

INSTRUCTIONS FOR COMPLETION OF ADM4310
INITIAL APPLICATION FOR DISABILITY LEAVE BENEFITS APPLICATION

This form is used only for an initial filing of disability benefits. If you are filing supplemental information for an extension of disability benefits, use form *ADM4311*.

COMPLETION OF FORM

- Type or print legibly.
- All sections of application must be completed.
- You are responsible for completing the Employee Statement, pages 2 and 3.
- Your physician is responsible for completing the Attending Physician Statement, pages 4 and 5.
- You are responsible for returning **all five (5) pages** of the form to your agency within **twenty (20) calendar days of the last day worked**.*
- You are responsible for any fee the physician may charge for completing the form.

PERSONAL DATA

- You must notify your supervisor of your absence and the expected date of your return to work.

WAITING PERIOD

- If approved for benefits, you must serve a mandatory waiting period before receiving benefits.

WORK RELATED CLAIMS

- You are required to file a claim for lost time wages directly with the Bureau of Workers' Compensation (BWC).
- Disability benefits are not payable for any work-related injury except:

(1) If your initial application for lost time wages is denied by BWC and you do not appeal the BWC order. You must submit a copy of the BWC denial with the disability application.

(2) If your initial application for lost time wages is denied by BWC and you appeal the BWC order, you may receive an advancement of disability benefits. You must submit the following with the disability application:

- a copy of the BWC denial order
- a completed Disability Agreement, *FORM4313*
- a copy of your Accident or Illness Report, *FORM4303*
- a copy of your Request For Temporary Total Compensation, *Form C- 84*

CONFIDENTIALITY

- Claim must be submitted to your agency.
- Claim information submitted directly to Benefits Administration Services will be forwarded to your personnel office.
- Your personnel office is required to keep all information about the nature of your illness/injury confidential.

PHYSICIAN INSTRUCTIONS

- Type or print legibly.
- Complete pages 4 and 5 without expense to the state of Ohio.
- Complete each section as thoroughly as possible.
- Attending physician should retain a **copy** of all 5 pages of form.
- The employee is responsible for returning the entire form to their personnel office within (20) twenty calendar days of the date the employee last worked.* **Failure to do so may result in denial of your patient's benefits.**

Disability benefits for State employees are authorized in Administrative Rules 123:1-33-12 through 123:1-33-16, 123:1-33-07 and the bargaining unit contracts.

Information about the Disability Leave Program is available in your *State of Ohio Employee Benefits Handbook* or on the benefits Web site: <http://www.state.oh.us/das/dhr/benindex.html>

*applications for employees covered under AFSCME 45, AFSCME 50, FOP 46 and FOP 48 must be received by the agency within forty-five (45) calendar days of the last day worked

Application for Disability Leave Benefits

Employee Statement

Please read ALL instructions on page 1 of the application before completing this application

PERSONNEL OFFICE USE ONLY
Date Employee's Statement Received in Office (Date Stamp Preferred)

Employee Name				Social Security Number	
Address		Street	City	State	Zip
Telephone (area code)		Home ()		Work ()	
E - Mail address					
Agency			Classification (job title)		
Date accident or illness began		Date became disabled		Date last worked	Date of first treatment
Date of most recent treatment				Date of next appointment with physician(s)	
Describe your disability					
Was disability due to an injury?		If yes, date of injury		How and where did accident happen?	
Yes ___ No ___					
List of all physicians treating you for this condition					
Name		Specialty		Telephone (area code)	Fax (area code)
Have you been hospitalized for this illness?		If yes, give name of hospital & city			Date(s) of confinement
Yes ___ No ___					
Additional hospitalizations/urgent care/emergency room visits/dates for this illness					

Employee Name _____		Social Security Number _____
Was your current illness/injury received in the course of and arising out of your employment with the State of Ohio, or any other employer? Yes _____ No _____		
Have you ever applied for workers' compensation benefits involving the same part of body as your current illness/injury or for a condition in any way related to your current illness/injury? Yes _____ No _____ If yes, provide		
BWC claim Number (s) _____		
Date (s) of illness/injury (s) _____		
Is your current illness/injury a reoccurrence of a previous illness/injury listed above? Yes _____ No _____	If yes, did you receive any lost time wage from BWC? Yes _____ No _____	
Have you filed a BWC claim for your current condition? Yes _____ No _____	Are you filing a BWC claim for your current condition? Yes _____ No _____	
Have you returned to work?	If yes, give date _____	If no, what date do you expect to return? _____
Are you returning to work part-time and applying for disability benefits on a part time basis?		Yes _____ No _____
Have you engaged in any occupation for wage or profit since the onset of your disability?		Yes _____ No _____
If yes, for whom:		
Name: _____	Address: _____	Phone: _____
Would you like to supplement disability by utilizing available leave time? Yes _____ No _____		
If yes, list type of leave you want to use _____		
EMPLOYEE CERTIFICATION/AUTHORIZATION FOR RELEASE OF INFORMATION		
<p>I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Department of Administrative Services or its representative and state agencies involved with my return to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize the Department of Administrative Services or its representative to release any such information it receives to my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in and state agencies involved with my return to work or claim for disability benefits. I understand my health plan, the state's mental health vendor, United Behavioral Health (UBH), state agencies or other party acting as a representative for the state may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall be valid as the original. I understand that it is my responsibility under ADA to contact my employer if I wish to apply for reasonable accommodations under ADA or to obtain information about my rights under ADA.</p>		
<p>I have read and understand the instructions on page 1 of this application. I certify that the above statements are true to the best of my knowledge and understand any misrepresentation on my part may result in the denial of my benefits.</p>		
This authorization will be valid for 180 days from date of signature.		
Date _____	Employee Name _____	

Please Note: Employee is responsible for returning pages 2, 3, 4 and 5 of this form to employing agency. Claim information submitted directly to Benefits Administration Services will be forwarded to the employee's personnel office. The personnel office is required to keep all information about the nature of the illness/injury confidential.

Application for Disability Leave Benefits

Attending Physician Statement

Instructions for completing this form are on page 1 of this application.

**PLEASE ATTACH COPIES OF OFFICE NOTES, EVALUATIONS, AND TESTING RESULTS.
INSUFFICIENT EVIDENCE MAY RESULT IN DISAPPROVAL.**

Employee Name	Date of Birth	Social Security Number
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Date patient became unable to work	Ever had same or similar condition: If yes, when and describe Yes _____ No _____
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Is condition arising out of employment? Yes _____ No _____

Date first consulted you for this condition	Additional dates of treatment including the most recent visit
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Frequency of visits: Weekly _____ Monthly _____ Other (explain) _____

Referrals

Date of most recent visit	Next scheduled appointment	EDC
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Diagnosis of disabling condition (s)	
Diagnosis _____	ICD-9 _____
Diagnosis _____	ICD-9 _____
Diagnosis _____	ICD-9 _____

Dates of Hospitalization	Name of Hospital
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Reason for hospitalization and/or type of surgery performed	If surgery performed, give date Mo. ____ Day ____ Yr. ____	If pregnancy, date of delivery Mo. ____ Day ____ Yr. ____
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Complications or other factors delaying recovery (describe)
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Subjective symptoms. (If psychiatric, describe mood and affect, ability to relate, ability to carry out daily activities, follow instructions, judgment, and ability to concentrate)

Medications	Dosage	Date initiated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Employee Name

Plan of treatment for a return to work.

What restrictions are placed on patient's work activities?

What job duties is the employee unable to perform?

1. In an 8-hour workday, person can: (Circle full capacity for each activity)
TOTAL (hours) Sit 0 1 2 3 4 5 6 7 8 Stand 0 1 2 3 4 5 6 7 8 Walk 0 1 2 3 4 5 6 7 8

2. Person can lift and carry: Never Occasionally (1- 33%) Frequently (34% -66%) Constantly (67% -100)
Up to 10 lbs.
11-20 lbs.
21-50 lbs.
51-100 lbs.
Over 100 lbs.

3. Person can push/pull: Never Occasionally (1% - 33%) Frequently (34% - 66%) Constantly (67% - 100)
Up to 10 lbs.
11-20 lbs.
21-50 lbs.
51-100 lbs.
Over 100 lbs.

4. Person can do repetitive movements as in operating controls:
Right hand/arm Yes No Left hand/arm Yes No

5. Other restrictions:

Patient's conditions prevents them from working:
Temporarily For longer than 12 months Permanently

If disability is temporary, patient's estimated date of release to return to work:
For regular occupation Mo. Day Yr.
On a part-time basis Mo. Day Yr.
part-time schedule: hours per day days per week # of weeks
For suitable work activities within the limitations listed above Mo. Day Yr.

Additional Remarks

Name (treatment provider) Please print Specialty Fed ID#
Street Address City State Zip Code
Telephone (area code) Fax (area code) E-mail address
Date form received Date signed Signature