NYS Public Employees Federation Workers' Compensation Information for PEF Members

PEF Health & Safety Department

healthandsafety@pef.org

STEPS TO TAKE IN A WORKERS' COMPENSATION CASE

AFTER ACCIDENT OR INJURY:

1 **NOTIFY** your employer as soon as possible.

- the law gives you 30 days, but sooner is better

2 **CALL** the Accident Reporting System (ARS)

- 1-888-800-0029

3 **FILE** a C-3 form with the Workers' Compensation Board.

- you must also sign and file a C-3.3 form if you have a previous injury or medical treatment to the same part of your body you are claiming in your case.

4 **GO** to a workers' compensation doctor who will file a C-4 form and treatment reports with the Workers' Compensation Board and the insurance company.

- get a copy of the C-4 form and treatment reports for your records.

5 **ASK** your Union steward or representative for information on Workers' Compensation and your contractual benefits.

- PEF is NOT notified if a member has a workers compensation claim or is out on workers compensation leave. Please contact the Union for important information on your rights and additional benefits for workers compensation.
- PEF Health & Safety staff are also available to answer questions, and can send you a Workers' Compensation information packet. Call 800-342-4306, ext. 254 or email HealthAndSafety@pef.org.

THE NEXT STEPS:

1 **YOUR EMPLOYER** must notify their insurance company. For New York State that is the New York State Insurance Fund (NYSIF).

2 **NYSIF** (the insurance company for New York State public employers) may accept your case and file a First Report of Injury (FROI) form number FROI-00, or contest your case and file a FROI-04 or SROI-04 form that notifies the Workers' Comp. Board (WCB) of NYSIF's specific reasons for controverting a claim, or it may wait until the case is indexed by the Workers' Compensation Board.

3 **THE WORKERS' COMPENSATION BOARD** will "assemble" a case when it receives your C-3 form or your employer's FROI-00 form, but it will not "index" your case until it also receives the C-4 form from the doctor.

IF THE CASE IS CONTESTED (CONTROVERTED):

1 **THE NYSIF -** If NYSIF determines the claim is questionable, they must file FROI-04 on or before the 18th day of disability, within 10 days after the employer learns of the alleged accident, or within 25 days after notice of indexing by the WCB.

2 **THE WORKERS' COMPENSATION BOARD** will schedule a pre-hearing conference, which (if necessary) will be followed by a trial.

- The Board will not schedule a pre-hearing conference unless it has both a C-3 form from you and a C-4 form from your doctor.
- You may benefit from legal representation if your case is contested. Contact a Workers Compensation Attorney for more information.

IF THE CASE IS ACCEPTED:

1 **PAYMENTS:** If you miss more than one week from work and you have medical reports stating that you are disabled, the insurance company should begin voluntary payments to you. Voluntary payments usually begin about four weeks after the accident.

- you should file a workers' compensation claim even if you do not miss time from work. Medical bills are payable even in "no lost time" cases and there may be awards for permanent injury.
- the amount of the payments depends on your average weekly wage, your degree of disability, and the date of your accident.
- as long as you are out of work you must see the doctor at least once every 45 days and the doctor must file C-4 forms and treatment reports.

NOTICES FROM THE WORKERS' COMPENSATION BOARD:

1 **ADMINISTRATIVE AND PROPOSED DECISIONS** – If you receive an administrative or a proposed decision, it will make legal findings in your case and will probably say that "no further action" is planned by the Board. You should have any administrative or proposed decision reviewed by your legal representative to make sure that they are correct and so that you do not lose out on additional benefits you are owed.

2 **NOTICE OF HEARING** – if a hearing is scheduled in your case, you should bring these with you:

- your most recent medical report
- your out-of-pocket expenses
- proof of your earnings if you are working
- proof of your job search if you are looking for work
- a few paystubs from before your accident.

3 **NOTICE OF DECISION** – after each hearing the Board will send you a Notice of Decision showing the findings and money awards that were made. Be sure to review these notices and contact your attorney or NYSIF case manager if you have any questions.

PERMANENT INJURY:

1 **SCHEDULE LOSS OF USE:** If you hurt an arm, leg, hand, foot, finger or toe, if you have vision loss or hearing loss, or if you have a facial scar, you may be entitled to an award even if you did not miss any time from work. You will need to get a specific report from your doctor to get the award, and you will probably benefit from legal representation. Remember, these payments are for loss of future earnings, so if you are out of work in the future this award is what pays your salary during that time out.

2 **PERMANENT PARTIAL DISABILITY:** If you injured your neck, back or other body part that is not eligible for a schedule loss, and if you cannot return to the job you were doing before you got hurt, you may be permanently partially disabled and entitled to weekly benefits for a period of time.

3 **PERMANENT TOTAL DISABILITY:** If you cannot do any work of any kind, you may be permanently totally disabled and entitled to weekly payments for life.

SECTION 32 SETTLEMENTS:

1 **NYSIF** (The insurance company) may offer you a Section 32 settlement as a final payment to end your case.

- Before agreeing to accept a Section 32 settlement you should discuss your case with your doctor and your legal representative.
- You should consider the benefits that may be available in your case, whether you have a use for the settlement money (such as starting a business or going back to school), whether you are likely to go back to work, your other sources of income, and your need for future medical treatment.
- A Section 32 settlement may have to be approved by Medicare and must be approved by the Workers' Compensation Board.

The PEF Occupational Health & Safety Department provides training and technical assistance on workplace health and safety concerns, and state and federal standards and regulations. Factsheets on a variety of topics and many other resources are also available. Contact us at 518-785-1900, ext. 254 or 800-342-4306, ext 254. e-mail - healthandsafety@pef.org

Produced by the New York State Public Employees Federation

Wayne Spence
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Q&A on Work- Related Injuries/Illnesses

1. What is the NYS Accident Reporting System (ARS)?

NYS has an electronic system for employees to report work-related injuries and illnesses. The first step is to call ARS, the Accident Reporting System, at the toll-free number:

1-888-800-0029

The ARS call center operator will give the employee an incident number. *Please note, this number is different from the carrier case number from NYSIF and the case number from the Workers Compensation Board*.

The criteria used by ARS to initiate a C-2 Employer's report of a work-related accident/illness are medical treatment beyond first aid OR one lost work-shift (1 full lost work day) or treatment beyond first aid or more than two first aid treatments.

2. Can the employer or State Insurance Fund determine if claims are compensable? (Article 13.1 (b))

The employer does not determine if claims are compensable. The NYS State Insurance Fund (SIF) makes an initial determination and can controvert a claim. The employer may ask the SIF to controvert a claim. However, the NYS Workers' Compensation Board (WCB) determines compensability of claims and its decisions are binding on all parties.

If a worker is injured on the job, they should complete the Worker's Compensation Board's form "Employee's Claim for Compensation" (C-3) as soon as possible to ensure benefits are not delayed or interrupted. More information on how to file a claim may be found on the WCB website: **www.wcb.ny.gov**, and at the SIF website: **http://ww3.nysif.com/**

Employers are also required to provide injured workers with a "Claimant Information Packet" that contains a C-3 and a C-3.3 "Limited Release of Health Information. It is very important that all injured members complete these forms and send them in to the Workers' Compensation Board. These forms can also be filled out electronically on the WCB website: **https://www.wcb.ny.gov/onlineforms/c3/C3Form.html**

3. What is the final attendance status for employees on workers compensation? (Article 13.2)

An employee who suffers a compensable occupational injury shall be placed on **leave of absence without pay** for all absences necessitated by such injury and shall receive the benefit provided by the Workers' Compensation Law.

4. Can injured workers use leave accruals? (Article 13.3 (f))

Injured workers who are absent for full days on Workers' Compensation may not charge leave credits **except** during the first seven calendar days of the initial waiting period. During the waiting period, employees have the option of using accruals or going on leave without pay. If the employee returns to work, and is absent for partial days that are related to their Workers' Compensation incident, the worker may use leave accruals to cover these absences.

5. Can accruals used during the waiting period be restored? (Article 13.3 (f))

When leave credits are charged and it is later determined that no waiting period was required, the employee shall be entitled to restoration of credits on a prorated basis.

6. Can an injured member use leave accruals if their case is controverted? (Article 13.3 (j))

If a case is controverted by the State Insurance Fund upon the grounds that the disability did not arise out of or in the course of employment, the employee may use leave credits (including sick leave at half-pay) pending a determination by the Workers' Compensation Board. If a case is controverted by SIF based on the grounds that a disability does not exist, leave credits cannot be used.

7. How is restoration of leave credits calculated? (Article 13.3 (k))

In cases where leave credits (and sick leave at half-pay eligibility) were charged during the waiting period or in the course of resolving a controverted claim decided in the employee's favor, they shall be restored proportional to the net monetary award credited to New York State by the Workers' Compensation Board or 60 percent of pre-disability gross wages as defined in 13.3(b) of Article 13, whichever is greater. In other words, individuals receive time back in proportion to the amount of money the state is reimbursed by the SIF for their absences.

8. What happens when restoration of vacation credits exceeds 40 days? (Article 13.3 (g))

When vacation credits are restored, causing the total vacation credits to exceed 40 days, injured workers are given a period of one year from the date of the return of the credits or the date of return to work, whichever is later, to reduce the total accumulation to 40 days.

9. Can injured members use leave accruals if their disability exceeds 12 Months? (Article 13.3 (I))

No

10. What happens if the work-related injury occurred during a previous collective bargaining agreement? (Article 13.4)

The benefits negotiated during that time period will be available to those affected.

11. What is the medical evaluation network program (MENP)? (Article 13.3)

The appointing authority will assume that all eligible employees have elected to participate in the MENP. Employees who do not want to participate must submit a written statement declining participation in the program, as soon after the accident as possible.

12. What are the options on choosing a medical provider under the MENP? (Article 13.3)

The MENP consists of consulting physicians employed by the State Insurance Fund. These doctors perform Independent Medical Examinations (IME) for SIF. An injured member must attend all scheduled medical exams or their benefits may be terminated. Medical evaluation network physicians make determinations on behalf of the SIF on an employee's degree of disability, prognosis for full recovery, or whether an injury is related to work. Eligible employees who participate in the MENP shall be placed on leave without pay and will receive the benefits provided by the Workers' Compensation Law and the added benefits provided by this Article. Such employees are also eligible for a mandatory alternate duty assignment.

13. Are employees required to go to a specified clinic?

No. Under the Workers Compensation Law, employees see any provider of their own choosing so long as they are a Worker's Compensation Board Certified Provider.

14. What happens if an injured member opts out of the MENP? (Article 13.3 (a), (c))

Employees who submit a written request to their personnel department to opt out of the MENP will receive only the workers' compensation statutory benefits. They will not receive any employer-enhanced benefits, supplement, or be eligible for the mandatory alternate duty program. Furthermore, they still must submit to independent medical examinations ordered by the State Insurance Fund or Workers' Compensation Board. **There is no benefit to opting out!**

15. What is the mandatory alternate duty (MAD) program? (Article 13.5)

New York State and the Public Employees' Federation (PEF) negotiated a MAD Program that allows employees receiving Workers' Compensation benefits to return to work in an assignment that meets the needs of the agency and the medical limitations of employees. This program was negotiated by PEF and the State as part of the changes in the Workers' Compensation benefit in the 1991-1995 agreement. Employees benefit from this program by receiving their regular salaries during the alternate duty assignment. Agencies benefit by being able to use the capabilities of these employees who would otherwise be unable to return to work.

The term "mandatory" as used in this program means that if workers meet the eligibility criteria and request a MAD assignment, they must be offered an assignment or receive a Workers' Compensation benefit supplement. Alternately, if injured members meet the eligibility criteria, their agency may require them to return to work in a mandatory alternate duty assignment even if they do not request it. Once a determination is made that a worker is 50% or less disabled their supplemental payments ceases. The only way to receive compensation other than the statutory wage replacement benefit is to request a MAD assignment. Note: the terms used to describe degree of disability are as follows:

Total = 100%

Marked = 75%

Moderate = 50%

Mild = 25%

NOTE: If an IME determines that you are moderate or mildly disabled, the SIF can cut your benefits unless your benefit rate has been established at a Workers' Compensation Board hearing by an Administrative Law Judge.

16. Eligibility requirements

Injured members are able to participate in the MAD Program if they meet the following criteria:

1. The worker must be determined to be partially disabled at 50% or less by the State Insurance Fund;

- AND -

2. The worker must have a prognosis of full recovery within 60 calendar days. Full recovery is defined as the ability to perform the full duties of the job held when injured. These medical findings may occur as a result of an examination by a State Insurance Fund consulting physician, by the treating physician, or in connection with a management-ordered medical evaluation. The employing agency determines what documentation will be acceptable to establish eligibility and determine physical limitations.

17. Mandatory alternate duty (MAD) assignments

A MAD assignment is a short-term assignment (not to exceed 60 days) that reflects physical limitations as described in the medical documentation accepted by management. It may involve performing some duties of a worker's regular position, some duties of another position, or a combination of tasks from several positions. The assignment may involve performing the same duties for the entire period or may consist of a series of different assignments, each performed for a specific period of time.

Injured members should receive the following information when offered a mandatory alternate duty assignment by their agency:

a. description of the proposed alternate duties

b. location of the assignment

c. work hours and workweek

d. name of the supervisor

e. starting and ending dates

The agency is expected to make every effort to tailor the assignment to employee's specific limitations and to discuss the assignment prior to its start.. The assignment may not necessarily fall within the regular title, grade, or job duties. The agency is not required to provide injured members with their regular work location, schedule, or workweek. However, once a mandatory alternate duty assignment is established for a fixed period of time, the provisions of Article 32 (Workday/Workweek) cover injured members during that same period. While performing a mandatory alternate duty assignment, the worker receives regular salary and is treated like any other employee in full pay status for attendance and leave and benefit purposes. It is the policy of the State to attempt to place employees in MAD assignments that are as close to their regular title and duties as possible based on the needs of the agency.

18. Can mandatory alternate duty assignments be appealed? (Article 13.5(f))

The MAD assignment will be based on the medical documentation accepted by management. If a member believes that some part of the proposed assignment constitutes a personal hardship, the member may express the concern to the appropriate agency official. The agency will respond in writing, with a copy to PEF, prior to the proposed start of the assignment or as soon thereafter as possible. Injured members may not grieve their agency's determination.

19. How do you apply for a mandatory alternate duty assignment?

Contact the employing agency to request a mandatory alternate duty assignment. A request can be made for a MAD assignment 65 days before an injured member's full recovery date. However, workers are not entitled to receive an assignment until 60 days before their full recovery date.

Once eligibility requirements are met, and a request for a MAD assignment has been made, the agency must do one of the following:

1. Offer a mandatory alternate duty assignment for up to 60 calendar days which takes into account physical limitations.

- OR -

2. If a MAD assignment cannot be provided, arrange for the effected worker to receive a supplemental payment that will provide 60% of their gross income when added to the workers' compensation law payment. The supplement will not be paid beyond the point the MAD assignment would have expired.

Injured members are not required to apply for a mandatory alternate duty assignment, but their agency may direct them to return to work on a MAD duty basis if they meet the eligibility criteria. If the worker declines a MAD assignment, the worker will be referred to the State Insurance Fund for a benefit determination.

If injured members meet the eligibility requirements and do not request a MAD assignment, or their agency does not direct them to return to work, the worker will continue to receive wage replacement benefits from the State Insurance Fund in accordance with the Workers' Compensation Law until fully recovered. However, the worker will not receive the supplement.

20. What is CareComp Network of CVS Caremark?

NOTE: The Prescription benefit program is currently out for bid. If the provider changes injured workers will be provided with the new information.

Eligible employees will be sent information on the CareComp Network of CVS Caremark workers' compensation prescription card program by the New York State Insurance Fund (NYSIF). Contact your health benefits administrator or your agency personnel office for more information. NYSIF's pharmacy benefits management program offers the option for a claimant to obtain medication for a work-related injury or illness through the CareComp Network of CVS Caremark. This does not change a claimant's right to use any pharmacy to obtain medication necessary to treat such an injury or illness.

Use the CVS Caremark Pharmacy Locator or call CVS Caremark at (866) 493-1640 to find a local network pharmacy. Call CVS Caremark for information about mail-order service.

Note: CVS Caremark network pharmacies bill NYSIF directly, so claimants do not have to pay out-of-pocket for medication. Claimants who have not received a CVS Caremark card, should call the NYSIF case manager handling their claim.

If you are injured at work or have a work-related illness:

- Call ARS, the Accident Reporting System, at the toll-free number, 1-888-800-0029. The ARS operator will give you an incident number. You may use the incident number for your prescription drug benefit.

21. When will injured members receive wage replacement payments?

If the State Insurance Fund, as New York State's workers' compensation insurance administrator, accepts responsibility for a claim, the first payment must be made within 18 calendar days after the disability begins or ten calendar days after the injured member notifies the employer, whichever is later. In order for the SIF to pay wage replacement benefits, they need to have an accident report from the employer (the C-2) and a medical report from the treating physician (C-4) indicating the disability is due to a job-related injury. It is also critical that treating providers fill out the sections of the C-4 that address whether or not an injured worker is disabled from work and also the degree of disability. If those sections are not completed, the SIF will not make payments. The employer also must complete a C-1, "Employer's Report of Injured Employee's Change Status In Employment Resulting From Injury". Payments are then due every two weeks for the period of the disability. If an injured member receives notice from the SIF that a claim is being disputed, call the SIF or employing agency to determine what the issues are.

22. Why are checks delayed or late?

Please Note: injured members who are entitled to wage replacement benefits from the SIF will receive two checks at approximately the same time at the beginning of a disability: a check from the agency for the two weeks worked prior to the accident (lag pay check) and a wage replacement check from the SIF for the initial period of disability. As a result of receiving these two checks at approximately the same time, injured members are now no longer on a two-week lag payroll cycle. Consequently, when workers recover, return to work and are restored to an agency's payroll, they will be required to make up this two week lag period. The result is that workers will not receive their first agency pay check after a return to work for approximately four weeks, while the SIF disability payments will stop close to the return to work date.

Another common cause for workers' compensation payment delays is that healthcare providers do not send in timely or complete medical reports every six weeks. The initial report is the C-4 and the follow up reports are the C-4.2. Injured members should discuss the importance of these reports being filed properly and on a timely basis with their providers.

23. How are wage replacement rates determined?

If injured members are disabled and are eligible for wage replacement benefits, they will receive two-thirds of their average weekly wage, but no more than the maximum benefit per week as listed below. The average weekly wage is determined by the State Insurance Fund based on payroll records for the year prior to the date of disability or accident. The formula used to calculate benefits is: **2/3 x average weekly wage x % of disability = weekly benefit** (but no more than the NYSAWW – see below).

Under the Workers' Compensation Law, disabilities are classified as total or partial. When a disability is classified as total, workers receive the maximum benefit based on their average weekly wage. When a disability is classified as partial, workers receive a percentage of their maximum benefit based on their average weekly wage. Note: if your average weekly wage (AWW) is high enough, you can still get the maximum benefit allowed under the law, even if you are 50% or less disabled. The weekly benefit is based on the date of accident and cannot exceed the maximums set for that year.

The New York State Average Weekly Wage (NYSAWW) is the average weekly wage of the state of New York for the previous calendar year as reported by the Commissioner of Labor to the Superintendent of Insurance on March 31 of each year.

Effective in 2010, the weekly maximum is updated on July 1st of each year. A full listing of the Schedule of Benefits, including the current benefit maximum and those dating back to 1985, may be found at
http://www.wcb.ny.gov/content/main/Workers/ScheduleMaxWeeklyBenefit.jsp

Date of Accident	Weekly Maximum
• July 1, 2021 – June 30, 2022	$1,063.05
• July 1, 2022 – June 30, 2023	$1,125.46
• July 1, 2023 – June 30, 2024	$1,145.43
• July 1, 2024 – June 30, 2025	$1,171.46
• July 1, 2025 – June 30, 2026	$1,222.42

24. What supplemental payments are available?

During the first nine months (39 weeks) of a disability*, if injured employees are determined to be **more than 50% disabled**, they may be eligible for the union negotiated supplemental payment in addition to the workers' compensation law wage replacement **** The 39 weeks run consecutively in the first 39 weeks of a continuous absence, or for 39 cumulative weeks for intermittent absences***. The supplement is designed to bring biweekly income (SIF payment and supplement combined) up to 60% of pre-disability gross salary, which is defined as an employee's annual salary plus geographic differential, shift differential, inconvenience pay and location pay. The SIF will notify OSC of wage replacement payment amounts when injured members are more than 50% disabled. OSC then will calculate the supplement and issue a check on the employing agency's regular payroll cycle to provide any supplement that an employee may qualify for. Please note that this supplement will be issued approximately 4 - 6 weeks after receipt of the workers' compensation law wage replacement payment, not concurrently. Once an injured worker has been determined to be 50% or less disabled, supplemental wage benefits will end and the injured member may request or may be required to return to work under the Mandatory Alternate Duty Program.

25. Are taxes taken from supplemental wages? (Article 13.3 (e))

Yes. Supplemental wages are taxable income. The wage replacement benefits paid by SIF are NOT taxable.

26. Which deductions are taken from supplemental payments?

All deductions previously taken from regular paychecks will be taken from supplemental checks if the amount of the supplement is sufficient to cover them. If the supplement is insufficient to cover all fixed deductions, the state will cancel them. Injured members are responsible for arranging to make payments directly for all payroll deductions not taken. If the supplement has been exhausted or has insufficient funds for health insurance premium deductions, the employee may pay those premiums directly or make arrangements for them to be deferred and taken retroactively when the employee returns to the payroll.

27. What happens to seniority, accruals, health insurance, and retirement credits? (Article 13.3 (h))

Injured members will be treated as though they are on the payroll for the length of their disability for up to a maximum of one year (52 weeks). While they are receiving Workers' Compensation payments directly from the State Insurance Fund, they will be treated as though they are on the payroll in full pay status for this one-year period. This means they will be entitled to accrue seniority and continuous service credit and will earn vacation, sick leave and personal leave. Injured members' health insurance will continue and they will be responsible for payment of the bi-weekly employee share of the premium. They will be treated as though they are on the payroll for retirement service credit. If they contribute to the Retirement System, they will continue to be responsible for these payments based on their normal salary. If they are a member of the Employees' Retirement System, they may be eligible for accidental or ordinary disability retirement benefits. For further information advise them to contact the Employees' Retirement System.

Members injured due to an assault will be treated as on the payroll for up to an additional one year (52 weeks) for the sole purpose of health insurance.

28. What Social Security benefits are available?

If a member is seriously and permanently disabled they may be entitled to monthly Social Security benefits, provided they are covered by the federal Social Security Act. For additional information about these federal Disability Insurance Benefits, write or call the nearest field office of the Social Security Administration.

29. What happens in the event of death?

If a member should die as a result of a compensable injury, their surviving spouse and dependents may be entitled to weekly cash benefits pursuant to the Workers' Compensation Law. Further information is available from your local Workers' Compensation Office. Additionally, Article 11 of the Contract provides for a $50,000 accidental death benefit to be paid to an employee's spouse and children or estate when a workers' compensation death benefit is awarded.

Children of members who receive the accidental death benefit, described above, are entitled to a payment by the State for tuition for each semester in which they enroll and attend any SUNY college or unit. Children attending an accredited private college or university within New York State are entitled to payment equal to the amount of SUNY tuition.

30. Does the State notify PEF when members are injured, file for workers compensation, or are out on a workers compensation leave?

NO! PEF does not receive notice or any accounting of members who have workers compensation claims. We only hear about it when members self-report to us, or we are notified by a Local PEF leader.

It is important that if you or another member has a workplace injury that they notify their Local PEF leader, PEF Field Representative, and/or the PEF Health and Safety Department at HealthAndSafety@pef.org so that we may send out a packet of important information on your rights and benefits.

Health and Safety Committees should also be reviewing Workers Compensation and Injury/Illness reports at their quarterly meetings.

The PEF OccupationalHealth & Safety Department provides training and technical assistance on workplace health and safety concerns, and state and federal standards and regulations. Factsheets on a variety of topics and many other resources are also available. Contact us at 518-785-1900, ext. 254 or 800-342-4306, ext 254. e-mail - healthandsafety@pef.org

Sources for information in this fact sheet: the NYS/PEF Collective Bargaining Agreement Article 13, NYS Workers' Compensation Law and NYS Civil Service Attendance and Leave Manual.

ATTENTION:

PHYSICIANS TREATING WORKER'S COMPENSATION CLAIMANTS WHO ARE PEF MEMBERS

Filling Out C-4 Forms and Narrative Reports

Protect your patients' disability pay – PEF members have contractual benefits in addition to their statutory benefit that depend on what you include in your report.

For your patients who are PEF members - please pay particular attention to sections including Causality, Degree of Disability and Work Status.

1. Your initial report must state your opinion that your patient's injury is **causally related to their employment**. Your report must **briefly cite the details** of the accident or occupational disease as told to you by your patient. **Without this prima facie medical evidence, your patient's claim will be disallowed**.

   Example: John Jones slipped and fell while working on a patient ward at his job as a nurse at the NYS Veterans Home, injuring his right shoulder. Therefore, I feel his current disability is causally related to his employment.

2. **Every** report should state your opinion of your patient's **current degree of disability at the time of each visit**, - this is the single most important piece of information used in determining your patient's disability rate.

3. Generally, your patients will be paid a disability rate consistent with your opinion of their degree of disability. Without your specific comments on this issue, their disability rate will be determinate by the opinion of the carrier's medical consultant, which may be less informed than yours.

4. Claimants are paid a percentage of their total disability rate, depending upon their degree of disability.

The degree of disability set by the judge may also impact supplemental pay benefits provided in the PEF/NYS contract.

If injured PEF members are determined to be more than 50% disabled, they may be eligible for union negotiated supplemental payments in addition to the workers' compensation law wage replacement.

5. **FYI**: The total disability rate for a worker's compensation claimant is 2/3 of his average weekly wage multiplied by his degree of disability up to a maximum weekly benefit (**currently $1,063.05 for July 1, 2011 – June 30, 2022**). See http://www.wcb.ny.gov/content/main/onthejob/wcBenefits.jsp

6. **PEF members must be MORE THAN 50% disabled in order to qualify for contractual supplemental pay benefits.**

   Degrees of disability and their corresponding percentages are:

Total 100%	**Moderate** 50%
Marked ..... 75 %	**Mild/Moderate**..... $33^{1/3}$ %
Moderate/Marked..... $66^{2/3}$%	**Mild** 25%

Health Insurance Coverage While You Are Out on Workers' Compensation Leave

Q: I am enrolled in the New York State Health Insurance Program (NYSHIP) and have been removed from the payroll because of an accepted work-related injury or occupational condition. Am I eligible to continue my health insurance coverage?

A: You are eligible to continue your health insurance while on Workers Compensation (Comp) Leave without Pay (LWOP) until you return to payroll, your employment ends, or for 12 months per injury, whichever is earlier. If your Workers Comp LWOP is due to a workplace assault, you may continue coverage until you return to payroll, your employment ends, or for 24 months per injury, whichever is earlier. Dental and vision benefits will remain in effect for the same duration.

Q: What portion of the cost of health insurance will I pay while on Workers Comp LWOP?

A: During the 12 or 24-month Workers Comp LWOP entitlement, you are responsible for paying the **employee share** of the premium (the same amount deducted from your paycheck while on the payroll). Dental and vision benefits will remain in effect at no cost to the employee. The Employee Benefits Division of the NYS Department of Civil Service will notify you in writing of your payment options for continuing health insurance during Workers Comp LWOP.

Q: What are my options for payment of the employee share of the premium while I'm on Workers Comp LWOP?

A: While on Workers Comp LWOP, you may pay your premium contribution directly to the Employee Benefits Division of the NYS Department of Civil Service every 4 weeks (monthly), or you may defer payment until you return to payroll, or your employment is terminated. The deferral of premiums is not automatic; you must sign and return the Deferral form to EBD (Employee Benefits Division) within 30 days of the date on the letter. To ensure the eligibility of your deferral of premiums, you are responsible for notifying EBD if you do not receive confirmation of your deferral form within 30 days of your submission. When returning to the payroll, your approved deferred premiums will be taken from your paycheck in increments of up to $100 until your accumulated balance of your Workers' Compensation leave is satisfied. However, if you are removed from the payroll again for any type of leave, or separate from State service, all prior unpaid premiums will be due immediately.

Q: How will the Employee Benefits Division (EBD) of the NYS Department of Civil Service collect the premium payments I deferred?

A: If you return to payroll from Workers Comp LWOP, EBD will collect the premium you deferred by taking special deductions of no more than $100 from your paycheck per

payroll period until the deferred premiums are fully paid. There will be a separate deduction for your current coverage. If your employment is terminated, all premiums due for coverage during your leave must be paid. If all premiums due are not fully paid, your coverage will be retroactively terminated as of the last date for which you paid premium. You will be responsible for refunding your health plan any claim payments made for services performed on or after the cancellation date. PLEASE NOTE: If your NYSHIP coverage is cancelled retroactively for non-payment of premiums, there may be serious repercussions. If you separate from State service while your coverage is cancelled, you may not be able to continue coverage for you and your dependents as a retiree, vestee, and dependent survivor or under COBRA provisions.

