PHS-1637-1
REV. 8/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE COMMISSIONED OFFICER'S REQUEST FOR DEPENDENCY DETERMINATION

PAYROLL USE ONLY

SOCIAL SECURITY NUMBER (SSN)	NAME *(LAST, FIRST, MIDDLE INITIAL)*	DATE OF LAST ENTRY ON ACTIVE DUTY *(IF RETIRED, LIST DATE OF RETIREMENT INSTEAD)*

CURRENT PAY GRADE	CURRENT DUTY STATION *(IF RETIRED, LIST CURRENT MAILING ADDRESS AND ZIP CODE)*	DUTY STATION TELEPHONE *(IF RETIRED, LIST CURRENT HOME PHONE AND AREA CODE)*
		( )

1. PURPOSE ☐ Establish Initial Dependency ☐ Re-Certification of Dependency Date of Last Certificate _____

DEPENDENCY INFORMATION

2. MARITAL STATUS ☐ Married *(Includes Separated)* ☐ Single *(Includes Widowed)* ☐ Divorced

3. a. I hereby claim the following dependents effective: _____ *(See Notes 1, 2, and 3)*

b. NAME(S) OF DEPENDENT(S) *(Last, First, Middle Initial)*	COMPLETE ADDRESS *(Include Zip Code)*	RELATIONSHIP	DATE OF BIRTH

DATE AND PLACE OF PRESENT MARRIAGE	IF THIS IS THE FIRST TIME YOU HAVE CLAIMED AN ADOPTED CHILD, SHOW DATE OF ADOPTION AND ADDRESS OF COURT ISSUING DECREE *(See Note 1)*

4. IF ANY CHILD(REN) NAMED ABOVE IS (ARE) NOT IN YOUR LEGAL CUSTODY, COMPLETE THE FOLLOWING:

NAME(S) OF CHILD(REN)	NAME AND ADDRESS OF PERSON HAVING LEGAL CUSTODY	AMOUNT OF YOUR MONTHLY CONTRIBUTION FOR SUPPORT OF CHILD(REN)
RELATIONSHIP OF CUSTODIAN TO CHILD(REN)		IF SUPPORT OF CHILD(REN) IS REQUIRED BY COURT ORDER OR DIVORCE DECREE, SHOW AMOUNT OF SUPPORT REQUIRED *(See Note 1)*

5. COMPLETE THIS SECTION ONLY IF DEPENDENT(S) LISTED IN ITEM 3 ABOVE ARE OTHER THAN YOUR LAWFUL SPOUSE AND/OR UNMARRIED CHILD(REN) UNDER 21 YEARS OF AGE: *(See Note 2)*

NAME(S) OF DEPENDENT(S)	MONTHLY AMOUNT OF CONTRIBUTION	DEPENDENT'S INCOME FROM OTHER SOURCES	DEPENDENT'S MONTHLY EXPENSES

I ☐ did ☐ did not claim the above-named dependent(s) on my Federal Income Tax return for the past calendar year. INTERNAL REVENUE OFFICE AT WHICH LAST FEDERAL INCOME TAX RETURN WAS FILED.

REASON DEPENDENT(S) WAS (WERE) NOT CLAIMED FOR FEDERAL INCOME TAX PURPOSES:

FOR UNMARRIED CHILD OVER 21 YEARS OF AGE EITHER PHYSICALLY OR MENTALLY HANDICAPPED, ATTACH A STATEMENT FROM A PHYSICIAN SHOWING HOW LONG THE CHILD HAS BEEN UNDER A PHYSICIAN'S CARE AND THE CAUSE AND DEGREE OF INCAPACITATION. IF THE CHILD IS IN THE CUSTODY OF SOMEONE OTHER THAN THE OFFICER, A STATEMENT SIGNED BY THE CUSTODIAN SHOWING AMOUNT OF OFFICER'S CONTRIBUTION AND ACTUAL MONTHLY EXPENSES OF THE CHILD IS ALSO REQUIRED.

6. IF DIVORCED, SHOW THE FOLLOWING:

DIVORCE DECREE GRANTED BY *(Court, State, Date):* *(See Note 1)*	ADDRESS OF FORMER SPOUSE *(Include Zip Code)*	TYPE OF DECREE: ☐ Final ☐ Interlocutory
FULL NAME OF PERSON FORMER SPOUSE REMARRIED		Date Decree is Final: _____

7. HAVE ANY OF THE ABOVE-NAMED DEPENDENTS SERVED AS A MEMBER OF THE UNIFORMED SERVICES OR PARTICIPATED IN FULL-TIME DUTY SINCE YOUR DATE OF LAST ENTRY ON ACTIVE DUTY? ☐ Yes ☐ No IF "Yes," COMPLETE THE FOLLOWING:

NAME(S) OF DEPENDENT(S)	SSN OF DEPENDENT(S)	BRANCH OF SERVICE	PERIOD OF SERVICE	DUTY STATION
			From: _____ Through: _____	

8. DID THE DEPENDENT(S) LISTED IN ITEM 3 ABOVE, OCCUPY GOVERNMENT QUARTERS OR HOUSING FACILITIES WITHOUT CHARGE EXCEPT FOR BRIEF PERIODS IN QUARTERS ASSIGNED TO ANOTHER UNIFORMED SERVICE MEMBER FROM THE EFFECTIVE DATE SPECIFIED ABOVE?
☐ Yes ☐ No IF "Yes," COMPLETE THE FOLLOWING:

NAME(S) OF DEPENDENT(S)	FROM:	TO:	LOCATION OF QUARTERS:

9. **IMPORTANT: Making a false statement or claim against the U.S. Government is punishable by fine of not more than $10,000 or imprisonment for not more than 5 years, or both (18 U.S.C. 287 and 1001).**

10. I will immediately notify the Office of Commissioned Corps Support Services, ATTN: Compensation Branch, Room 4-50, 5600 Fishers Lane, Rockville, MD 20857-0001, of any change in the dependency status of my dependent(s) OR if I am assigned to or released from assignment to Government quarters. I certify that the facts I have stated in connection with this request are true and correct to the best of my knowledge.

