DSS INTERNAL WORKERS' COMPENSATION PROCESS

OBJECTIVE OF THE TRAINING

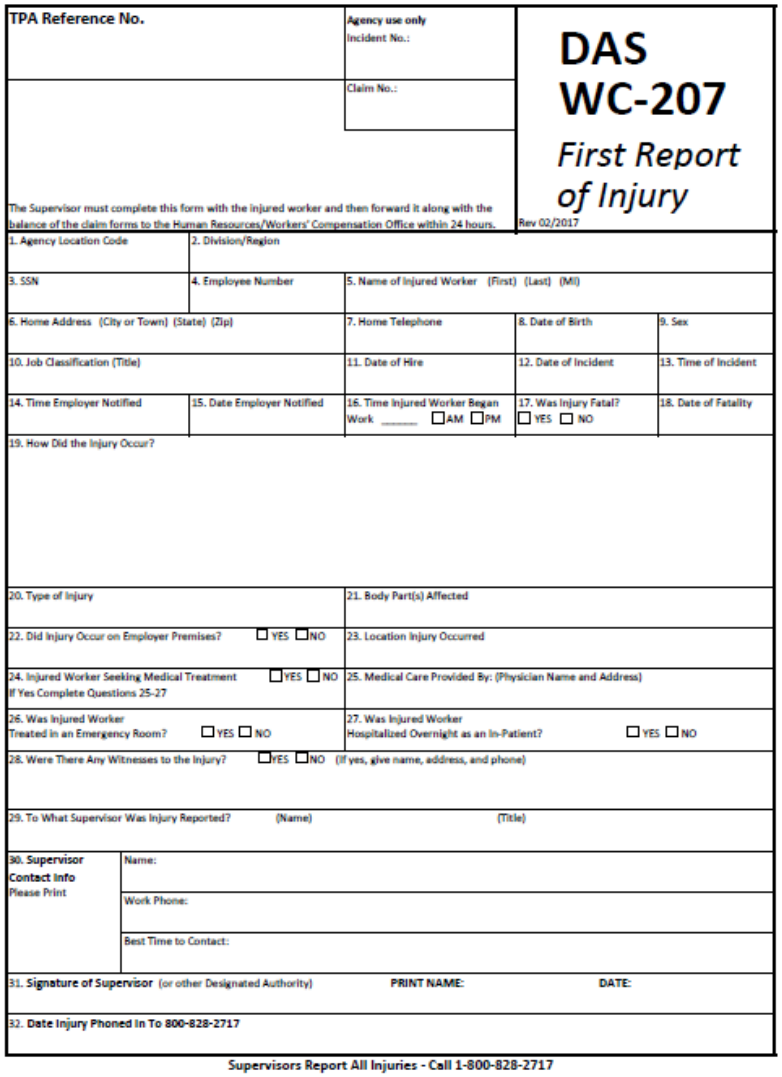
How to file a Workers' Compensation Claim

All employees are instructed to contact their supervisor when incurring a work related injury or illness. The supervisor's role is divided into two functions: Claim Reporting and Claim Review.

You are the most effective person in the reporting and review of the claim because you are the person with whom the injured employee communicates with to initiate a claim for benefits.

Your attention to claim reporting and claim review will allow the claim to be handled with prompt attention, avoid complications for employees and provide useful information to protect employees from exposure to future injuries.

SUPERVISOR RESPONSIBILITY



TPA Reference No.

Agency use only
Incident No.:

Claim No.:

DAS WC-207
First Report of Injury

The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim forms to the Human Resources/Workers' Compensation Office within 24 hours.

Rev 02/2017

1. Agency Location Code	2. Division/Region			
3. SSN	4. Employee Number	5. Name of Injured Worker (First) (Last) (MI)		
6. Home Address (City or Town) (State) (Zip)		7. Home Telephone	8. Date of Birth	9. Sex
10. Job Classification (Title)		11. Date of Hire	12. Date of Incident	13. Time of Incident
14. Time Employer Notified	15. Date Employer Notified	16. Time Injured Worker Began Work ____ ☐AM ☐PM	17. Was Injury Fatal? ☐YES ☐NO	18. Date of Fatality
19. How Did the Injury Occur?				
20. Type of Injury		21. Body Part(s) Affected		
22. Did Injury Occur on Employer Premises? ☐YES ☐NO		23. Location Injury Occurred		
24. Injured Worker Seeking Medical Treatment ☐YES ☐NO If Yes Complete Questions 25-27		25. Medical Care Provided By: (Physician Name and Address)		
26. Was Injured Worker Treated in an Emergency Room? ☐YES ☐NO		27. Was Injured Worker Hospitalized Overnight as an In-Patient? ☐YES ☐NO		
28. Were There Any Witnesses to the Injury? ☐YES ☐NO (If yes, give name, address, and phone)				
29. To What Supervisor Was Injury Reported? (Name) (Title)				
30. Supervisor Contact Info Please Print	Name:			
	Work Phone:			
	Best Time to Contact:			
31. Signature of Supervisor (or other Designated Authority)		PRINT NAME:	DATE:	
32. Date Injury Phoned In To 800-828-2717				

Supervisors Report All Injuries - Call 1-800-828-2717

- Sign Report and call into **Gallagher Basset Reporting Hotline** to receive a Reference Number.
- Complete First Report of Injury (DAS WC-207)

- In response to the WC-207-1, the Workers' Compensation Liaison will send a letter to the employee confirming the receipt of the Workers' Comp claim.

The Letter Must Include:

- Medical requirements (treatment)
- FMLA Rights
- Timesheet coding for medical appointments
- Forms to be completed by the Employee

A listing of Medical Provider Network for Workers' Compensation Doctors can be found on the DAS Website:

http://das.ct.gov/cr1.aspx?page=64

Important forms to be completed are:

- 3rd Party Liability

DAS
Concurrent Employment Third Party Liability Form

For WC-211 Rev. 2/05

EMPLOYEE TO COMPLETE

Employee Name (last) (First) (MI)	Social Security Number
Address (No. and Street)	Telephone Number
City or Town	Date of Injury
Employing State Agency	Date of Birth
Address of Employing Agency (No. and Street) Zip	Date First Employed by State

EMPLOYEE INSTRUCTIONS

The information requested on concurrent employment below is necessary to determine your Workers' compensation benefit rate:

1. You must complete this form for every Workers' Compensation claim you file.
2. You must keep the information contained in this form current while you are receiving Workers' Compensation benefits.
3. You must return this form to your personnel office within three days.

Note: If your claim is for Temporary Total or Temporary Partial disability benefits, you must advise your employer of any other earnings while receiving these benefits. Failure to do so may result in civil and/or criminal liability.

CONCURRENT EMPLOYMENT CHECK IF ANY OF THE FOLLOWING APPLY: ☐ NONE

☐ Employed by Another State Agency ☐ Employed Outside State Government

Name of Other Employer	Supervisor's Name	Telephone Number of Employer
Address of Employer (No. and Street)	City or Town	State Zip

THIRD PARTY LIABILITY INFORMATION

1. Was the cause of your accident/injury the result of the actions of a party other than you or your employer?

Yes ☐ No ☐

If you checked yes, please describe the facts.

Name the Third Party _____

Address _____

Insurance Carrier of Third Party _____

2. Were there any witnesses?

Yes ☐ No ☐

Name of witnesses _____

3. Have you initiated a claim against this responsible Third party?

Yes ☐ No ☐ Date _____

I DECLARE THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM AWARE THAT PROVIDING FALSE INFORMATION MAY RESULT IN CIVIL, OR CRIMINAL LIABILITY.

Signature _____ Date _____

Tax Filing Status Form 1A

State of Connecticut
Workers' Compensation Commission
Please TYPE or PRINT IN INK

Rev. 3-17-2006

1A

WCC File #

Date filed in District

(for WCC use only)

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

EMPLOYEE

Name _____ Soc. Sec.# (optional) _____

Address _____

City/Town _____ State _____ Zip Code _____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S., we need the following information:

DATE OF INJURY:

The Filing Status and Exemption(s) indicated at left MUST reflect employee's Federal tax status for the Date of Injury provided here.

1. Select your Federal tax filing status based upon your ACTUAL filing status as of the date of injury listed at right:
   ☐ Single ☐ Head of Household ☐ Married filing jointly ☐ Married filing separately
2. Number of exemptions (including yourself) as of the date of injury listed at right = _____
3. Check all appropriate boxes:
   ☐ Employee 65 years of age or older ☐ Employee legally blind ☐ Spouse 65 years of age or older ☐ Spouse legally blind
4. FICA withheld for the above-named employee? ..... ☐ YES ..... ☐ NO — ***If NO, insurer must manually calculate weekly benefit rate.***
5. List name (yourself too), date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above:*

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

WARNING: Any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Employee's Signature _____ Date _____

- DAS-WC-715 (Request for Use of Accrued Leave while on Workers' Comp)

Request for Use of Accrued Leave with Workers' Compensation

DAS WC-715

3-10

This form covers an employee election to utilize or not utilize accrued leave (existing balances and additional accruals as credited) during the interim period and/or to supplement lost wage benefits on an approved workers' compensation claim. The Agency Section shall be completed with the initial agency processing of the **LOST TIME** claim and provided to the injured employee with instruction to make an election and ***RETURN WITHIN 10 BUSINESS DAYS***. This form is to be maintained in the injured worker's agency workers' compensation file.

AGENCY SECTION

Agency Name	Department ID

Employee Name	Employee ID

Date of Injury	Daily Pay Rate	LEAVE BALANCES As of date of injury Denoted in Hours	Sick	Vacation	Personal	Holiday Comp	Comp

EMPLOYEE ELECTION SECTION - Please check your choice of the options available to you then sign and return to your agency Workers' Compensation office **within ten business days.** Failure to return the completed form to the agency will be administered as an election **not** to utilize accrued leave during the interim period and **not** to supplement the approved workers' compensation lost wage benefit.

USE OF ACCRUED LEAVE FOR INTERIM PERIOD

☐ I elect NOT to use accrued leave during the interim period (after the first day of my incapacity and continuing until such time as a determination of compensation is made).

☐ I elect to use accrued leave during this interim period. By choosing this option I will receive my full base pay while a determination of compensation is being made. I understand that, once a compensation award has been made, I must repay the State an amount equal to the net pay I would have received during such interim period in order for my leave balances to be restored. I further understand that sick leave must be used first, followed by my designated choice of vacation, personal, holiday compensatory time and/or compensatory leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2,3,4,5 in each box:	Sick	Vacation	Personal	Holiday Comp	Compensatory
	1				

USE OF ACCRUED LEAVE WHILE RECEIVING WORKERS' COMPENSATION

☐ I elect NOT to use any of my accrued leave while I am receiving Workers' Compensation lost wage benefits.

☐ I elect to use accrued leave, which in addition to the lost wage benefits awarded to me under Workers' Compensation, will result in my receiving the equivalent of my full base pay while I am receiving Workers' Compensation lost wage benefits. I further understand that sick leave must be used first, followed by vacation and/or personal leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2 or 3 in each box:	Sick	Vacation	Personal
	1		

STATEMENT OF APPLICANT

I have read and understand the above explanation of the choices available to me as a result of my application for workers' compensation. Once made, this election cannot be revoked and will remain in effect until all accrued leave (including any future accruals that may be credited to me) is exhausted or until I return to my pre-injury number of scheduled work hours. **I agree to the conditions applicable to the choices I have checked above.**

SIGNATURE OF EMPLOYEE | DATE SIGNED

W-6
(Rev. 05/15)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

SECURITY/SAFETY INCIDENT REPORT

☐ Theft ☐ Accident ☐ Vandalism ☐ Injury ☐ Other: _____
(please specify)

Name: _____
Last *First* *M.I.*

_____ _____
Work Address *Telephone Number*

Date Occurred: ___/___/___ Date Reported: ___/___/___

Where Incident Occurred: _____

Investigating Officer: _____ Case Number: _____

Witness: _____
Name *Address* *Phone*

Witness: _____
Name *Address* *Phone*

This form must be signed by your Office Manager (see next page) before being forw to the Central Office Operations Unit. Please follow the directions on the next pag forward the completed form within 48 hours to DSS, Operations Unit, 55 Farmi Avenue, Hartford, CT 06105.

Employee Explanation:

Attachments: Attach Police Report if applicable. Thefts of State property also requir CO-853. For accidents involving State vehicles, attach DAS Fleet Operations Form M 1. Attach a continuation sheet for additional comments when required.

_____ _____
Employee Signature Date

INSTRUCTIONS FOR COMPLETING SECURITY/SAFETY INCIDENT REPORT

- Check what type of incident occurred, *e.g.,* theft, accident, vandalism, etc.
- List your name, address, and phone number.
- Give appropriate dates for when the incident occurred and when you reported it to the police.
- Give the Police Officer or State Trooper's name and case number.
- List name(s), address(es), and phone number(s) of witness(es).
- Give a clear and concise explanation of what occurred (who, what, where, when and how) and sign.
- Have your Office Manager complete the items below and sign.