Q: I am a NYSHIP enrollee and have been removed from the payroll because of a controverted work-related injury or occupational condition. What portion of the cost of health insurance will I pay while on LWOP?

A: You are eligible to continue your health insurance coverage while in LWOP status but you must pay **both the employer's and the employee's share (100%) of the premium**. The Employee Benefits Division of the NYS Department of Civil Service will mail you a PS-431 bulletin explaining what you have to do to continue medical, dental, and/or vision coverage while on LWOP.

Q: I am a NYSHIP enrollee and have been removed from the payroll because of a controverted work-related injury or occupational condition. Do I qualify for a waiver of premium?

A: If you are totally disabled for at least six biweekly pay periods, you may qualify for a waiver of the medical insurance premium while on LWOP if you are enrolled in the Empire Plan. A Waiver of Premium is not automatic. Contact your Health Benefits Administrator for information about this benefit and the PS-452 Waiver of Premium application. You must continue to remit premium payments until you are notified that your waiver is approved. If the waiver is approved, you will not have to pay any premium charges for up to 12 months, or until you return to payroll, or your employment ends, whichever is earlier. See your NYSHIP benefits booklet for further information regarding waivers of premium. HMO enrollees are not eligible for waivers of premium.

Q: I am on Workers Comp LWOP or LWOP and have questions about my enrollment and/or billing status. Who should I contact for assistance?

A: Call the Employee Benefits Division (EBD) of the NYS Department of Civil Service at (518)457-5754 in the Albany, NY area, or (800)833-4344 between 9 a.m. and 4 p.m. Monday through Friday.

Leave Without Pay – Standard Practices while out on LWOP

When an employee is placed on an unpaid leave type which does not qualify for an employer premium contribution

Medical is automatic – Dental & Vision are automatically terminated, unless the member elects/enrolls

- Members are Ineligible for Pre-Tax if out on a Leave of Absence

- If a member is receiving a paycheck and charging accruals at 50% or more, they are not on leave and their benefits are not affected – employee share will continue to be deducted from their pay

Medical: Coverage is automatic and will remain active unless the member suspends or disenrolls (this is not advised)
Carrier: Empire/UHC
Member Contact: Civil Service or HBA

Dental & Vision
Carrier: Anthem & Davis Vision
Plan: New York State Dental and Vision Plan
Member Contact: Civil Service or HBA

Coverage is not automatic; coverage is automatically terminated unless the member takes action to re-enroll. Member must arrange for coverage with their Agency Health Benefits Administrator (HBA) before going out on leave. (If the member is going on leave because of military duty, special provisions may apply)

Enrollment/Continuing Coverage: The member must complete the PS-404 form, electing single/family and Dental/Vision. This must be submitted to their HBA/Civil Service.

Discontinuing Coverage: The member can suspend coverage (this is not advised), the last day of coverage would be 28 days from the last day on payroll in which they were paid. **This is not advised** because once the member returns from a leave of absence, they would then be responsible for a large lump sum to re-enroll. If the coverage was canceled while they were on leave, they may re-enroll when they return to work, provided they still meet the eligibility requirements. Members need to contact their Agency Health Benefits Administrator to reactivate coverage and it will begin on the first day of the month in which they return to work.

Cost (found in Direct Pay flyer, annually updated): Dental and Vision are funded by the state, therefore the member is responsible for the full premium sharer on COBRA or Leave without Pay. After a member has enrolled, the New York State Department of Civil Service Employee Benefits Division will bill them on a monthly basis, Members are billed monthly (about every 28 days). The first bill is received generally between 2-4 weeks from the start of the LWOP date.

Maternity Leave
Members can use sick leave or other accruals during this period. They are recommended to exhaust their accruals prior to starting their leave date to remain in pay status, with full benefits.
"Maternity leave" is not a specific leave type in the State's System (NYBEAS). Many employees who go out on maternity leave are placed on either Family and Medical Leave Act (FMLA) or Paid Family Leave (PFL – **PEF does not carry PFL currently**) – typically 12 weeks. Those leave types still entitle the employee to a State premium contribution and they are only responsible for the employee portion of the premium. Employees who are not eligible for FMLA or PFL, or those employees who choose not to take FMLA or PFL, are placed on a standard leave without pay, and do not receive a State contribution.

Family and Medical Leave Act (FMLA)
Eligible members are entitled to a maximum of 12 weeks – unpaid annual leave for specific reasons. Members are responsible for the employee share of the premium. Members can (not advised) waive their Empire Plan Health Coverage during this period.

Leaves of 28 days or less: If the member is off payroll for 28 days or less and have not requested coverage to be suspended or canceled, their share of the premium will automatically be deducted from their paycheck when they return to work.

Voluntary Leave If a member is out on Voluntary Leave of Absence and has exhausted all leave accruals, the member would be responsible for the full premium share.

Disciplinary Suspension & Workers Compensation Members may continue coverage by paying the full share premium – Refer to specific details in the NYSHIP General Information Book via Civil Service portal

- Some members, prior to an unpaid leave, use VRWS but actually work 5 days and bank 1 or 2 days to use when they are out on leave. This would require the agency let them come back on payroll prior to the suspension so they could "bank" enough days to get through the suspension.
- If you are absent from work because of an accepted work-related injury, illness or occupational condition, you are eligible to continue your health insurance coverage at the employee share of the premium for up to 12 months per injury, illness or occupational condition (or up to 24 months per accepted assault case) The standard allotted time for Workers' Comp in 12 months. The states system NYBEAS automatically transitions the profiles from Workers' Comp to Leave Without Pay at 12 months unless they are advised otherwise by the agency Health Benefits Administrator. Civil Service must receive a letter or notification from the Health Benefits Administrator confirming an extension approval for up to 24 months.
- You will be responsible for the employee share of the premium while you are on Workers' Compensation leave. Employees who are on an approved Workers' Compensation leave will receive an informational letter from EBD regarding the billing and payment of premiums. Groups eligible to defer their premiums will also receive a deferral form. The deferral of premiums is not automatic; you must sign and return this form to EBD within 30 days of the date of the letter. To ensure the eligibility of your deferral of premiums, you are responsible for notifying EBD if you do not receive confirmation of your deferral form within 30 days of your submission. When returning to the payroll, your approved deferred premiums will be taken from your paycheck in increments of up to $100 until your accumulated balance of your Workers' Compensation leave is satisfied. However, if you are removed from the payroll again for any type of leave, or separate from State service, all prior unpaid premiums will be due immediately.

Military Leave
Must contact HBA to verify eligibility to remain active. If coverage is not continued during leave, it may be reinstated without any waiting period when returning to work - Refer to specific details in GIB

Other Information This information can be found on the New York State Civil Service website should you need further detail: https://www.cs.ny.gov/employee-benefits/hba/group/1/10/3/dental/index.cfm?page=2

Information on Payment of PEF Dues & Insurance Premiums

Dear PEF Member:

I understand from New York State that you are going on a leave of absence and/or may otherwise no longer be on payroll. If you are no longer paying PEF membership dues by payroll deduction, your dues must be submitted directly to PEF to maintain membership. If you have not already done so, please contact Susan Dunckle at Susan.Dunckle@pef.org or 518-785-1900 ext. 261 as soon as possible to arrange for payment.

Please be advised that you must continue to pay membership dues to enjoy the many important benefits and services that are only available to active dues paying members. For example, only active dues paying members are eligible for PEF representation during questioning by the employer, including interrogations by the employer and/or the Justice Center; in statutory or administrative proceedings or to enforce statutory or regulatory rights; or in any disciplinary grievance or arbitration seeking to penalize an employee for alleged misconduct. Only active dues paying members are provided with free legal representation when the State seeks to terminate them. Only active dues paying members receive representation in licensing or credentialing matters, in PERB cases, in Civil Service Law matters, or regarding PESH complaints and other litigation and legal matters during which members' due process rights are at stake.

You must also remain an active dues paying member to be eligible for the significant benefits and discount programs provided by the PEF Membership Benefits Program, including: insurance protection, legal services, financial planning, education and training, travel services,

discounted tickets for movie theaters, water/theme parks, sporting events, performing arts, and much more. Please call the PEF Membership Benefits Program directly at (518) 785-1900, ext.

243 to ensure you do not lose out on the benefits you have come to value and appreciate, especially your insurance coverage which protects you and your family.

Furthermore, by failing to pay dues you will lose your right to participate in the internal affairs of the union, such as voting on union contracts, running for union office, voting in union elections or participating in the union's internal process for choosing political candidates that are most sympathetic to the union and its members.

To ensure that your PEF membership is not jeopardized please contact Susan Dunckle at Susan.Dunckle@pef.org or 518-785-1900 ext. 261 as soon as possible.

Scott Harms

PEF Director of Organizing

Workers' Compensation Online Resources

NYS Public Employees Federation Health & Safety Department

https://www.pef.org/departments/health-safety/

NYS Office of Employee Relations

https://oer.ny.gov/workers-compensation

Injured Workers Bar Association of NY, Inc.

www.injuredworkersbar.org Find and Attorney: https://www.injuredworkersbar.org/find-an-attorney#/

The Injured Workers' Bar Association is comprised of attorneys from throughout New York State who concentrate their practice in representation of injured workers for the Workers' Compensation Law.

New York State Workers' Compensation Board

http://www.wcb.ny.gov

Find information and forms from the Workers' Compensation Board.

Workers Compensation – Information for Workers, Claims Process, Benefits, etc.

http://www.wcb.ny.gov/content/main/Workers/lp_workers-comp.jsp

Schedule of Maximum Weekly Benefit

http://www.wcb.ny.gov/content/main/Workers/ScheduleMaxWeeklyBenefit.jsp

New York State Insurance Fund

http://ww3.nysif.com/

Workers' Compensation information and online services for workers and employers.

NYSIF Online Account User Guide

https://ww3.nysif.com/ - look for the Online Account User Guide on the Claimant Tab

NYSIF Claimant Packet

https://ww3.nysif.com/en/Employer/WCpolicyholder/AboutClaims/ClaimantInfoPacket

Occupational Health Clinic Network

https://www.health.ny.gov/environmental/workplace/clinic_network.htm

The New York State Occupational Health Clinic Network (OHCN) is the nation's only statewide clinic network. The network offers specialized medical diagnoses, high-quality care and support services to all workers, retirees and residents in New York. The OHCN assists thousands of injured workers in New York of by helping them to return to work quickly and safety and by preventing disease and injuries. No worker will be turned away because of an inability to pay, and can OHCN can bill directly to most major health insurance carriers.

Comp Alliance

https://compalliance.org/

A coalition of injured workers and other stakeholders committed to protecting the rights of injured workers under the New York State Workers' Compensation Law

Committees/Coalitions on Occupational Safety and Health

https://nationalcosh.org/

The National Council for Occupational Safety and Health (National COSH) is a federation of local and statewide "COSH" groups: Committees/Coalitions on Occupational Safety and Health. COSH groups are private, non-profit coalitions of labor unions, health and technical professionals, and other advocates for worker health and safety.
The organizations have various initiatives which include free trainings to reduce occupational injuries and illnesses and workshops on a variety of health and safety issues.
National Council for Occupational Safety and Health

Contact Information
Email: info@nationalcosh.org

Feal Good Foundation! Inc.

https://fealgoodfoundation.com/

The Feal Good Foundation is a non-profit organization. Its mission is to assist 9/11 First Responders and others who may have been injured or made ill as a direct result of their rescue, recovery, and cleanup efforts at the World Trade Center Site following the 9/11 attacks. The Feal Good Foundation also advocates for First Responder rights by educating the public and proper authorities. The assistance offered to injured and ill first responders includes financial assistance, referrals to medical and legal professionals, advocacy support, and other forms of assistance.

Contact Information
Mailing Address:
144 Shenandoah Blvd
Nesconset, NY 11767
Phone: 631-724-3320
Email: feal13@aol.com

Comp Alliance

https://compalliance.org/

The New York State Workers' Compensation Alliance is a non-profit, registered political action committee. It is a coalition of injured workers and other stakeholders committed to protecting the rights of injured workers under the New York State Workers' Compensation Law.

The New York Workers' Compensation Alliance works closely with the Workers' Compensation Board, the State Assembly, and the State Senate to protect the due process rights of injured workers.

The Alliance engages in lobbying activities to improve workers' compensation in favor of New York's workers. The website provides information on workers' compensation legislation and news.

Contact Information
Address: Comp Alliance
900 Sewart Avenue, Suite 600
Garden City, NY 11530
Members & Claims Line: (866) 697-6922
Prospective Members: (866) 697-7665
Dedicated Fax: (516) 794-5254

PEF Members:

Workers Compensation Claim Forms You Should Know

The following forms are available on the NYS Insurance Fund (NYSIF) website at https://ww3.nysif.com/Home/FooterPages/Column1/Forms . Forms are also available in multiple languages.

Injured Worker		
Form Number	*Form Name*	*Purpose*
C-3	Employee's Claim for Compensation	To be filed by the claimant when making a claim within two years of accident, or within two years after employee knew or should have known that injury or illness was related to employment.
C-3.3	Limited Release of Health Information - HIPPA	Claimant may file if they received treatment for a *previous* injury to the same body part or for an illness similar to the one described in the current Claim. This form allows the health care providers listed by the Claimant to release health care information about previous injury/illness to the employer's workers' compensation insurer. There are some exceptions (e.g. HIV, mental health treatment, etc).
C-257	Claimant's Record of Medical and Travel Expenses	To be used by claimant to keep a record of reimbursable expenses in connection with a workers' compensation case. Bring completed form, with receipts, to hearings and present to Workers' Compensation Law Judge.

Workers' Compensation Claim Forms - Employer		
Form Number	*Form Name*	*Purpose*
FROI – 00 C-2	Electronic Employer's Report of Work-Related Injury/Illness (online reporting) Employer's Report of Work-Related Injury/Illness (paper form)	To be filed by the employer within 10 days after of the employer's knowledge of a work-related injury, provided the injury has caused or will cause the injured employee's loss of time from regular duties of one day beyond the workday or shift during which the accident occurred; or has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid.
Claimant Information Packet	Claimant Information Packet	Must be provided by the employer to the injured employee before filing First Report of Injury (FROI-00).
C-11	Employer's Report of Injured Employee's Change in Employment Status Resulting from Injury	Employer's Report of Injured Employee's Change in Status or Return to Work. File this form as soon as employment status of injured employee changes. Change in employment status includes return to work, discontinuance from work, an increase or decrease of regular hours of work.

