

**U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation
Division of Coal Mine Workers' Compensation**



**OMB No.: 1240-0020
Expires: 05/31/2024**

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 OFFICE TOLL-FREE NUMBERS

Greensburg, PA	800-347-3753	Johnstown, PA	800-347-3754
Charleston, WV	800-347-3749	Parkersburg, WV	800-347-3751
Mt. Sterling, KY	800-366-4628	Pikeville, KY	800-366-4599
Denver, CO	800-366-4612	Columbus, OH	800-347-3771

PRIVACY ACT NOTICE

The following statement is made in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. (1) Submission of this information is required by law (30 U.S.C. 922, and 20 CFR 725.513). (2) The information you furnish on this form may be used by other Government agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim including potentially liable coal mine operators and their insurance carriers; contractors providing automated data processing services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies in obtaining information about eligibility for benefits. (3) The Information may be disclosed to comply with Federal laws requiring the release of information from our records; or to conduct research and audit activities needed to assure the continuing integrity and improvement of the U.S. Department of Labor representative payee program. (4) 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, Room N-3464, 200 Constitution Avenue, N.W., 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.

CM-623 (05/2021)

REPRESENTATIVE PAYEE REPORT

This report is for the period from : 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 Yes No | Visit Yes No | Telephone Yes No | Letter 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", please indicate the source 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 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.

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)

RELATIONSHIP TO BENEFICIARY OR TITLE

Date

Business

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