U.S. Department of Labor
Office of Workers' Compensation
Division of Coal Mine Workers' Compensation

Reset Print

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REPRESENTATIVE PAYEE REPORT

INSTRUCTIONS

This is your Representative Payee Report. You are required to file it when the beneficiary dies, when you are no longer serving as the beneficiary's representative payee, or at OWCP's request. **You must complete and return the report** whether you are the beneficiary's relative, friend, or court appointed guardian, or you are an official of a bank or a public or private agency or institution. You should keep a record of the amount of benefits you received and how you used them, because the report will be reviewed by the U. S. Department of Labor and is subject to verification. You will be notified if verification is required. DO NOT submit receipts, canceled checks, etc., with this report. If you need help completing the report, please call your nearest Black Lung Office at the toll-free 800-number shown in the list below. This report must be completed and returned within 30 days.

YOUR JOB AS A REPRESENTATIVE PAYEE

Your job as a representative payee is to use the Black Lung benefits you receive for the personal care and well-being of the beneficiary. You must keep yourself informed of the beneficiary's needs so you can decide how the benefits should be used. **You must** notify the U.S. Department of Labor when the beneficiary changes residence or if you no longer exercise responsibility for the care and welfare of the beneficiary. **You must** report the beneficiary's death, marriage, adoption, employment, or release from a hospital or institution. **You must** also report the beneficiary's receipt of any State Workers' Compensation Benefits and changes in school attendance or disability status, if the person for whom you receive benefits is a student or disabled.

NOTICE

If you misuse benefits received as a representative payee, you may be convicted of a felony and fined under Title 18, U.S.C., or imprisoned for not more than 5 years, or both. The court may also order restitution. 42 U.S.C. 408, incorporated by 30 U.S.C. 923(b), 940.

BLACK LUNG DISTRICT OFFICES TOLL-FREE NUMBER
1-800-347-2502

Greensburg, PA	Johnstown, PA
Charleston, WV	Pikeville, KY
Denver, CO	Columbus, OH

PRIVACY ACT NOTICE

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) the Black Lung Benefits Act (BLBA) (30 U.S.C. 901 et seq.), as amended, is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor, which receives and maintains personal information, relative to this application, on claimants and their immediate families; (2) information obtained by OWCP will be used to determine eligibility for benefits payable under the BLBA; (3) information may be given to other government agencies, coal mine operators potentially liable for payment of the claim or to the insurance carrier or other entity which secured the operator's compensation liability, contractors providing automated data processing services to the Department of Labor; and representatives of the parties to the claim; (4) information may be given to physicians or other medical service providers for use in providing treatment, making evaluations and for other purposes relating to the medical management of the claim; (5) information may be given to the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matters arising in connection with the claim; (6) information may be given to Federal, state or local agencies for law enforcement purposes, to obtain information relevant to a decision under the BLBA, to determine whether benefits are being or have been paid properly, and where appropriate, to pursue administrative offset and/or debt collection actions required or permitted by law; (7) disclosure of the claimant's or deceased miner's Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary, and the SSN and/or TIN and other information maintained by the OWCP may be used for identification and for other purposes authorized by law; (8) failure to disclose all requested information, may delay the processing of this claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits; and (9) this information is included in a System of Records, DOL/OWCP-2 published at 81 Federal Register 25765, 25858 (April 29, 2016) or as updated and republished.

PUBLIC BURDEN STATEMENT

We estimate that it will take an average of 90 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, N.W., Suite C3520-DCMWC Washington, D.C. 20210.
DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims staff to ask about this assistance.

REPRESENTATIVE PAYEE REPORT

This report is for the period from: _____ To: _____

IDENTIFYING INFORMATION
DEPARTMENT OF LABOR USE ONLY

Name and address of representative payee:

_____

_____

_____

Name and address of beneficiary:

_____

_____

_____

DOL's Case ID Number: _____

1a. Show below all places where the beneficiary lived during the report period shown above. (Check appropriate box and supply information.)

☐ With you ☐ With a relative (answer 1b.) ☐ With an unrelated person (answer 1b.)
☐ In a public institution: hospital, home for aged, nursing home, etc. (answer 1b.)

1b. Give the name and address of each person with whom the beneficiary lived.

Name and Address

_____

_____

_____

Date of residence:
From: _____
To: _____

Name and Address

_____

_____

_____

Date of residence:
From: _____
To: _____

2. How did you find out what the beneficiary's needs were, if the beneficiary did not live with you?

_____

3. Do you maintain contact with the beneficiary by:

Same household	Visit	Telephone	Letter
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. Funds on hand from Black Lung benefits at beginning of this report period. If you have filed a previous U.S. Department of Labor Black Lung Representative Payee accounting report, this amount should be the same as the figure shown on your last report (item #9) as remaining balance.

5. Total Black Lung benefits received during the reporting period:

6. Total Black Lung funds available during this reporting period: (Item #4 plus #5)

7. How available Black Lung benefits were used during the reporting period:

a. Amount used for beneficiary's food and shelter: (Show in "REMARKS" section of this report the name and address of the any person or entity receiving food and shelter payments.)

b. Amount used for beneficiary's clothing:

c. Amount used for beneficiary's medical and dental care:

d. Amount used for personal needs of the beneficiary:

e. Amount used for support of beneficiary's dependents:

f. Amount used for other items: (show purpose for which funds were used in "REMARKS" section of this report)

8. Total amount used during the reporting period (Add 7a through 7f)

9. Balance remaining at the end of this period (item 6 minus 8)

10. How is balance of the funds, shown in item #9, held, saved, or invested?

	AMOUNT	Name(s) that appears on each account.*
Cash		
Checking Account		
Insured savings account		
U.S. Savings Bonds		
Other (Specify) _____		

* Specify who's name(s) appear on each account, i.e., "Your name for beneficiary", "Beneficiary's name by your name'', "Your name on-behalf-of (OBO) beneficiary", etc.

NOTE: Benefits must be held in an account which shows that the money belongs to the beneficiary. If you are not sure whether the account you have established shows this ownership, you should consult your bank and, if necessary, change the account title appropriately.

11. If all benefits listed in item #6 of this report were held, saved, or invested, please explain how the beneficiary's needs were met:

12. During this period, did the beneficiary have any benefits/income other than U.S. Department of Labor Black Lung Benefits?

☐ Yes ☐ No If yes, indicate the sources of the income:

Source: _____ Frequency of Payment _____ Amount:

Source: _____ Frequency of Payment _____ Amount:

Source: _____ Frequency of Payment _____ Amount:

Source: _____ Frequency of Payment _____ Amount:

13. Have you ever been convicted of a felony?

☐ Yes ☐ No If yes, explain below in remarks section.

Remarks

If you misuse benefits received as a representative payee, you may be convicted of a feloney and fined under Title 18, U.S.C., or imprisoned for not more than 5 years, or both. The court may also order restitution. 42 U.S.C. 408, incorporated by 30 U.S.C. 923(b), 940.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN ON THIS FORM IS TRUE

SIGNATURE OF PAYEE (if signed by mark (X), two witnesses must sign below)		TELEPHONE NUMBER (include area code) Business
RELATIONSHIP TO BENEFICIARY OR TITLE	Date	Home

WITNESS SIGNATURES ARE REQUIRED ONLY IF THE PAYEE's SIGNATURE ABOVE HAS BEEN SIGNED BY MARK (X)

SIGNATURE OF WITNESS	DATE:	SIGNATURE OF WITNESS	DATE: