

**INSTRUCTIONS FOR COMPLETION OF ADM4311
SUPPLEMENTAL REPORT FOR DISABILITY LEAVE BENEFITS**

This form is to be used as a supplemental report. If you are filing for initial disability benefits, use form *ADM4310*

COMPLETION OF FORMS

- Type or print legibly
- All sections of application must be completed
- You are responsible for completing the Employee Statement, page 2
- Your physician is responsible for completing the Attending Physician Statement, pages 3 and 4
- You are responsible for returning all four (4) pages of the form to your agency by the date given in the last letter sent by Benefits Administration Services
- 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

RETURN TO WORK

- To return to work on a part-time basis, you must have the approval of your agency
- Only employees receiving full-time benefits or those who are returning part-time immediately following the mandatory 14 day waiting period are eligible to receive part-time benefits
- You must return to work in a Transitional Work Program if recommended by your attending physician and your agency can provide such a program

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

- Claims 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

DISABILITY RETIREMENT

- If your condition is permanent or will last greater than 12 months you may be required to file for disability retirement benefits to continue receiving disability leave benefits

PHYSICIAN INSTRUCTIONS

- Type or print legibly
- Complete pages 3 and 4 without expense to the state of Ohio
- Complete each section as thoroughly as possible
- Attending physician should retain a **copy** of all 4 pages of the form
- The employee is responsible for returning the entire form to their personnel office within a specified time frame. **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

Information about the Disability Leave Program is available on the benefits Web site:

<http://das.ohio.gov/Divisions/HumanResources/BenefitsAdministration/Disability.aspx>

Supplemental Report Disability Leave Benefits Employee Statement

Please read the instructions on page 1 before completing this application

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

Employee's Name		State of Ohio User ID	Date of birth
Address	Street	City	State Zip
Telephone (area code)	Home	E-mail address	
Work	Cell		
Have there been any changes in your condition since your original claim? Yes ____ No ____ If yes, please explain.			
Any conditions that have become disabling that were caused by or resulting from your job? Yes ____ No ____ If yes, please describe			
Have you been hospitalized since your original claim? Yes ____ No ____		If yes, give dates of confinement	
Name of Hospital		Reason for confinement	
Have you returned to work? Yes ____ No ____ If yes, give date:		If no, what date to 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, did you receive compensation? Yes ____ No ____	
Place of Employment:		Address:	
Telephone :	Provide dates worked:	Your position:	
If your claim was not as an advancement of workers' compensation, have any conditions become disabling that were caused by or resulting from your job? Yes ____ No ____ If yes, please describe:			
EMPLOYEE CERTIFICATION/AUTHORIZATION FOR RELEASE OF INFORMATION			
<p>I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Department of Administrative Services or its representatives and state agencies involved with my return to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize the Department of Administrative Services or its representative to release any such information it receives to my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in and state agencies involved with my return to work or claim for disability benefits. I understand my health plan, the state's mental health vendor, United Behavioral Health (UBH), state agencies or other party acting as a representative for the state may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall be valid as the original. I understand that it is my responsibility under ADA to contact my employer if I wish to apply for reasonable accommodations under ADA or to obtain information about my rights under ADA.</p> <p>I have read and understand the instructions on page 1 of this application. I certify that the above statements are true to the best of my knowledge and understand any misrepresentation on my part may result in a denial of my benefits.</p> <p>This authorization will be valid for 180 days from date of signature.</p>			
Date		Employee's 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.

Supplemental Report
Attending Physician Statement

Instructions for completing this form are on page 1 of the 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 _____	State of Ohio User ID _____
Diagnosis of disabling condition(s)		
Diagnosis _____	ICD-9 _____	
Diagnosis _____	ICD-9 _____	
Diagnosis _____	ICD-9 _____	
Treatment dates since last report _____	Date of next appointment _____	
Has patient been hospitalized since initial claim Yes ____ No ____	Dates of hospitalization _____	
Reason for hospitalization _____	Name of Hospital _____	
If surgery performed, provide date and type of surgery Mo. ____ Day ____ Yr. ____ Surgery _____		
Complications or other factors delaying recovery (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) 		
List any change in medication since onset of disability		
Medications	Dosage	Date initiated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Plan of treatment for a return to work. 		
What restrictions are placed on patient's work activities? 		

Employee Name _____

What job duties is the patient unable to perform?

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

TOTAL (hours)	Sit	0	1	2	3	4	Stand	0	1	2	3	4	Walk	0	1	2	3	4
			5	6	7	8			5	6	7	8			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 prevents them from working:

Temporarily ___ For longer than 12 months ___ Permanently ___

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

___ For regular occupation Mo. ___ Day ___ Yr. ___

___ On a part-time basis Mo. ___ Day ___ Yr. ___

part-time schedule:

hours per day _____ days per week _____ # of weeks _____

___ For suitable work activities within the limitations listed above Mo. ___ Day ___ Yr. ___

Additional Remarks

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

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.