CURRENT DATE	SIGNATURE OF OFFICER

NOTE: 1. Attach a copy of the court order or divorce decree if this is your first certificate or if the adoption/divorce has occurred subsequent to the date of your last certificate.
2. A complete form PHS-1637-2, *"Parent's/ Parent-In-Law's Dependency Statement,"* must be attached to this form if you claim a parent / parent-in-law as a dependent.
3. A complete form PHS-1637-4, *"Child's Dependency Statement,"* must be attached to this form if you claim a child(ren) and are divorced / separated from the child(ren)'s other parent.

PSC Media Arts (301) 443-1090 EF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE COMMISSIONED CORPS

INSTRUCTIONS FOR COMPLETING FORM PHS-1637-1

GENERAL: Read the instructions and Privacy Act statement below before completing the form. All responses should be typed or printed in ink. Submit completed form to:

Office of Commissioned Corps Support Services
ATT: Compensation Branch
5600 Fishers Lane, Room 4-50
Rockville, MD 20857-0001

HEADING: Applicable to all Public Health Service (PHS) Commissioned Corps officers. Self-explanatory.

Item 1: Place an "X" in the box(es) which identifies the action(s) being requested.

Item 2: Self-explanatory.

Item 3: a. Effective date to be entered is the latest of the following dates:
1. call to active-duty date;
2. date of marriage;
3. date individual became an eligible dependent pursuant to established policy;
4. date Government quarters were terminated; or
5. if the purpose of submitting the form is "Recertification" and the last digit of your SSN is 1, enter "1 Jan _____ (year)"; 2, enter "1 Feb _____ (year)"; 3, enter "1 Mar _____ (year)"; 4, enter "1 Apr _____ (year)"; 5, enter "1 May _____ (year)"; 6, enter "1 Jun _____ (year)"; 7, enter "1 Jul _____ (year)"; 8, enter "1 Aug _____ (year)"; 9, enter "1 Sep _____ (year)"; 0, enter "1 Oct _____ (year)".

b. Enter all eligible dependents. If the address is the same for all dependents, list only once. If additional space is required, identify dependents on a separate sheet of paper and attach the paper to this form. Include sponsor's name and SSN.

Item 4: Complete only if child(ren) listed in Item 3 is/are not in the officer's legal custody.

Item 5: Complete only if dependent(s) listed in Items 3 is/are other than the officer's legal spouse and/or dependent child(ren) under 21 years of age. Dependent's income from other sources must include all wages, compensation, pensions, annuities, alimony, retirement benefits, and the reasonable value of gifts and contributions received from others. Dependent's monthly expenses should only reflect the dependent's average living expenses during the past calendar year which can be documented. You may include a reasonable value for quarters and/or subsistence furnished by someone other than the dependent. (Reference Commissioned Corps Personnel Manual, Subchapter CC22.)

Item 6: Complete only if divorced and dependent(s) is/are identified in Item 3.

Item 7: Complete only if dependent(s) is/are listed in Item 3. The uniformed services include the Army, Navy, Air Force, Marines, Coast Guard, Commissioned Corps of the National Oceanic and Atmospheric Administration, and PHS Commissioned Corps.

Item 8: Self-explanatory.

Item 9: Self-explanatory.

Item 10: Self-explanatory.

PRIVACY ACT NOTICE FOR PHS COMMISSIONED OFFICER'S REQUEST FOR DEPENDENCY DETERMINATION FORM PHS-1637-1

This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). Our authority to collect this information is 37 U.S.C. 403; 42 U.S.C. 202 et seq.; and Executive Order 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

The information provided on this form will become part of record systems 09-40-0001, "PHS Commissioned Corps Personnel Records," HHS/PSC/HRS and 09-40-0010, "Pay, Leave, and Attendance Records," HHS/PSC/HRS.

PRINCIPAL PURPOSE AND ROUTINE USES - This information is used to determine whether an individual's dependency on a PHS commissioned officer entitles the officer to additional Basic Allowance for Housing (BAH). This information will be used only as necessary in personnel and pay administration processes carried out in accordance with established regulations and published notices of systems of records. Copies of these systems of records may be obtained by contacting the office to which you submit this form.

EFFECTS OF NONDISCLOSURE - Disclosure of the Social Security Number (SSN) is mandatory under provisions of Executive Order 9397 to obtain benefits and services as or on behalf of a commissioned officer. The SSN is also used to distinguish a record from those of commissioned officers who may have similar names and dates of birth. Failure to provide the remaining information will result in denial of this claim, delay and/or errors in determining dependency, late payment or non-payment, or refund of BAH if payment is based on erroneous information. All statements are subject to verification.