Workers' Compensation Claim Forms – Medical Provider		
Form Number	*Form Name*	*Purpose*
C-4	Attending Doctor's Report	• initial report within 48 hours of first treatment; • 15-day report within 17 days of first treatment; • 45-day progress report at 45-day intervals while continuing treatment Always include detailed information of your findings
C-4.1	Continuation to Carrier/Employer Billing Section C-4, C-5, PS-4 or OT/PT-4	Use as continuation sheet when more than six dates of service must be shown in the billing portion of Form C-4. (May also be used with Forms C-5, PS-4 and OT/PT-4)
OT/PT-4	OT/PT–4 "Occupational Therapist's or Physical Therapist's Report	• initial report within 48 hours of first treatment; • 15-day report within 17 days of first treatment; • 45-day progress report at 45 day intervals while continuing treatment. Always include detailed information of your findings.
FCE-4	Practitioner's Report of Functional Capacity Evaluation	The Functional Capacity Evaluation (FCE) is used to determine the level of safe maximal function at the time of maximum medical improvement; to determine whether additional treatment or referral to a work hardening program is indicated.

Prepared by NYS Public Employees Federation SOURCE (as of 1-2-18): New York State Insurance Fund https://ww3.nysif.com/Home/FooterPages/Column1/Forms

WHAT IS THE MANDATORY ALTERNATE DUTY PROGRAM?

New York State and the Public Employees' Federation (PEF) negotiated a Mandatory Alternate Duty Program that allows employees receiving Workers' Compensation benefits to return to work in an assignment that meets both the needs of the agency and the medical limitations of employees.

This program was negotiated by PEF and the State as part of the changes in the Workers' Compensation benefit in the 1991-1995 agreement and continues through the 2023-2026 agreement. Employees benefit from this program by receiving their regular salaries during the alternate duty assignment. Agencies benefit by being able to utilize the capabilities of these employees who would otherwise be unable to return to work.

The term "mandatory" as used in this program means that if you meet the eligibility criteria and request a mandatory alternate duty assignment, you must be offered an assignment or your agency will have to pay you a Workers' Compensation benefit supplement as if you are totally disabled. Alternatively, if you meet the eligibility criteria, your agency may require you to return to work in a mandatory alternate duty assignment even if you do not request it. Once a determination is made that you are 50% or less disabled your supplemental payments cease. The only way to receive compensation other than the statutory benefit is to request a mandatory alternate duty assignment or challenge the disability determination in a WCB hearing.

NOTE: Most agencies require that the injured employee request an alternate duty assignment. It is a good idea to make such requests in writing so that they are documented.

Eligibility Requirements

You are able to participate in the Mandatory Alternate Duty Program if you meet the following criteria:

- You must be classified as partially disabled at 50% or less by the State Insurance Fund;

  - AND -

- You must have a prognosis of full recovery within 60 calendar days. **Full recovery is defined as the ability to perform the full duties of the job you held when injured**. These medical findings may occur as a result of an examination by a State Insurance Fund consulting physician or by your own physician. Your agency determines what documentation will be acceptable to establish your eligibility and determine your physical limitations.

Mandatory Alternate Duty Assignments

A mandatory alternate duty assignment is a short-term assignment (up to 60 calendar days per injury) that reflects your physical limitations as described in the medical documentation accepted by management.

Please note that your MAD assignment may be extended at management's discretion.

Your assignment may involve performing some duties of your regular position, some duties of another position, or a combination of tasks from several positions. Your assignment may also be performing the same duties for the entire period, or may consist of a series of different assignments, each performed for a specific period of time.

You should receive the following information when offered a mandatory alternate duty assignment by your agency:

a. Description of the proposed alternate duties
b. Location of the assignment
c. Work hours and workweek
d. Name of your supervisor
e. Starting and ending dates

Your agency is expected to make every effort to tailor the assignment to your specific limitations and to discuss the assignment with you. The assignment may not necessarily fall within your regular title, grade, or job duties. Your agency is not required to provide you with your regular work location, schedule, or workweek. However, once a mandatory alternate duty assignment is established for a fixed period of time, the provisions of Article 32 (Workday/Workweek) cover you during that same period.

While performing a mandatory alternate duty assignment, you receive your regular salary and are treated like any other employee in full pay status for attendance and leave and benefit purposes. It is the policy of the State to attempt to place employees in mandatory alternate duty assignments that are as close to their regular title and duties as possible based on the needs of the agency.

The mandatory alternate duty assignment will be based on the medical documentation accepted by management. If you believe that some part of the proposed assignment constitutes a personal hardship, you may express your concern to the appropriate agency official. Your agency will respond in writing prior to the proposed start of your assignment or as soon thereafter as possible. You may not grieve your agency's determination. You should provide a copy of your request and management's response to your PEF representative.

Applying for a Mandatory Alternate Duty Assignment

Contact your agency to request a mandatory alternate duty assignment. You can request a mandatory alternate duty assignment 65 days before your full recovery date. However, you are not entitled to receive an assignment until 60 days before your full recovery date.

Once you meet the eligibility requirements, request a mandatory alternate duty assignment, and provide your agency with acceptable medical documentation, your agency must do one of the following:

1. Offer a mandatory alternate duty assignment for up to 60 calendar days which takes into account your physical limitations.

   - OR -

2. If a mandatory alternate duty assignment cannot be provided, arrange for you to receive a supplemental payment that will provide you with 60% of your gross income when added to the SIF payment. The supplement will not be paid beyond the point the mandatory alternate duty assignment would have expired.

You are not required to apply for a mandatory alternate duty assignment, but your agency may direct you to return to work on a mandatory alternate duty basis if you meet the eligibility criteria. If you decline a mandatory alternate duty assignment, you will be referred to the State Insurance Fund for a benefit determination.

If you meet the eligibility requirements and do not request a mandatory alternate duty assignment, or your agency does not direct you to return to work, you will continue to receive wage replacement benefits from the State Insurance Fund in accordance with the Workers' Compensation Law until you are fully recovered. However, you will not receive the supplement.

Disabilities beyond 60 days

If the disability continues beyond the 60 days, the employee may request and extension of the assignment. If the extension is not granted by management, the employee continues to receive wage replacement benefits from the State Insurance Fund in accordance with the Workers' Compensation Law until you are fully recovered.

Civil Service Law § 71 – Information for PEF Members

Leave, Termination and Reinstatement Rights of Disabled Employees Under Civil Service Law § 71

Sections 71-73 of New York State Civil Service Law set forth the employment rights of occupationally and non-occupationally disabled employees. The main thing PEF leaders and stewards need to know is that no state or local-government employee can be placed on disability leave, refused reinstatement from such leave, or terminated from occupational or non-occupational leave without being given notice and an opportunity to contest the employer's decision.

CSL Section 71 ‹ Disability leave

Civil Service Law § 71 deals with employees on occupational disability leave. It provides that an employee shall be allowed leave from his or her position due to an occupational injury or disease as defined in the Workers' Compensation Law. An occupationally disabled employee is entitled to a cumulative leave of absence of at least one-year. The appointing authority may terminate an employee after the employee has been absent on § 71 leave for a cumulative one-year period, or two years for assault cases.

If the employee is terminated, NYCRR § 5.9 outlines the specific type of written notice the employee must receive, as well as the time in which it must be given.

When the employee recovers sufficiently to return to work, the employee may be required to undergo a medical examination.

If the state disputes the employee[1]s ability to return to work, the employee cannot be refused reinstatement, or fired, without notice and a hearing. These rights are spelled out in state Civil Service Department regulation § 5.9 that was adopted in the settlement of a federal civil-rights action brought by PEF.

ADA ‹ Federal protections

Sections 71-73 must also be read in conjunction with the federal Americans with Disabilities Act (ADA) and New York State Human Rights Law (HRL). Under the ADA and HRL, an employer is prohibited from discriminating against qualified individuals with disabilities in hiring, promotions, compensation, termination, or other terms and conditions of employment. A qualified individual with a disability is anyone who has the skills, experience and education required for the job and can perform the job's essential functions, with or without a reasonable accommodation. Any decision about whether an employee can be placed on leave, refused reinstatement from leave, or terminated must be consistent with ADA and HRL standards.

When a member raises concerns about their rights under one of these sections of law, the matter should be brought promptly to the attention of the appropriate PEF field representative. If the field representative cannot provide the answers, the matter will be submitted to the PEF legal department for review. The legal department often provides advice and, in certain circumstances, representation in cases arising under Sections 71-73.

(Prepared by the PEF Office of General Counsel)

Employee Rights Under Civil Service Law § 71

Overview

Occupationally-injured employees have significant job protections under the *Civil Service Law. CSL* § 71 provides that an employee shall be allowed leave from his or her position due to an occupational injury or disease as defined in the *Workers' Compensation Law*. *CSL* § 71 further provides that an occupationally disabled employee is entitled to a *cumulative* leave of absence of at least one year (two years for assault cases). The employer may extend a Section 71 leave beyond that time, but is not required to do so.

Restoration From Section 71 Leave

At any time during the Section 71 leave, the employee may request restoration to duty. If the appointing authority agrees that the employee is fit, the employee will be returned to duty. The appointing authority has the right, however, to require the employee to undergo an examination by a physician designated by the appointing authority (either an Employee Health Services physician or a physician in the Medical Evaluation Network provided by Article 13 of the PEF/State contract). Prior to this examination, the appointing authority must provide the designated physician and the employee with a statement of the regularly assigned duties of the employee's position.[1] If the physician finds that the employee is medically fit, the appointing authority must restore the employee to duty.

Even if the examining physician finds that the employee is not medically fit, and recommends that the employee not be returned to duty, it is still within the appointing authority's discretion to restore the employee to duty. The appointing authority need not consider more than one application for restoration to duty from an employee during a single six-month period.

In the event that the appointing authority determines, based on the physician's recommendation, that the employee is not fit to return to duty, the employee is entitled to written notice of the decision. This notice must be delivered in person or by certified mail to the employee's home. **The employee has 10 working days to appeal the decision in writing.** An employee who appeals is entitled to a full due process hearing on the issue of his or her ability to return to work. At the hearing, the hearing officer will receive documents and testimony, as well as written and oral arguments, concerning the medical condition of the employee, the duties of the position, and the ability of the employee to perform those duties.

The hearing officer then submits the record of the proceeding and his or her recommendations to the appointing authority. The appointing authority issues written findings of fact and a determination, usually within 30 days, in which the appointing authority will either:

1. restore the employee to duty;
2. continue the employee on leave; or
3. terminate the employee upon a finding of permanent disability.

[1] The analysis of whether an employee is fit to return to duty must comply with the standards set forth in the *Americans with Disabilities Act* (ADA). The employer must determine, based on the medical report, if the employee is fit to perform the essential duties of the position with or without a reasonable accommodation.

PEF Field Representatives are available to represent bargaining unit employees in these hearings.

Termination of Section 71 Leave After One Year

The appointing authority may terminate an employee after the employee has been absent on section 71 leave **for a cumulative period of one year (2 years for assault cases)**. If the employee is terminated, **the employee must receive written notice of the termination, in person or by mail, at least 30 days prior to the effective date of the termination**.

The termination notice that the employee receives must include:

1. The proposed effective date of termination;
2. the right to apply to the appointing authority for reinstatement to duty if medically fit;
3. the obligation to submit to a medical examination to determine fitness to perform the duties of the position;
4. the right to a hearing to contest a finding of unfitness for restoration to duty; and
5. the right after termination of employment to apply to the Civil Service Department within one year of the end of the disability for reinstatement to the position, if vacant, to a similar position, or to a preferred list.

An employee who wishes **to contest termination under Section 71,** based on a claim that he or she has recovered sufficiently to perform the essential functions of the job with or without a reasonable accommodation, **may demand a hearing and is entitled to representation by PEF counsel at that hearing if he or she has medical documentation establishing he or she was medically able to perform the duties of the position, with or without a reasonable accommodation, at the time of the termination. The employee must also be able to produce a physician who is willing and able to testify at the hearing to that effect.**

Reinstatement After Termination

An employee who has been terminated pursuant to Section 71 may apply to the Civil Service Department for **reinstatement** if the disability ceases, but **must do so within one year from the end of the disability**. Upon application for reinstatement, a statement of the duties of the employee's former position must be served upon the former employee, together with notice of the date, time and place of the medical examination. After the examination, the former employee must be notified in writing of the findings of the physician by certified mail to his or her home. If the employee is found fit to return to perform the duties of his or her former position, the employee must be reinstated to his or her former position if vacant, or be placed on a preferred list.

If the former employee is found not fit to perform the duties of the position, he or she may apply to the President of the Civil Service Commission in writing for a hearing on the issue of fitness. The application for a hearing must be submitted within ten working days of service of the notice of an adverse medical finding or, to be on the safe side, ten days from the date of the letter itself. A hearing will be conducted during which the parties can present oral and written evidence. The hearing officer then submits a recommendation to the President of the Civil Service Commission, who will then issue written findings of fact

and a determination either directing or denying the reinstatement. An employee may appeal such a determination to the Civil Service Commission in writing within 30 days of the service of the determination denying reinstatement or, to be on the safe side, within 30 days of the date of the determination itself. The appeal, however, may only be made on the basis of manifest error and is limited to the written record. The decision of the Civil Service Commission is final and subject to judicial review via Article 78 of the *Civil Practice Law and Rules*.

Conclusion

Occupationally injured workers have significant legal protections under *CSL* § 71 and Section 5.9 of Civil Service regulations. No employee can be refused reinstatement from leave or terminated without notice and an opportunity to dispute the allegation that he or she is still unable to work. These rights are in large part the result of PEF's efforts, and PEF Field Representatives and attorneys are available to advise and represent members on all aspects of *Civil Service Law* § 71.

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

You were injured at work. What now?

The New York State Workers' Compensation Board has received notice you suffered a workplace injury or illness, so we're preparing a workers' compensation case in your name. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Do this within 30 days of injury.
- Medical reports are necessary for your case. Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, it must notify this Board. You should file an employee claim (C-3 form) reporting your injury as soon as possible. (You **must** notify the Board of your injury or illness within two years.) If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

Three ways to file a C-3 or C-3.3

Visit www.WCB.NY.Gov and click Workers to complete the form.

Call (877) 632-4996. A Board employee will complete the form with you.

Complete the enclosed paper forms and mail them to the Board.

Health Care Bills

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Board disallows your case. If your case is disputed, the providers are paid when the Board decides your case. *If the Board decides against you, or if you don't pursue a case, you will have to pay the doctor or hospital.*

Your employer's insurance covers medically necessary drugs and equipment your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

New York State Workers' Compensation Board
PO BOX 5205
Binghamton, NY 13902-5205
wcb.ny.gov (877) 632-4996

Generally, you can choose any doctor authorized by the Board. You can also use occupational health clinics. However, if your employer's insurer has a preferred provider organization to provide care for workers' compensation injuries, you must get your initial treatment from those providers. If that insurer also has a pharmacy or diagnostic network, you must get service within these networks. If the insurer uses these networks, it must also tell you its service providers and how to use them.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and insurers dispute a claim. When that occurs, the Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Board sets their fees and they will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. You would pay them back out of your lost wages award. To get a DB-450 form, visit **www.wcb.ny.gov** and click Workers; visit a Board office; or call (877) 632-4996.

