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

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

COMPLETION OF FORMS

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

PERSONAL DATA

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

WAITING PERIOD

- If approved for benefits, you must serve a **mandatory 14-day** waiting period** before receiving benefits

WORK RELATED CLAIMS

- You are required to file a claim for lost time wages directly with the Bureau of Workers' Compensation (BWC)
- Disability benefits are not payable for any work-related injury except:
  - (1) If your initial application for lost time wages is denied by BWC and you do not appeal the BWC order. You must submit a copy of the BWC denial with the disability application
  - (2) If your initial application for lost time wages is denied by BWC and you appeal the BWC order, you may receive an advancement of disability benefits. You must submit the following with the disability application:
    - a copy of the BWC denial order
    - a completed Disability Agreement, *FORM 4313*
    - a copy of your Accident or illness report, *FORM 4303*
    - a copy of your request for Temporary Total Compensation, *Form C-84*

CONFIDENTIALITY

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

PHYSICIAN INSTRUCTIONS

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

BEHAVIORAL HEALTH CONDITIONS

United Behavioral Healthcare, the state's behavioral health care provider, manages disability claims for state of Ohio employees who are enrolled in a state health plan

To request a disability assessment, an employee may contact their agency, the Employee Assistance Program (EAP), Department of Administrative Services - Disability Services unit or UBH directly at 1-800-852-1091

- To be eligible for disability leave benefits for a behavioral health condition, the following must apply:
  - › The employee must have a behavioral health/substance abuse condition that prevents the employee from working
  - › The employee must be in treatment with a behavioral health/substance abuse specialist and
  - › The employee must follow the treatment plan prescribed by their provider

Disability benefits for State employees are authorized in Administrative Rules 123:1-33-01 through 123:1-33-11 and the bargaining unit contracts

***** *Contract exceptions for filing - FOP 46 & FOP 48 please refer to your contract.*

****** *Contract exceptions for length of waiting period - Attorney General, FOP 46 and FOP 48, Refer to your contract.*

Information about the Disability Leave Program is available on the benefits Web site:
http://das.ohio.gov/Divisions/HumanResources/BenefitsAdministration/Disability.aspx

Application for Disability Leave Benefits

Employee Statement

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

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

Employee Name		Date of birth	EMPLID
Address Street	City	State	Zip
Telephone (area code) Home ( )	Work ( )	Cell ( )	
E-mail			
Agency		Job Title	
Date accident or illness began	Date became disabled	Date last worked	Date of first treatment
Date of most recent treatment		Date of next appointment with physician(s)	

Describe your disability

Was disability due to an injury? Yes ___ No ___	If yes, date of injury	How and where did accident happen?

List of all physicians treating you for this condition

Name	Specialty	Telephone (area code)	Fax (area code)

Have you been hospitalized for this illness? Yes ___ No ___	If yes, give name of hospital & city	Date(s) of confinement

Additional hospitalizations/urgent care/emergency room visits/dates for this illness **(Please provide medical reports from these visits)**

Employee Name	Employee ID Number

Was your current illness/injury received in the course of and arising out of your employment with the State of Ohio or any other employer? Yes____ No ____

Have you ever applied for workers' compensation benefits involving the same part of body as your current illness/injury or for a condition in any way related to your current illness/injury? Yes ____ No ____ **If yes, provide:**

BWC claim Number (s) _____ _____ _____ _____ _____

Date (s) of illness/injury (s) _____ _____ _____ _____ _____

Is your current illness/injury a reoccurrence of a previous illness/injury listed above? Yes ____ No ____	If yes, did you receive any lost time wages or other compensation from BWC? Yes ____ No ____ If yes, provide type of compensation and timeframe:
Have you filed a BWC claim for your current condition? Yes ____ No ____	Are you filing a BWC claim for your current condition? Yes ____ No ____

Have you returned to work?	If yes, give date	If no, what date do you expect to return?

