DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECOMMENDATION FOR CASH AWARD

I. EMPLOYEE DATA *(If individual award, complete Items 1-11, as appropriate. If group award, complete Items 1 and 5-11, as appropriate. For group award, list the name, SSN, and amount recommended for each employee on a separate sheet and attach to this form.)*

1. Name of Individual *(Last, First, MI)*		**Name of Group**	**2. Social Security Number**
3. Pay Plan/Series/Grade	**4. Salary**	**5. Organization** (OPDIV, Office, Division, etc.)	
6. Name of awards coordinator or individual responsible for distributing the check.			**Phone Number**

II. SYSTEM INPUT DATA (TO BE COMPLETED BY PERSONNEL OFFICE)

A. NOAC	**B. Effective Date**	**C. Legal Authority Code**
D. Award Amount *(Enter amount from Block 13)*	**E. Benefit Amount**	**F. Individual/Group Award Code**

III. TYPE OF AWARD

7a. Performance Award *(Do not attach performance appraisal) (check one)*	**b. Based on rating of** *(check one)*	**c. Date Rating Finalized** *(mm,dd,yyyy)*
☐ PMRS (GM) ☐ EPMS (GS/FWS)	☐ Level 5 (Outstanding) ☐ Level 4 (Excellent) ☐ Level 3 (Fully Successful)	
8. Special Act or Service Award*	**9. Suggestion Award***	**10. Invention Award***
Period covered (mm,dd,yyyy): FROM: _____ TO: _____	Suggestion number: _____	_____ Patent number _____ Date application filed _____ Date patent issued

Benefits *(Complete for special act or service, suggestion, or invention, as appropriate)*

a. Benefit amount (tangible savings): $ _____

b. Intangible savings *(check appropriate box in (1) and (2))*

(1) Value of Contribution	(2) Extent of Application
☐ Moderate	☐ Limited
☐ Substantial	☐ Extended
☐ High	☐ Broad
☐ Exceptional	☐ General

*(See HHS Instruction 451-1, Incentive Awards, for required documentation to attach to this form)

IV. AWARD RECOMMENDATION AND APPROVAL

ACTION	NAME/TITLE	SIGNATURE	DATE	AMOUNT
11. Initiating Official				
12. Concurring Officials				
13. Approving Official				
14. Signature of Fiscal Officer Obligating Funds		**15. Appropriation/CAN Numbers**		**Date**
16. Signature of Reviewing Personnel Office Official				**Date**

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(l), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.