Help is Available

People sometimes need help getting back to work. Your employer may have a *return to work* program that can get you back to work in light duty or an alternative position while you heal. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for more assistance.

What's Next?

Your employer or its insurance carrier will contact you if your claim is accepted. When that happens, your treatment will be paid and lost wage benefits begin. If your case is challenged, the Board will notify you about resolving the case. If more information is necessary, the Board will contact you and tell you how to file it.

IMPORTANT CONTACT INFORMATION

Workers' Compensation Board, Including Disability Benefits	**(877)632-4996**	**General_Information@WCB.NY.Gov www.WCB.NY.Gov**
NYS Bar Association Lawyer Referral and Information Service	**(800)342-3661**	**lr@nysba.org.**

NYSIF Pharmacy Info – CVS Care Mark

NYSIF New York State Insurance Fund

The workers' compensation insurance carrier for employees of New York State is The New York State Insurance Fund (NYSIF) which has a contract with CVS Caremark, a pharmacy benefits manager (PBM) that offers convenient prescription filling services.

NYSIF has implemented an instant enrollment or "short-fill" service with CVS Caremark. The new service allows injured workers immediate acceptance by any pharmacy in the CareComp pharmacy network administered by CVS Caremark. Although New York law does not require us to provide this benefit, we have elected to provide a limited number of cost-effective medication benefits for new claims filed for **work-related injuries or illnesses** in order to help injured workers get through the first, difficult days after an injury and before the claim is accepted.

An employee injured at work should report the injury to the Accident Reporting System (ARS). At this time the employee will be given an ARS incident number.

When submitting a prescription, the injured worker should give the pharmacy the following information:

- The ARS incident number
- GROUP is: NYSIF

The pharmacy should then contact CVS Caremark at 1-866-493-1640.

For instances where an ARS incident number is not able to be obtained right away, the employee should bring the completed "Workers' Compensation Prescription Services ID" form to any pharmacy participating in the CareComp pharmacy network administered by CVS Caremark.

The temporary ID form is completed by the state agency first, then the injured worker.

- Agency fills in:
  - Agency's Name
  - Policy Number (240960)
- Injured worker fills in:
  - First and Last Name
  - Mailing Address
  - Date of Injury
  - Date of Birth
  - Social Security Number

Injured workers can quickly find local participating pharmacies by visiting: **www.wcrxpharmacylocator.com** or by calling the CVS Caremark 24-hour patient care hotline at 1-866-493-1640.

The injured employee will receive a permanent ID card and packet from CVS Caremark within 10 days of NYSIF's confirmation of the accident. If you have any questions, please contact NYSIF, your workers' compensation carrier, at 1-888-875-5790.

The workers' compensation insurance carrier for employees of New York State is The New York State Insurance Fund (NYSIF) which has a contract with CVS Caremark, a pharmacy benefits manager (PBM) that offers convenient prescription filling services.

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When an employee sustains a work-related injury, the form on the other side of this page (**Workers' Compensation Temporary Prescription Services ID**) may be used to fill prescriptions at any participating pharmacy in the CareComp Network. It makes getting **prescriptions for your work-related injury** very easy.

Step 1: Agency fills in:

- Agency's Name
- Policy Number (240960)

Step 2: Injured employee fills in his/her:

- First and Last Name
- Mailing Address
- Date of Injury
- Date of Birth
- Social Security Number

Step 3: Injured employee brings to pharmacy:

- Completed temporary ID form
- Prescription(s) for work-related injury

Step 4: Within 10 days of the New York State Insurance Fund's confirmation of the accident, the injured employee will receive a packet from CVS Caremark. The packet will contain a permanent ID card that should be used when filling prescriptions for the work-related injury.

Note: Injured workers can quickly find local participating pharmacies by visiting: www.wcrxpharmacylocator.com or by calling the CVS Caremark 24-hour patient care hotline at 1-866-493-1640.

If you have any questions about this form, please contact NYSIF, your workers' compensation carrier, at 1-888-875-5790.

NYSIF New York State Insurance Fund

CVS CAREMARK

Workers' Compensation Temporary Prescription Services ID
Important Information

ATTENTION **INJURED WORKER**

This Workers' Compensation Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact CVS Caremark Customer Service at 1-866-493-1640.

ATENCIÓN: TRABAJADOR LESIONADO

Este formulario de Identificación para Servicios Temporales de Prescripción de Recetas por Compensación del Trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de CVS Caremark, en el teléfono 1.866.493.1640.

Pharmacist/Employer – When form is completed, fax to CVS Caremark: **1-866-493-1644**

Claimant information will be added by CVS Caremark to allow medications to process. This information can also be phoned in at 1-866-493-1640

New York State Insurance Fund	**Group#: NYSIF**
Attention: All items below must be completed.	
AGENCY'S NAME: _____	INJURED WORKER'S NAME: _____ FIRST MI LAST:
AGENCY'S WORKERS' COMPENSATION POLICY NUMBER: 240960	INJURED WORKER'S MAILING ADDRESS: _____ STREET:
DATE OF INJURY: __ __ / __ __ / __ __ __ __ MM / DD / CCYY	_____ CITY, STATE ZIP
INJURED WORKER'S DATE OF BIRTH: __ __ / __ __ / __ __ __ __	*Help Desk: This is a POS Program through CVS Caremark only. For Assistance call the CVS Caremark Help Desk at: 866.493.1640*
ID#: _____ Injured Worker's Social Security Number	

Attention Pharmacist:

New York State Insurance Fund's prescription program is administered by CVS Caremark. The following are the steps necessary to submit a prescription for New York State Insurance Fund claimants.

Please follow the action steps listed below to enter the claim.

Step 1	Enter Bin Number 610235
Step 2	Enter PCN: WRK
Step 3	ID: Injured Worker' Social Security Number

NEED ASSISTANCE? **Pharmacist**, if you have any questions while processing the claim, please call the CVS Caremark Help Desk at **1-866-493-1640.**

INJURED ON THE JOB?

An Employee's Guide to Workers' Compensation in New York State

New York State Workers' Compensation Board

Privacy Statement

All documents the Workers' Compensation Board has about your case are private. Under workers' compensation law, only the parties to your claim may receive information from your case file. Beyond you and your attorney or representative, the parties who may see information include

- your employer and your employer's attorney
- your employer's workers' compensation insurance carrier and its attorney

That insurance carrier may share information with health care providers it hires to examine you. Your health care providers will have to share your health information with that insurer when they bill for their services.

Anyone who obtains a court order authorizing access to your claim information is also included. Your information may also be shared with government entities if they are processing a claim for benefits or investigating fraud.
No one may disclose your information to anyone who is not authorized to see it.

You may give written permission to anyone you choose to access your claim information, in two ways.

1. File an original Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records. This is available from *www.wcb.state.ny.us/content/main/forms/Forms_CLAIMANT.jsp*, or by calling 1.866.750.5157.

2. File an original notarized letter or form where you authorize a particular person or entity to see your claim information.

You may submit an authorization at any time. It's always helpful to share a copy of that document with the person you authorize to see your records. Some people authorize their spouse or child to access their records when they initially file for benefits.

Prospective employers may not ask you to give them information about your workers' compensation claims before hiring you.

Table of Contents

The C-3 and C-3.3 forms follow the text of this document.

This pamphlet is a general, simplified presentation of workers' compensation provisions and procedures. It is not a substitute for the law or legal advice.

The Workers' Compensation Board does not discriminate on the basis of race, color, national origin, sex, religion, age, disability or sexual preference when providing services or in employment.

Workers' compensation fraud is a felony, punishable by fines and up to seven years imprisonment. To report fraud, call 1-888-363-6001.

What is Workers' Compensation?

Workers' compensation is a form of insurance. Most employers must carry this insurance for workers who are injured or become ill because of their jobs. It provides for medical care, and wages you lose because your ability to work is affected. Employers pay for this insurance and may not ask you to pay anything toward the cost. The benefits are paid by an insurance carrier, or by the employer if it insures itself. Benefits are paid according to the law, and the Workers' Compensation Board ensures they are correctly provided.

The Workers' Compensation Board is a state agency that oversees how employers and insurers handle the claims of injured workers. A claim is paid if the insurer agrees the incident is work-related, or if the Board orders it. An employer or its insurer can dispute the claim. If that happens, the Board will try to resolve the dispute within 90 days. For example, the insurer may believe the incident didn't occur at work. It may not even agree that it covered your employer when you were hurt. Other issues may also arise. Whatever the reason, the Board will try to resolve it as quickly as possible.

You don't need to lose time from work to file a claim. No one needs to be found at fault for you to receive benefits. Claimants don't receive less if they were careless, nor do they receive more if the employer is at fault. However, a worker loses the right to benefits if the injury results solely from using drugs or alcohol, or from trying to injure herself or someone else.

HOW TO FILE A CLAIM

You must report the injury, in writing, to your employer within 30 days of the accident. **The Board must be notified of your case within two years of the accident.** *You must also file a claim for compensation as soon as possible.*

You may file Form C-3, Employee's Claim for Compensation, one of three ways.

1. Online, go to www.wcb.state.ny.us/content/main/onthejob/howto.jsp to complete the form.

2. Complete a paper C-3 and mail it to the nearest Board office. A C-3 is in the center of this pamphlet, and Board addresses are on the back.

3. Call 1-866-396-8314. A Board representative will complete it with you.

You will be notified by mail if a hearing is necessary.

Who Is Covered?

- Workers in all for-profit businesses.
- County and municipal employees.
- Public school aides, including New York City aides. New York City shop teachers are covered; other New York City teachers are covered in another system.
- Employees of the state of New York, including some volunteer workers.
- Domestic workers employed 40 or more hours per week by the same employer. This includes full-time sitters, companions, and live-in maids.
- Farm workers whose employer paid $1200 or more for farm labor in the previous calendar year.
- Anyone else the Board determines is an employee.

Nonprofit entities, members of religious orders, employers of clergy and teachers, and domestic workers employed fewer than 40 hours a week may voluntarily carry coverage. It isn't mandatory.

Who Isn't Covered?

- People working at educational, religious or charitable institutions who don't teach or do manual labor.
- People covered by federal workers' compensation laws. This includes postal workers, certain maritime trades, interstate railroad, and federal employees.
- Anyone doing yard work or casual chores at a one-family, owner-occupied home. (A minor handling power-driven machinery, including a power lawn mower, is covered.) There may be coverage under a homeowner's policy.
- Certain foreign government employees.
- New York City police officers, firefighters, teachers and sanitation workers are covered by another system. Other uniformed police and firefighters may also be excluded.
- Real estate salespeople and media sales representatives who sign contracts stating that they are independent contractors.
- Sole proprietors, partners, and one/two person corporations with no employees may be covered but do not need it under the law.

A Worker's Responsibilities

1. Try to return to work as soon as you're physically capable. Your employer may have transitional or light duty work for you.
2. You're responsible for looking for work within your physical abilities. This may mean working outside your previous occupation.
3. Respond to all inquiries and documents from the Board and the insurer in a timely manner.
4. Advise the Board and other parties of address changes.
5. Attend all hearings and appointments. Arrive on time.
6. Answer questions thoroughly and honestly.
7. Participate actively in your case. Don't let events happen around you.
8. Understand any agreements you make.
9. Ask questions of your representative and the Board.

Medical Care

A worker who is injured on the job or becomes ill from his work will have his health care for that condition paid under a workers' compensation claim. This care is covered whether or not you lose time from work. It is also paid in addition to any benefits you get for missed wages.

Health care providers must be authorized by the Board to see workers' compensation patients. The Board has lists of providers who are authorized to treat you. You can find a doctor on *www.wcb.state.ny.us/hps/HPSearch.jsp*, or by calling 1-800-781-2362. You can receive care from any of these providers, or from your own doctor, if he or she is registered. The providers will send the bills directly to the insurer and the Board. **Do not pay any bills unless the Board disallows your case.** You may also receive reimbursement for travel to and from a health care provider's office.

If specific medical services are disputed, the insurer must pay any undisputed portion. It must also explain in writing why the services were not paid, and request any information needed to pay them. Your doctors may ask you to sign Form A-9. This states you'll pay the bills if the Board does not allow your claim, or if you drop your case before it's accepted.

Preferred Provider Organizations

If the insurer has a network of providers to care for injured workers, you must use those providers. This is called a Preferred Provider Organization (PPO). The insurer must notify you of this. If you aren't satisfied with the care you receive from the PPO, you may select an authorized provider outside the PPO after 30 days of treatment.

Diagnostic Networks

Insurers may also require you to use its network of facilities for diagnostic tests. Make sure to tell your doctors and other providers if the insurance carrier requires you to use its network for diagnostic test.

Types of Services Covered

Medical
Osteopathic
Dental
Podiatric
Psychological
(by referral)
Chiropractic Treatment
Surgery
Hospital Care

Laboratory Tests
Prescribed Drugs
Nursing Services
Surgical Appliances
Prosthetic Devices

Preauthorization is sometimes required.

Pharmacy Charges

You can go to any pharmacy, unless the insurer uses a network. Make sure the pharmacist knows you have a workers' compensation case, because many will bill the carrier directly, rather than you. However, the pharmacy can ask you to pay for the prescription up front. The insurer must reimburse you within 45 days. The pharmacy can only charge you the amount specified by law, so even if you pay in advance, you will be fully reimbursed. You're not responsible for a copayment.

If you must use an insurer's network pharmacy, the insurer must tell you how you should use it. Those pharmacies are paid directly. You will not be responsible for any charges.

Exceptions

1. *Testing*: The insurer may not demand you use a network provider for a diagnostic test in a medical emergency. It may not demand you use a network that does not have a provider or facility within a *reasonable distance*, which is *one mile from your home or employment in an urban setting, and ten miles in a suburban or rural setting.*

2. *Pharmacy*: The insurer may not demand you use network pharmacies if it is not reasonably possible in a medical emergency. *You don't need to use network pharmacies if they don't offer mail order or aren't located a reasonable distance from you, either.*

Rehabilitation and Social Work

Rehabilitation services help people return to work, and to lead full and active lives. Specific services are explained below.

Medical rehabilitation helps people reach maximum independence and functioning. It provides workers with information and helps them obtain medical care, physical accommodation or other special needs. Only a physician may recommend medical rehabilitation, so talk to your doctor. This service is arranged outside the Board.

Vocational rehabilitation helps people whose disability prevents them from returning to their usual job. Counselors help injured workers find employment that fits their abilities. They also help develop a plan to return to work. This may include vocational counseling and referrals for training and selective job placement.

Social workers assist people when family or financial problems interfere with their returning to work. Social workers help people cope with their disability and discuss their concerns about rehabilitation. They can also help workers prepare to return to work.

The Board has counselors, social workers and claims examiners who coordinate and monitor other services. If you could benefit from these services, contact the Board. The office telephone numbers are on the back cover of this pamphlet.

Occupational Disease

An occupational disease is contracted as the result of your work. It arises from a specific aspect of the work that you perform. For example, people who remove asbestos may contract asbestosis. People who work on computers may suffer carpal tunnel syndrome.

You may be disabled by an occupational disease even if you don't lose time from work.

The rules governing the time limits for filing an occupational disease claim are complex. You should file as soon as you know you're ill, or suspect that you have an occupational disease.

People disabled by occupational diseases receive the same benefits they would for an on-the-job accident. In the case of death, the dependents must file within two years of the date of death.

Occupational Hearing Loss

The law states a different time period to file a claim for occupational hearing loss than from other disabilities. A waiting period must pass before you file a claim. That period is your choice of

- Three months after leaving the employment where you were exposed to the harmful noise, or
- Three months from the date you're removed from the harmful noise in the workplace. Removal can include wearing protective gear, so ask for it at work. You can contact OSHA at 1-800-321-OSHA for help if necessary.

The Board will consider the last day of whichever period you choose as the date of disability in determining when your benefits begin.

Occupational hearing loss claims have different time limits. You may file beyond the typical two-year limit if you do it within 90 days of learning the hearing loss is job-related.

Wage Replacement (Cash) Benefits

Claimants who are totally or partially disabled for more than seven days receive benefits for lost wages. The amount you receive is based on your average weekly wage for the 52 weeks prior to the date of injury, including overtime. It's based on your gross earnings, not your take-home pay. The Board will use two-thirds of your average weekly wage, and then adjust it by the extent of your disability:

2/3 x average weekly wage x % of disability = weekly benefit

The weekly maximum benefit is two-thirds your average weekly wage. If you suffer a total disability, you get two-thirds your weekly wage, up to the maximum (see below). For example, if you earn $750 per week and are totally (100%) disabled as of today, you receive two-thirds of $750, or $500 per week. You're 100% disabled, so you receive all of the benefit.

If you're 50% disabled and earned $750 per week, your benefit is $250. To calculate it: two-thirds your $750 average weekly wage equals $500. Then, because you are 50% disabled, your benefit is half of $500, or $250.

The benefit rate is computed the same way, whether you are temporarily or permanently disabled. The maximum weekly wage benefit is based on accident date. It does not increase as maximum benefits increase.

Date of Accident	Weekly Maximum Wage Benefit
July 1, 1992 - June 30, 2007	$400
July 1, 2007 - June 30, 2008	$500
July 1, 2008 - June 30, 2009	$550
July 1, 2009 - June 30, 2010	$600
July 1 each succeeding year	2/3 of NYSAWW*

* The New York State Average Weekly Wage is calculated on March 31 for the previous calendar year.

If you're disabled more than 14 days, you may get wage benefits from the first day. Otherwise, the first 7 calendar days of the disability are not covered. Medical care for your injury is provided as long as it's needed, as determined by the Board.

Note: If the insurer disputes your case, it may withhold your wage replacement benefit until the Board directs it to pay you.

Reduced Earnings Benefits

If you can return to work but your injury keeps you from earning the same wages you once did, you may be entitled to a benefit that will make up two-thirds of the difference. These are reduced earnings benefits.

Disability Classifications

Your doctor will state how much your injury disables you. The insurer may disagree with that judgment. That insurer can require you to see a doctor it chooses for an *independent medical exam*. The Board will decide how disabled you are (the *degree of disability)* from among those opinions. Your lost wage benefit is based on degree of disability. There are four classes.

Temporary Total Disability You cannot work and earn wages, but only on a temporary basis. You're entitled to the full allowable wage benefit.

Temporary Partial Disability You've temporarily lost some ability to work and earn full wages. You'll receive a percentage of your salary equal to the percentage of disability. For example, if you're 25% disabled, you'll get 25% of your award, for the time you're disabled.

Note: All injuries, even those later found *permanent*, are first *temporary*. All benefits are also subject to the maximum weekly amount.

Permanent Total Disability You completely lost the ability to work and earn wages. **There's no limit on the number of weeks of benefits.**

Permanent Partial Disability, Nonschedule Loss
You lost some part of your ability to work. If you were injured before March 13, 2007, you can get benefits as long as the disability results in wage loss. Injuries after then may receive up to 10 years of benefits, as shown below. (You can apply for reclassification, and additional benefits, after that period.) Even if the disability doesn't impact wages, medical care is always paid.

Permanent Partial Disability, Schedule Loss
This category involves loss of arm, hand, finger, leg, foot and toe or their use, and loss of eyesight or hearing. The law specifies the number of weeks in benefits you receive for this loss.

Disfigurement
People whose faces, head or neck are permanently disfigured may get up to $20,000, depending upon the extent of injury and date of accident.

Resolving Disputed Claims

Insurers will often accept a claim and promptly begin paying benefits. However, an insurer can dispute a claim, for various reasons. It may not agree you were injured, it may not believe the injury occurred while it provided insurance, or any number of other situations. Board claims examiners and conciliators first attempt to resolve issues. If they can't, the Board will hold hearings in front of a workers' compensation law judge. The judge takes testimony, reviews your medical records and wages. Then, the judge decides the issue, and sets the amount of any award.

Either side may appeal that decision. This must be done in writing within 30 days of the decision. Three Board commissioners review appealed cases. They may agree, change part of a decision, or reject it. They may also return the case for more hearings. Insurers don't have to pay lost wage benefits while the case is being reviewed by the three commissioners. An insurer can accept part of a case and appeal another. In that instance, it must pay the accepted part of the award while the case is reviewed. The insurer must pay your wages and medical bills if your award is upheld by those commissioners, even if it appeals further.

Either side may appeal that decision, to the full Board of workers' compensation commissioners. If the full Board takes the case, it will either agree, change or overturn the decision.

Appeals from Board decisions may be taken within 30 days to the Appellate Division, Third Department, Supreme Court of the State of New York. That decision may be appealed in the Court of Appeals.

You always have the right to an attorney or licensed representative. That person may not ask for or take a fee from you. The Board determines the fee for legal services.
That fee is deducted from the lost wages award.

Disability Benefits During a Dispute

If you aren't receiving benefits because your claim was disputed, you may get disability benefits in the meantime. You can file a DB-450 form, available from *www.wcb.state.ny.us/content/main/forms/db450.pdf* or by calling 1-800-353-3092. You pay back any disability payments from your lost wage benefits.

Death Benefits

There is a benefit for the family of workers who die from an injury or illness suffered on the job. The benefit is payable whether the worker dies right after an injury or later.

The worker's spouse and children will receive two-thirds of the employee's average weekly wage, up to the weekly maximum amount. The spouse and children share that weekly benefit; they do not each receive the full benefit. Children receive the benefit until age 18, or until 23 if they attend college. If a child is blind or physically disabled, he or she will receive the benefit for life. The spouse receives the benefit until remarriage. If the spouse remarries, he or she gets a final payment equal to two years of benefits.

The benefit is payable first to a spouse and minor children or dependent grandchildren. If there are no other dependents, then a different benefit is paid. The surviving parents or the deceased worker's estate may be entitled to $50,000. Funeral expenses may also be paid. That benefit is up to $6,000 in metropolitan New York counties, and up to $5,000 in all others.

Social Security Benefits

Your injury or illness may entitle you to Social Security Disability benefits, as well as workers' compensation. People with a permanent disability or a disability that lasts at least 12 months may qualify. Contact a Social Security Office to learn more.

Discrimination

An employer may not fire you or hold it against you if you file a workers' compensation claim. You're also protected from retaliation for testifying in a workers' compensation case. Employers may not discriminate against you in hiring, too. You have two years to make a discrimination complaint. File Form DC-120 with the Board. You can call a Board office for the form, or find it at *www.wcb.state.ny.us/content/main/forms/dc120.pdf.*

If the Board finds that a worker was improperly fired, it will order the employee restored. The employee will also receive back pay lost by that discrimination.

AMERICANS WITH DISABILITIES ACT

The 1990 Americans with Disabilities Act prohibits discrimination against people with disabilities in employment. It ensures equal access to government services, public accommodations, transportation, and telecommunications. This law can help injured employees who want to return to work. Call the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities at 1-800-949-4232 for more information.

A Timeline for Your Case

Immediately: Get medical treatment. Tell your supervisor about the accident and how it occurred. You must also notify your employer of the accident, in writing, within 30 days. You should file a C-3 form with the Board, too.

Within 48 hours of treatment: Your doctor files a medical report with the Board. Copies must also be sent to you and your representative, and to the employer or its insurance carrier.

Within 10 days of accident notification: The employer reports the injury to the Board and the insurer on Form C-2.

Within 14 days of receiving Form C-2: The insurer gives you a written statement of your legal rights within 14 days of learning of the accident or with the first check, whichever is earlier. If you must use its provider network, the insurer must also give you that contact information.
Within 18 days of receiving Form C-2: The insurer must accept your claim or explain why it disputes it. It must inform you, any representative and the Workers' Compensation Board. If you didn't notify the employer promptly, it must act within 10 days of learning of the accident. If the case is disputed and you're losing time from work, file for disability benefits.

Every 2 weeks: The insurer pays lost wage benefits to you (if the case is accepted). It will pay your healthcare providers directly. The insurer must notify the Board if it stops or modifies your benefits.

Periodically: See your doctor and get treatment as recommended. The doctor will submit progress reports to the Board and insurer.

Common Questions about the Law

Q. What is covered under Workers' Compensation Law?
A. Injuries on the job and work-related illnesses,as well as occupational diseases.

Q. What if I don't file a claim for workers' compensation?
A. You may lose the right to benefits for lost wages and medical care. You should file a C-3 reporting your own injury or illness, even though your employer's insurer must notify this Board when it accepts or disputes your case.

Q. How is the cash benefit for temporary total disability determined?
A. The temporary total disability benefit is two-thirds of the average weekly wage you earned in the year before the accident. There is a maximum amount you can receive per week (see page 6). Your maximum benefit is set by what is in effect on the date of the injury.

Q. Is medical care provided even if no time is lost from work?
A. Yes. Medical care is provided for your condition even if no time is lost from work.

Q. Must I wait for medical care?
A. No, but physicians must request authorization to perform procedures that cost more than $1,000 each. This $1,000 threshold pertains to each procedure, not the total cost of care. Insurers must respond to the request within 30 days. Authorization is not necessary in case of an emergency.

Common Questions about the Law (continued)

Q. May a doctor treat me if the insurer does not answer a request for approval?
A. Yes. Insurers have 30 days to reply to an authorization request. If the insurer does not reply in 30 days, the provider may perform the services. If the service is a diagnostic test and the carrier requires claimants to use its network, the test must still be obtained from a network provider.

Q. Are prescription medications covered under the law?
A. Yes. Once your claim is established, pharmacies may bill the insurer directly. You may receive a card or document you can show a pharmacy stating you have coverage. If the carrier has a pharmacy network, it will tell you, and you must use those pharmacies. The only exceptions are in a medical emergency, or if the pharmacies don't offer mail order and there isn't a location reasonably close to you. You may have to pay the pharmacy for service before your claim is established. The carrier must then pay you when the case is established. There is no copayment.

Q. What happens when an insurance carrier contests a claim?
A. To contest a claim, a carrier must notify the Board within 18 days of the disability, or within 10 days of learning of the accident, whichever is later. The carrier must explain why it disputes the claim. You are then entitled to present your case to the Board. You will be notified of a pre-hearing conference. The Board seeks to resolve most cases within 90 days.

Q. Must I have a medical examination when the employer or insurer requests it?
A. Yes. The insurer may have you examined by a qualified provider who is authorized by this Board, within a reasonable distance for you to travel. Refusing this exam may affect your claim.

Q. May an insurer suspend or change the cash benefits?
A. Yes, but you are then entitled to a hearing. A carrier must submit evidence for the change to the Board, and the Board decides. A carrier may not change your benefit after the Board decides it without the Board's approval.

Q. Do I have to use an attorney?
A. No, but an attorney can be helpful in disputed and complex cases. You may represent yourself, or use an attorney or a licensed representative (list of licensed representatives is found at *www.wcb.state.ny.us/content/main/Reps/LisRepListing-Sec24a.pdf*). Any fees are approved by the Board, and deducted from your award. **Do not pay your counsel directly.**

Q. What can I do if I disagree with the Board's decision?
A. You may appeal in writing within 30 days of the filing date of the decision. You must explain why you disagree with the decision. Three Board commissioners will review your case. If you disagree with that review, you can appeal to the full Workers' Compensation Board of Commissioners. They may or may not consider it.

Q. What can I do if I'm not satisfied with the outcome of the appeal?
A. You may appeal to the Appellate Division, Third Department, within 30 days after the decision is served.

Q. Are there penalties for falsehoods in claims?
A. It's a felony to willfully misrepresent a case to obtain benefits. Penalties include up to seven years imprisonment and fines. A claimant may also lose the right to benefits. It's also a felony for an insurer to raise a false issue in an attempt to deny a worker benefits it knows the worker is entitled to receive.

Directory of WCB Services and Board Offices

Board Services

Customer Service
1.877.632.4996

Advocate for Injured Workers
1.800.580.6665

Health Care Provider
1.800.781.2362

Administrative Review Division
1.877.258.3441

Fraud Referral Hotline
1.888.363.6001

Disability Benefits
1.800.353.3092

Board Offices

Albany District Office
100 Broadway - Menands
Albany, NY 12241
1.866.750.5157

Binghamton District Office
State Office Bldg., 44 Hawley Street
Binghamton, NY 13901
1.866.802.3604

Buffalo District Office
Statler Towers, 3rd Floor
107 Delaware Avenue
Buffalo, NY 14202
1.866.211.0645

Rochester District Office
130 Main Street West
Rochester, NY 14614
1.866.211.0644

Syracuse District Office
935 James Street
Syracuse, NY 13203
1.866.802.3730

Send mail for these upstate districts directly to these addresses.

Brooklyn District Office
111 Livingston Street
Brooklyn, NY 11201
1.800.877.1373

Hauppauge District Office
220 Rabro Drive, Suite 100
Hauppauge, NY 11788-4230
1.866.681.5354

Hempstead District Office
175 Fulton Avenue
Hempstead, NY 11550
1.866.805.3630

Manhattan District Office
215 W. 125th Street
New York, NY 10027
1.800.877.1373

Peekskill District Office
41 North Division Street
Peekskill, NY 10566
1.866.746.0552

Queens District Office
168-46 91st Avenue
Jamaica, NY 11432
1.800.877.1373

Claims-related mail for these districts should go to the *downstate centralized mailing address:*

PO Box 5205 • Binghamton, NY • 13902-5205

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___ - ___ - ____ 5. Phone Number: (___) _____ 6. Gender: ☐ Male ☐ Female

7. Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (___) _____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
   _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____
    _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

Limited Release of Health Information
(HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____
   _____
7. Your legal representative's name and address (if any):_____
   _____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name Relationship to Claimant Signature Date

Versión en español al reverso de la forma.

C-3.3 (11-08)

Divulgación limitada de información sobre la salud (HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre) 2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento) 5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

*Check here if you allow your health provider(s) to release **mental health care** information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre **tratamientos de salud mental.**)*

B. YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud) 2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde]) 5. Phone Number (Nº de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) Relationship to Claimant (Relación con el reclamante) Signature(Firma) Date(Fecha)

C-3.3 (11-08) **www.wcb.state.ny.us**

Divulgación limitada de información sobre la salud (HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

*Check here if you allow your health provider(s) to release **mental health care** information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre **tratamientos de salud mental**.)*

B. YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas áreas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (Nº de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar,** la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) Relationship to Claimant (Relación con el reclamante) Signature(Firma) Date(Fecha)

Section E - Return to Work (cont):

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed,
   the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the appropriate WCB district office (DO) at the address listed below:

Albany DO - 100 Broadway-Menands, Albany NY 12241 (866) 750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton,Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY13901 (866) 802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland,Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 (866) 211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 (866) 211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans,Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 (866) 802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga,Oswego,St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC (800) 877-1373; in Hempstead (866) 805-3630; in Hauppauge (866) 681-5354; in Peekskill (866) 746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)
C-3.0 (3-09)

NEW YORK STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to _____,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at _____.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

OC-110A (12-17)
Prescribed by the Chair, Workers' Compensation Board

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one-hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

Occupational Health Clinic Locations and Phone Numbers

To find a health clinic, select from the list of regions.

Western Region

Services Allegany, Cattaraugus, Chautauqua, Erie, and Niagara Counties
Center for Occupational and Environmental Medicine
Phone: 716-898-5858
Website https://www.ecmc.edu/health-services-and-doctors/center-for-occupational-environmental-medicine/

Finger Lakes Region

Services Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, and Yates Counties
Finger Lakes Occupational Health Services
585-244-4771

800-925-8615
Email FLOHS@urmc.rochester.edu
Website https://www.urmc.rochester.edu/finger-lakes-occupational-health.aspx

Central Region

Services Broome, Cayuga, Chemung, Chenango, Cortland, Delaware, Jefferson, Lewis, Madison, Onandaga, Oswego, St. Lawrence, Schuyler, Steuben, Tioga, and Tompkins Counties
Occupational Health Clinical Center
315-432-8899
Website http://ohccupstate.org/

Eastern Region

Services Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties
EmblemHealth Health@Work
518-690-4420
Website https://healthatwork.emblemhealth.com/

Mid-Hudson Region

Services Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties
Mount Sinai Selikoff Centers for Occupational Health
888-702-0630
Website https://www.mountsinai.org/care/occupational-health

Cooperstown Specialty Agricultural Clinic

Services Otsego County
New York Center for Agricultural Medicine and Health
607-547-6023
800-343-7527
Website https://www.nycamh.org/

New York City Region

Services Bronx, Kings, New York, Queens, and Richmond Counties
Mount Sinai Selikoff Centers for Occupational Health
888-702-0630
Website https://www.mountsinai.org/care/occupational-health

Bellevue/NYU Occupational & Environmental Medicine Clinic
212-562-4572
Website https://med.nyu.edu/departments-institutes/population-health/divisions-sections-centers/epidemiology/bellevue-nyu-occupational-environmental-medicine-clinic

Long Island Region

Services Nassau and Suffolk Counties
Occupational & Environmental Medicine of Long Island
516-492-3297 (New Hyde Park)
631-439-5300 (Islandia)
Email OEMLI@northwell.edu
Website https://www.northwell.edu/occupational-medicine-epidemiology-prevention/occupational-environmental-medicine

For More Information

For further information, contact your local occupational health clinic, or the New York State Department of Health at 518-402-7900.

Questions or comments: boh@health.ny.gov
Revised: April 2022

What if I need compensation right away?

In limited cases, you may ask for an emergency award, up to $2,500.

What if I move after filing a claim?

Send a letter with your new address, phone number(s) and email address, if you have one, to:

New York State Office of Victim Services
Alfred E. Smith State Office Building
80 South Swan St., Second Floor
Albany, New York 12210

You may also submit your signed change of address request online through the Victim Service Portal: ovs.ny.gov.

Where can I get more information or help in my community?

OVS funds victim assistance programs across New York State. These programs can assist you with filing your claim with OVS and can provide immediate help, including access to counseling, legal advice and emergency shelter, among other services.

For more information, visit ovs.ny.gov or call 800-247-8035 to learn more.

As a victim of crime in New York State you should know:

- You can get a free copy of the police report (New York State Executive Law §646).
- You are protected by law from threats or intimidation from the suspect or the suspect's family. Local police departments and district attorneys (DAs) can explain these laws to you.
- You have a right to be involved in certain stages of the criminal justice process. Local police departments and DAs can explain your role in the criminal justice process, the important steps in the process, and how you can get information about those steps.
- You have the right to make a statement at the time of the defendant's sentencing, if you are the victim of a felony.
- You have the right to be notified of the defendant's incarceration status. You can call VINE at 888-846-3469 to provide your contact information.

For more detailed information on your rights as a crime victim, please refer to the publication "The Rights of Crime Victims in New York State," which is available at ovs.ny.gov.

Every Crime Victim Matters

A Guide To Crime Victims' Compensation In New York State

ovs.ny.gov

800-247-8035

NEW YORK STATE | Office of Victim Services

How do I apply for compensation?

- Complete the OVS application
- Meet the eligibility requirements
- Have a current or future eligible out-of-pocket loss as a result of the crime

Who may be eligible for compensation?

- The victim must be an innocent victim of the crime
- Victims of crime who were physically injured as a result of the crime
- Victims of crime who are under 18, 60 and over, or disabled, who were not physically injured
- Certain relatives, including surviving spouse, grandparent, parent, stepparent, guardian, brother, sister, stepbrother, stepsister, child, stepchild, grandchild, or any other person dependent for his or her principal support upon the victim of a crime who died as a direct result of such crime
- A surviving spouse, grandparent, parent, stepparent, guardian, brother, sister, stepbrother, stepsister, child, stepchild, or grandchild of a victim of a crime who died as a direct result of such crime and where such crime occurred in the residence shared by such family member or members and the victim
- Individuals who paid for or incurred burial costs for an innocent crime victim
- Child victims, a child who witnesses a crime, and the child's parent, stepparent, grandparent, guardian, brother, sister, stepbrother or stepsister
- Victims of certain menacing, unlawful imprisonment, kidnapping, criminal mischief, robbery, criminal obstruction of breathing or blood circulation, harassment, aggravated harassment, criminal contempt, stalking, or hate crime charges who have not been physically injured
- Vulnerable elderly, incompetent, or physically disabled persons who cannot care for themselves
- Certain victims of labor trafficking or sex trafficking
- Victims of terrorist acts outside of the United States who are residents of New York State
- Victims of frivolous lawsuits brought by individuals who committed crimes against the victims

What other steps must I take to be eligible?

- Report the crime within one week to police or another criminal justice agency
- File a claim with OVS within one year of the crime
- If late with either crime reporting or claim filing, justify the delay in writing
- Cooperate with police, the district attorney's office and OVS

What kind of expenses may I be eligible for?

OVS offers compensation related to: personal injury, death and loss of essential personal property. The specific expenses OVS may cover include:

- Medical and counseling expenses
- Loss or damage of essential personal property (up to $500)
- Burial/funeral expenses (up to $6,000)
- Lost wages, savings, or lost support, including lost wages of parents if a child victim is hospitalized (up to $30,000)
- Transportation (necessary court appearances for prosecution)
- Occupational/vocational rehabilitation
- Use of shelters by domestic violence victims and their children
- Crime scene clean-up (up to $2,500)
- Good Samaritan property losses (up to $5,000)
- Moving expenses (up to $2,500)

What if my property was lost, damaged or destroyed because of the crime?

- If you are under 18, 60 or over, disabled or were injured, you may apply for benefits to repair or replace your essential personal property lost, damaged or destroyed as the direct result of a crime that was not covered by any other resource
- Essential means necessary for your health, safety and welfare, such as eyeglasses and clothing

How do I obtain an application?

- Visit ovs.ny.gov to file a claim online
- Contact any victim assistance program near you; an advocate can help you file an application
- Obtain an application from any police department or hospital emergency room

What other documents does OVS need from me?

Depending on the type of claim, you may need to provide copies of some or all of the following when you file your application online or via surface mail:

- Police reports
- Insurance cards
- Receipts for essential personal property
- Proof of relationship (examples: victim's birth certificate, marriage license)
- Death certificate and funeral contract
- Itemized medical bills
- Letters from any insurers denying or authorizing payment for the services listed on the form
- Proof of age (examples: driver's license, birth certificate)
- Legal guardianship papers

What if I don't have the documents OVS needs?

You may submit only the application. OVS will contact you once your claim has been accepted and request any additional documentation needed to process your claim.

Please keep in mind that OVS cannot make a decision on your application without the required documents, as they are necessary to determine if you are eligible for assistance.

What is the HIPAA authorization form?

This form allows providers to discuss health information with OVS. You must sign this form for each health care provider that has treated you.

Who can sign the application?

The victim must sign the application. If the victim is under 18 or is physically or mentally incapable of signing, then his/her legal guardian must sign.

NEW YORK STATE | Office of Victim Services

Claim Application and Instructions

How to Apply for Compensation

Who can apply for compensation?

Innocent victims of crime, certain relatives, dependents, legal guardians and eligible Good Samaritans can apply to the Office of Victim Services (OVS) for compensation of out-of-pocket expenses not covered by insurance or other resources.

What kind of expenses can I get compensated for?

OVS offers compensation related to personal injury, death and loss of essential personal property.

The specific expenses OVS may cover include:

- Medical, pharmacy and counseling expenses
- Loss of Essential Personal Property *(up to $500, including $100 for cash)*
- Burial or Funeral Expenses *(up to $6,000)*
- Lost Wages or Lost Support *(up to $30,000) (Parents or guardians of hospitalized minor children may be eligible for this benefit.)*
- Transportation (court/medical)
- Occupational/Vocational Rehabilitation
- Security Devices and DV Shelter Costs
- Crime scene clean-up *(up to $2,500)*
- Good Samaritan property losses *(up to $5,000)*
- Moving expenses *(up to $2,500)*

How do I ask for compensation?

Send us your completed OVS application along with copies of:

- Police reports
- Medical bills
- Correspondence with insurance companies or benefits plan saying if they will cover your loss
- Insurance cards
- Receipts for essential personal property
- Death certificate and funeral contract
- Victim's birth certificate
- Proof of age (driver's license, birth certificate etc.)
- Legal guardianship papers

What if I don't have some of the papers OVS needs?

Send your application in right away. You can send the other documents later.

What if my property was lost, damaged or destroyed because of the crime?

If you are under 18, 60 or over, disabled or were injured, you may apply for benefits to replace your *essential* personal property or cash that was not covered by any other resource.

Essential means necessary for your health and welfare, like eyeglasses and clothes.

What if I move?

Send OVS a signed letter right away. Tell us your new address and phone number. Also let us know if your email address changes.

Who can sign the claim?

Generally, the victim must sign the claim. However, if the victim is under 18, or is physically or mentally incapable of signing, then the legal guardian (the person receiving the benefits) must fill out section 2 of the claim and sign the claim.

If the victim died, the person asking for benefits must fill out section 2 of the claim and sign the claim.

Is there another way to apply?

Yes. Visit ovs.ny.gov to access the secure Victim Service Portal (VSP) and file an application online.

Do I have to fill out the attached HIPAA form?

Yes. Fill out one HIPAA form for **each** service provider. You can photocopy a blank form to make extra copies.

80 S. Swan Street
Albany, NY 12210-8002
(518) 457-8727

55 Hanson Place
Brooklyn, NY 11217-1523
(718) 923-4325

ovs.ny.gov

800-247-8035

Rev. December 2020

Court Ordered Restitution Information

What is restitution?
Restitution is compensation paid to a victim by the perpetrator of a criminal offense for the losses or injuries incurred as a result of the criminal offense. It must be ordered by the Court at the time of sentencing, and is considered part of the sentence.

Restitution is **NOT** for payment of damages for future losses, mental anguish or "pain and suffering."

When the District Attorney's (DA) office advises the Court that you have requested restitution or when the victim impact statement contained in the probation investigation report (pre-sentence, pre-plea or pre-disposition report) indicates that the victim seeks restitution, the Court must order restitution unless the interests of justice dictate otherwise. When the judge does not order restitution, the judge must clearly state his/her reasons on the record.

What can I request as restitution?
You can ask for any expense you incur as a result of the criminal offense – even for items the OVS may not be able to reimburse. Restitution may include, but is not limited to, reimbursement for medical bills, counseling expenses, loss of earnings, funeral expenses, insurance deductibles and the replacement of stolen or damaged property.

Who is entitled to restitution?
Anyone who has been the victim of a criminal offense and has suffered injuries, economic losses or damages can seek restitution. Many times, victims who deserve restitution do not request it. This can occur because victims are not aware that they are entitled to restitution, or do not know what steps to take to go about receiving the restitution they deserve.

How do I ask for restitution?
You should contact the DA's office and advise them of the extent of your injury, your out-of-pocket losses and the amount of damages you are requesting.

It is your responsibility to give the police, DA and, upon request, the local probation department copies of the bills and other documents showing the extent of your injuries, your out-of-pocket losses and the amount of damages you want considered by the Court. Your claim for restitution will be included in any probation investigation report (pre-sentence, pre-plea or pre-disposition report). Be sure to:

- Keep accurate records such as original receipts of any expenses you have as a direct result of the criminaloffense.
- Give copies of these receipts to the police, DA and local probation department.

You need to clearly explain your need for restitution as soon as possible to the DA, the victim/witness advocate, and the probation department. Plea agreements can occur within days of the actual criminal offense. If this information is not provided before the plea agreement and sentencing, you may have to pursue the perpetrator in Civil Court.

