

**State of Ohio
Agency Disability Questionnaire**

The following employee has filed a disability claim for a behavioral health condition. Completion of this questionnaire will allow the Department of Administrative Services, Benefits Administration Services - Disability Unit (DAS/BAS/Disability), United Behavioral Health (UBH) and the Employee Assistance Program (EAP) to better assist the employee in receiving the services that he/she needs and to allow for an efficient, smooth transition back to work. As the employer, we need your assistance in answering the following questions so that we can obtain the agency's perspective of the employee's job duties and any issues that may affect the employee's ability to return to work or perform their job duties

Please be advised that all information included on this form will become part of the employee's disability file and should be handled as sensitive and confidential. It should only be shared by those parties involved with assisting the employee below. Please complete this form and submit to DAS/BAS/Disability with all initial claims being filed for a behavioral health condition. You may also be asked to complete this form again as the claim progresses and a return to work plan is in process. Feel free to contact your DAS/BAS/Disability claims representative if you have questions. Thank you for your assistance.

Identifying Information: (This section completed by DAS)	
Employee Name	Claim #:
Agency	Eligible for Disability Retirement <input type="checkbox"/> Yes <input type="checkbox"/> No
Work Responsibilities (Completed by agency)	
Employee's Job Title:	
Provide employee's current PD and below provide a detailed description of their duties: <i>(attach additional paperwork if insufficient space)</i>	
Has the employee been disability separated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Safety concerns in the position <i>(Add examples)</i> :	
Performance Issues/Problems:	
Disciplinary process in place or pending? <input type="checkbox"/> Yes, (Please explain and include pertinent dates) <input type="checkbox"/> No	

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Are you aware of any documented EEO issues or complaints pertaining to this employee?
 Yes, please explain No

Which of the following work modification is your agency **ABLE** to provide on a transitional basis?
(Check all that apply)

- Part-time return to work, Maximum number of weeks allowed:
- No overtime, Maximum number of weeks allowed:
- No double shifts, Maximum number of weeks allowed
- No client/inmate duties, Maximum number of weeks allowed
- Limited/reduced duties, Maximum number of weeks allowed
- Other, Please explain: _____

Has an Independent Medical Examination been completed by the agency? Yes No
If yes, please provide a copy along with this questionnaire to DAS/BAS/Disability

Will you be requesting an Independent Medical Examination prior to the employee's return to work?
 Yes No

Are there any concerns regarding this employee that would be important for us to know/address prior to his/her return to work?

Name & Title:	Date:
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Please provide the name, job title and contact information for those at your agency that would be involved in discussions with DAS, UBH or EAP pertaining to any issues that may affect the employee's ability to return to work or perform their job duties.

Name & Title	Phone & e-mail

Additional Comments: