEOIC, 200 Constitution Ave., NW, Room C-3510, Washington, D.C. 20210* and reference OMB Control Number 1225-0093.

Note: Please do not return the completed form to this address.

OMB Control Number: 1225-0093
Expiration Date: 02/29/2024

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EQUITY ASSESSMENT

Creating equity in our program means recognizing that different people have different circumstances. Some people face conditions and circumstances that make it more difficult to achieve the same goals.

"Equity data" describes aspects of your personal identity. DEEOIC does not collect this type of data, however we want to know if you feel like your own personal circumstances have made it difficult for you to navigate this program.

OWCP/DEEOIC is committed to finding ways to focus on equity for all, including people who have been historically marginalized or adversely affected by inequality. We strive to best serve all our customers, including racial and ethnic minorities, persons with disabilities, the LGBTQ+ community, rural communities, and other underserved populations. We want to improve program accessibility and inclusion.

Keeping the above information in mind, please indicate if you've experienced challenges with our program because of your:	
Ability or disability status	☐
Racial or ethnic identity	☐
Age	☐
Sex/Gender identity	☐
Sexual orientation	☐
Veteran status	☐
Religion	☐
Social class	☐
Geographic location (rural/remote)	☐
Other________________	☐

Based on your selection(s) to the left, how can DEEOIC better address your specific needs?

Please agree or disagree with the following state-ments by circling a numerical response:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
I feel comfortable talking with DEEOIC representatives about the unique issues I face.	5	4	3	2	1	n/a
I am treated fairly by DEEOIC representatives.	5	4	3	2	1	n/a
I am able to find and access the correct information and tools from DEEOIC to achieve my goals.	5	4	3	2	1	n/a

CLOSED

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