Are you returning to work part-time and applying for disability benefits on a part time basis? Yes ____ No ____

Have you engaged in any occupation for wage or profit since the onset of your disability? Yes ____ No ____

If yes, name of employer:

Address: Phone: Your position:

Would you like to supplement disability by utilizing available leave time? Yes ____ No ____

If yes, list type of leave you want to use

EMPLOYEE CERTIFICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Department of Administrative Services or it representative and state agencies involved with my return to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize the Department of Administrative Services or its representative to release any such information it receives to my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in and state agencies involved with my return to work or claim for disability benefits. I understand my health plan, the state's mental health vendor, United Behavioral (UBH), state agencies or other party acting as a representative for the state may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall be valid as the original. I understand that it is my responsibility under ADA to contact my employer if I wish to apply for reasonable accommodations under ADA or to obtain information about my rights under ADA.

I have read and understand the instructions on page 1 of this application. I certify that the above statements are true to the best of my knowledge and understand any misrepresentation on my part may result in a denial of my benefits.

This authorization will be valid for 180 days from date of signature.

Date	Employee Name

Please Note: Employee is responsible for returning ALL pages of this form to employing agency.

Claim information submitted directly to Benefits Administration Services will be forwarded to the employee's personnel office.

The personnel office is required to keep all information about the nature of the illness/injury confidential.

Application for Disability Leave Benefits - Attending Physician Statement

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

PLEASE ATTACH COPIES OF OFFICE NOTES, EVALUATIONS, AND TESTING RESULTS.
INSUFFICIENT AND/OR ILLEGIBLE MEDICAL EVIDENCE MAY RESULT IN THE DENIAL OF BENEFITS.

Employee Name	Date of Birth	EMPLID

Date patient rendered disabled from working	Ever had same or similar condition: If yes, when and describe Yes ____ No ____

Is condition arising out of employment? Yes ____ No ____

Date first consulted you for this condition	Additional dates of treatment including the most recent visit

Frequency of visits: Weekly _____ Monthly _____ Other _____	Referrals

Date of most recent visit | Next scheduled appointment | EDC

Diagnosis of disabling condition(s)

Diagnosis _____ ICD-9 _____

Diagnosis _____ ICD-9 _____

Diagnosis _____ ICD-9 _____

Dates of Hospitalization	Name of Hospital

Reason for hospitalization and/or type of surgery performed	If surgery performed , give date Mo _____ Day _____ Yr _____	If pregnancy, provide delivery date Mo _____ Day _____ Yr _____

Complications or other factors contributing to disability (describe)

Subjective symptoms. (If psychiatric, describe mood and affect, ability to relate, ability to carry out daily activities, follow instructions, judgment, and ability to concentrate)

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

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information”, as defined by GINA, includes an individual’s family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee Name

Plan of treatment for a return to work

What restrictions are placed on patient's work activities?

What job duties is the employee unable to perform?

1. In an 8-hour workday, person can: (Circle full capacity for each activity)

TOTAL (hours) Sit 0 1 2 3 4 5 6 7 8 Stand 0 1 2 3 4 5 6 7 8 Walk 0 1 2 3 4 5 6 7 8

2. Person can lift and carry:

	Never	Occasionally (1- 33%)	Frequently (34% -66%)	Constantly (67% -100)
Up to 10 lbs.	_____	_____	_____	_____
11-20 lbs.	_____	_____	_____	_____
21-50 lbs.	_____	_____	_____	_____
51-100 lbs	_____	_____	_____	_____
Over 100 lbs.	_____	_____	_____	_____

3. Person can push/pull:

	Never	Occasionally (1% - 33%)	Frequently (34% - 66%)	Constantly (67% - 100)
Up to 10 lbs.				
11-20 lbs.	_____	_____	_____	_____
21-50 lbs.	_____	_____	_____	_____
51-100 lbs.	_____	_____	_____	_____
Over 100 lbs.	_____	_____	_____	_____

4. Person can do repetitive movements as in operating controls:

Right hand/arm _____ Yes _____ No Left hand/arm _____ Yes _____ No

5. Other restrictions:

Patient's condition(s) prevents them from working:

Temporary _____ **For longer than 12 months** _____ **Permanently** _____

If disability is temporary, patient's estimated date of release to return to work:

___ For regular occupation Mo _____ Day _____ Yr_____

___ For part-time basis Mo _____Day _____Yr_____

part-time schedule: hours per day _____ days per week _____

___ For suitable work activities within the limitations listed above Mo_____Day_____Yr_____

Additional Remarks

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