The DA is under an obligation to petition the Court to order restitution on your behalf.

In all felony criminal cases, many misdemeanor criminal cases and all juvenile delinquency and persons in need of supervision (PINS) cases, a pre-sentence or predisposition investigation report is required. The local probation department will contact you about the issue of restitution as it pertains to your case.

How is restitution determined?
The amount of restitution is based on proof of your out-of-pocket losses incurred as a result of the criminal offense. The perpetrator has a right to object to the amount of restitution. The Court may hold a hearing on the issue of restitution where the Court may consider the perpetrator's ability to pay. The DA's office may contact you and ask you to testify at the restitution hearing. If you have a concern about appearing personally in Court, you should explore alternatives with the DA assigned to your case.

If the OVS has paid your bills, the Court may order that restitution payments be made to the OVS for those paid items. It is important that you advise the DA's Office that you filed a claim with the OVS.

If you filed a claim with the OVS, it is important that you advise the OVS if the Court orders the perpetrator to pay restitution.

Rev. December 2020

Read *How to Apply for Compensation* before filling out this form.

Application for Compensation

New York State Office of Victim Services

Please print. Answer all questions. *It is a crime to file a false claim!*

Victim Assistance Program Use Only		
OVS VAP ID#	Program Name/Phone	Advocate Name/Email

1 Tell us about the victim.

Last Name	First Name	MI	Social Security # ☐Check here if you do not have one. _____-_____-_____	Date of Birth
Mailing Address: *Street* *Apt. # (or P.O. Box)* *City* *County* *State (or Foreign Country)* *Zip Code*				

Race/Ethnicity: ☐White ☐Black ☐Asian ☐Hispanic ☐American Indian/Alaskan Native ☐Pacific Islander/Native Hawaiian ☐Other ☐Multi-Race

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Lives with partner

Gender: ☐ Male ☐ Female **Was the victim disabled at the time of the crime?** ☐Yes ☐No ☐Unknown

How did you first hear about the Office of Victim Services?

☐Police ☐Hospital ☐District Attorney ☐Victim Assistance Program ☐Radio/TV ☐Brochure/Poster ☐Internet ☐Other

2 If you are *not* the victim, and you are signing this claim, you are the claimant. Tell us about you. (See "Who can sign the claim?" on the instructions page.)

Last Name	First Name	MI	Social Security # ☐Check here if you do not have one. _____-_____-_____	Date of Birth
Mailing Address: *Street* *Apt. # (or P.O. Box)* *City* *County* *State (or Foreign Country)* *Zip Code*				

What is your relationship to the victim? (*Check **only** one.*)

☐ Parent ☐ Spouse ☐ Child ☐ Legal Guardian ☐ Attorney ☐ Other *(Explain)*: _____

***3* Tell us about the crime.** *(Check **only** one.)*

The victim died because of:
- ☐ Motor Vehicle (DUI/DWI)
- ☐ Motor Vehicle (Other)
- ☐ Terrorism
- ☐ Arson
- ☐ Human Trafficking
- ☐ Other Homicide: _____

The victim was injured because of:
- ☐ Assault
- ☐ Sexual Assault
- ☐ Child Physical Abuse/Neglect
- ☐ Child Sexual Abuse
- ☐ Motor Vehicle (DUI/DWI)
- ☐ Motor Vehicle *(not DUI/DWI)*
- ☐ Child Pornography
- ☐ Stalking
- ☐ Kidnapping
- ☐ Terrorism
- ☐ Arson
- ☐ Robbery
- ☐ Human Trafficking
- ☐ Other *(Explain)*: _____

The victim lost essential personal property because of:
- ☐ Burglary
- ☐ Motor Vehicle (DUI/DWI)
- ☐ Motor Vehicle *(not DUI/DWI)*
- ☐ Human Trafficking
- ☐ Robbery (No injury)
- ☐ Other *(Explain)*: _____
- ☐ Arson
- ☐ Criminal Mischief
- ☐ Fraud/Financial Crime

Where did the crime happen? (*Check **only** one.*) ☐ Work ☐ Owned residence ☐ Apt. Bldg. ☐ Public Street ☐Subway/Bus ☐Parking Lot ☐Restaurant/Bar ☐School/School grounds ☐Shopping Mall ☐ Other *(Explain)*: _____

Was this a crime related to domestic violence?	☐ Yes	☐ No	☐ Unknown
Was this a crime related to bullying?	☐ Yes	☐ No	☐ Unknown
Was this a crime related to elder abuse/neglect?	☐ Yes	☐ No	☐ Unknown
Was this a hate crime?	☐ Yes	☐ No	☐ Unknown
Was the victim driving a livery cab when the crime happened?	☐ Yes	☐ No	☐ Unknown
Was the victim's property lost or damaged while trying to prevent or stop a crime against someone else or while helping the authorities stop the crime?	☐ Yes	☐ No	

Crime Report #:_____ **Police or criminal justice agency reported to**:_____

County where crime happened:_____ Date of crime:_____ Date crime was reported: _____

If more than 7 days between the date of crime and date the crime was reported, explain why: _____

If more than 1 year between the date of crime and the date you are filing this claim, explain why: _____

Describe the crime in your own words: _____

Rev. December 2020

4 **Tell us about the suspect.** Suspect's name *(if you know):* _____

Has the suspect been arrested for this crime? ☐ Yes ☐ No
Has the suspect been prosecuted for this crime? ☐ Yes ☐ No ☐ Not Yet
Does the suspect live in the same house as the victim OR is the suspect a member of the victim's family? ☐ Yes ☐ No
Has the court issued an order of protection in this case? ☐ Yes ☐ No *(If Yes, attach a copy.)*
Has the DA asked the court to order restitution? ☐ Yes ☐ No ☐ Not Yet
Did the court order the suspect to pay restitution? ☐ Yes *(Amount $_____)* ☐ No ☐ Not Yet

NOTE - If you are eligible for compensation, the OVS may be able to reimburse for the expenses listed below. These items should also be requested as part of court ordered restitution. Applicants are encouraged to share this information with prosecutors if there is a criminal case. See the Court Ordered Restitution Information page for important information about restitution.

5 **Tell us about your expenses related to this crime.** *(Check all that apply.)*

☐ Medical/Ambulance ☐ Loss of Support (Death Claim Only) ☐ Lost Wages Personal Transportation
☐ Crime Scene Cleanup ☐ DV Shelter ☐ Medical/Counseling
☐ Security Device/System ☐ Vocational/Rehabilitation ☐ Moving/Storage ☐ Court
☐ Counseling ☐ Funeral/Burial ☐ Essential Personal Property
☐ Other *(Explain):* _____

6 **List any essential personal property, like cash, eyeglasses, or clothing that needs to be replaced because of this crime**. *(If none, skip to 7.)*

Describe what was lost/damaged:	Cost	Describe what was lost/damaged:	Cost
1.	$	4.	$
2.	$	5.	$
3.	$	6.	$

Homeowner/Renter Insurance Company	Policy or ID #	Deductible $
Auto/Other Insurance Company	Policy or ID #	Deductible $

— If there were no injuries and you are only asking for essential personal property benefits, skip to 15. —

7 **Tell us about the victim's or the parent's employment and insurance for Lost Wages.**
If you do not want us to contact your employer, you cannot ask to be reimbursed for Lost Wages. (*Skip to 8.)*

Was the victim/parent of hospitalized minor victim employed when the crime happened? ☐ Yes ☐ No *(If No, skip to 8.)*
Did the victim/parent of hospitalized minor victim miss work because of the crime? ☐ Yes ☐ No
Was the victim/parent self-employed? ☐ Yes ☐ No *(If Yes, attach copies of last year's federal tax return and all schedules.)*

Employer's Name, Address, and Phone #:

_____ ( )
Employer *Street* *City* *State* *Zip Code* *Phone #*

Other Employer's Name, Address, and Phone #:

_____ ( )
Employer *Street* *City* *State* *Zip Code* *Phone #*

Name, Address, and Phone # of doctor who certified victim could not go to work:

_____ ( )
Doctor *Street* *City* *State* *Zip Code* *Phone #*

Tell us about any insurance company that will cover the victim's lost time at work. *(If none, write "None" below and skip to 8.)*

	Policy or ID # or "None"		Policy or ID # or "None"
1. Unemployment Insurance		5. Workers' Compensation	
2. Disability Insurance		6. Other insurance	
3. Pension Plan		7. Social Security Benefits (ssn required)	SSN ___-___-___
4. Other insurance		8. SSI Benefits (ssn required)	SSN ___-___-___

8 **If the victim died, fill out below if you have any burial expenses.** *(If not, skip to 9.)*
Also, attach a copy of the funeral home contract, other bills for burial expenses, and a photocopy of the Death Certificate, if you have them.

Name of Funeral Home: _____ Phone #: ( ) _____

Address: _____
Street *City* *State* *Zip Code*

9 If the victim was injured or died because of this crime, fill out below.

Describe the victim's injuries, briefly: _____

_____

Did the victim receive any medical treatment? ☐ Yes ☐ No *(If **No**, skip to section 10.)*

Tell us about the health professionals who treated the victim for injuries related to this crime:

	Full Name	Complete Address	Phone #
First Hospital	_____	_____	(____) _____
Other Hospital	_____	_____	(____) _____
First Doctor *(not in* hospital*)*	_____	_____	(____) _____
Other Doctor	_____	_____	(____) _____
First Dentist	_____	_____	_____
Victim's Counselor	_____	_____	(____) _____

***10* Tell us about the victim's dependents or others who depended on the victim for support.** *(If none, skip to 11.)*

Dependent	Name	Social Security # _____-_____-_____	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? ☐ Yes ☐ No
Other Dependent	Name	Social Security # _____-_____-_____	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? ☐ Yes ☐ No
Other Dependent	Name	Social Security # _____-_____-_____	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? ☐ Yes ☐ No

If more than 3 dependents, attach a separate sheet and check here: ☐

***11* Did anyone besides the victim receive counseling because of this crime?** *(If no, skip to 12.)*

Who received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			
Who else received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			

If more than 2 people received counseling because of this crime, check here and attach a separate sheet to describe. ☐

***12* List any insurance covering the victim or the victim's dependents.** *If no insurance, write **"None"** below. If you have applied but are not covered yet, write "Pending" under Policy or ID #.*

	Policy or ID #	*Name of person(s) covered by this insurance:*
Primary Insurance Company		
Major Medical Insurance Company		
Other Insurance *(Union, Dental, Vision, etc.)*		
Medicare		
Medicaid		
Workers' Compensation		
Auto Insurance		
Other insurance		

13 If the victim died, tell us about any life insurance and death benefits.
(If the victim did not die, or does not have any life insurance or death benefits, skip to 14.)

	Company Name	Address	Phone #	Policy or ID #
Life Insurance			( )	
Pension Plan			( )	
Other Insurance/Plan			( )	
Medicaid			( )	
Workers' Compensation			( )	

If any other insurance or death benefits, list here: _____

Do any of these policies cover the victim's burial expenses? ☐ Yes ☐ No

Has anyone applied for the Social Security Death Benefit? ☐ Yes ☐ No

14 Tell us about your financial situation. You MUST fill out ALL sections below. If none, enter zero (0).

How many dependents do you have? _____

What is your total annual income (from ALL sources)? If you are not sure, estimate: $ _____

List ALL your assets and ALL your debts below. If you are not sure, estimate. Attach additional pages, if needed.

Your Assets – If none, enter zero (0).		**Your Debts** – How much do you owe now?	
Savings, stocks, bonds	$		**If none, enter zero (0).**
Real Property (house, etc.)	$	Mortgage	$
Proceeds from life insurance	$	Loans	$

15 Is a private lawyer (not DA) representing you? ☐ Yes ☐ No

If Yes:

_____ _____ ( )
Lawyer's Name Address Phone #

16 Authorization to speak with representative:

If you would like to give permission to a family member, friend or other person to speak to OVS regarding your claim, enter here.

_____ _____ ( )
Name of Person Address Phone #

17 Victim/Claimant's Authorization:

I ACKNOWLEDGE that accepting an award from the Office of Victim Services (OVS) creates a lien in favor of the State of New York on any recovery relating to the crime upon which this claim is based, including any judgment, settlement or order of restitution. I further authorize any funeral director, attorney, employer, police or other public authority, insurance company or any person who rendered services to the above, or having knowledge of the same, to furnish the OVS or its representatives the following information: Workers' Compensation records, information relating to the crime or any injuries or death suffered as the result of the crime, and information relating to this claim. If an award is made, I authorize the OVS to make payments directly to the provider of services. I also authorize the OVS to share my information and records compiled for this claim with the local Victim Assistance Program (VAP) in order for the VAP to assist the OVS in processing my claim and making its determination. If a private lawyer has been indicated above, I also authorize the OVS to share my information and records compiled for this claim with the lawyer in order for him/her to act as my representative. I understand a separate Notice of Appearance from my lawyer will be needed in addition to this authorization. If a family member, friend or other person is indicated above, I authorize the OVS to share my information and records compiled for this claim with that person in order that they assist me with this claim.

A photocopy of this authorization shall be deemed as effective as the original.

_____ _____ ( )
Claimant's Signature Date Daytime Phone #

Email: _____ Language you prefer to speak: ☐ English ☐ Spanish ☐ Simplified Chinese ☐ Traditional Chinese ☐ Haitian Creole ☐ Italian ☐ Korean

Interpreter Needed: ☐ Yes ☐ No ☐ Russian ☐ Other _____

To process your claim, mail us the following documents. ***(Keep a copy for your records.)***

- All bills and receipts for services listed on this form
- Your completed, signed claim form
- One completed HIPAA form for **each service provider** listed on this form (You can photocopy the HIPAA form.)
- Letters from any insurers denying or authorizing payment for the services listed on this form.

Remember: You must bill your insurance company or benefits plan **before** the OVS can pay.

Mail your documents to: New York State Office of Victim Services
AE Smith Building
80 S. Swan Street
Albany, NY 12210-8002

Rev. September 2016

HIPAA

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number XXX-XX-__ _____
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
NYS OFFICE OF VICTIM SERVICES – AE SMITH BLDG., 80 S. SWAN ST., ALBANY, NY 12210-8002

9(a). Specific information to be released:

- ❑ Medical Record from (insert date)_____to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other:_____

_____

Include: (*Indicate by Initialing*)

_____**Alcohol/Drug Treatment**

_____**Mental Health Information**

_____**HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here_____I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

NEW YORK STATE OFFICE OF VICTIM SERVICES

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
At request of the individual for purposes of establishing eligibility for New York State Office of Victim Services benefits.	***This authorization will expire upon the termination of the individual's eligibility for Office of Victim Services benefits.***
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**