Please forward a completed form to the Operations Unit within 48 hours of occurrence.

Office Manager's Report of Investigation:

Office Manager's Suggestions to Prevent Re-Occurrence:

_____ _____
Office Manager's Signature Date

The Operations Unit will review and acknowledge receipt of the completed incident report. Recommendations for closure of incident will be made when appropriate.

PHYSICIANS WORKERS' STATUS REPORT
For Employees of The State of Connecticut
PER-WC-208 REV. 12/14

State of Connecticut
Department of Administrative Services
Workers' Compensation Division

INSTRUCTIONS

1. To be completed by initial care or attending physician and provided to the injured worker as part of the office visit.
2. Mail or fax copy to State of Connecticut Third Party Claim Administration Company within 24 hours of the office visit.

- Gallagher Bassett Services, Inc., 55 Hartland St., Suite 400, East Hartford, Connecticut 06108
  Fax: (860) 291-9875
  Phone: (860) 256-3400

To be Completed By Initial Care Physician or Attending Physician

Employee Name | Social Security Number | State Agency

Division | Facility | Address

Date of Office Visit: ____/____/____ Date of Injury: ____/____/____ (Circle) Initial Visit ☐ Follow-Up Visit ☐

Diagnosis: _____

Treatment Plan: _____

Evidence of pre-existing condition: Yes ☐ No ☐ Injury/Illness casually related to worker's employment: Yes ☐ No ☐

Patient work disposition (Please check the appropriate work disposition)

1. ____ Patient is capable of full and regular duty.
2. ____ Patient is not capable of any form of work.
3. ____ Patient is capable of modified/restricted work as indicated below

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

	Never	Occ.	Freq.	Cont.	No Restrictions
a. Patient is able to:					
Bend					
Squat					
Kneel					
Stand					
Walk					
Climb Stairs					
Twist					
Rotate					
Push/Pull					
Lift above shoulder					
Reach above shoulder					

	Never	Occ.	Freq.	Cont.	No Restrictions
b. Patient is able to lift					
Up to 10lbs					
11-24lbs					
25-34lbs					
35-50lbs					
51-74lbs					
75-100lbs					

	Never	Occ.	Freq.	Cont.	No Restrictions
c. Patient is able to carry					
Up to 10lbs					
11-24lbs					
25-34lbs					
35-50lbs					
51-74lbs					
75-100lbs					

	Never	Occ.	Freq.	Cont.	No Restrictions
d. Patient is able to use hands					
Keyboard Typing					
Grasping					

e. Is patient involved with treatment and/or medication that might affect his/her ability to work?
☐ No
☐ Yes: Explanation: _____

f. Will patient be required to use any assistive devices or braces while working regular or modified/restricted duty?
☐ No
☐ Yes: Explanation: _____

Physician Comments: _____

The restrictions are in effect until: ____/____/____ Next appointment Date: ____/____/____

Name of Physician: _____ Signature: _____
Please Print

ARRIVED: _____
DEPARTED: _____
TRAVEL: _____

Authorization to Release Information

I hereby authorize this Medical Provider to release my information acquired in the course of my examination or treatment for the above injury to my employer or it's representative.

Patient's Name (Print) | **Patient's Signature** | **Date**

http://das.ct.gov/images/1090/DAS%20208%20Worker%20Status%20Report.pdf

- Workers' Comp Information Sheet (next page)

CONTACT LIST AND PHONE NUMBERS

GBS Injury Reporting Hotline
1-800-828-2717

GBS Recurrence Reporting Hotline
1-866-220-6534

Gallagher Bassett Services, Inc.
55 Hartland Street
Suite 400
East Hartford, CT 06108

Main Phone Number:	860-256-3400
Toll Free Number:	866-422-7622
FAX Numbers:	860-291-9875
	860-291-9839

Prime Health Services (Medical Network)
7110 Crossroad Blvd.
Brentwood, TN 37027 866-348-3887

myMatrixx (Pharmacy Network)
5706 Benjamin Center Drive
Tampa, FL 33634-5262 877-804-4900

Department of Administrative Services
Workers' Compensation Division
165 Capitol Avenue
Hartford, CT 06106

Phone Number:	860-713-5002
FAX Number:	860-713-7458

Workers' Compensation Fraud
Reporting Hotline: 800-927-0456

The Human Resources Liaison Must Ensure:

- A copy of the WC-207 and 207-1 forms and all supporting documentation go to Central Workers' Comp Unit.

- Central Workers' Compensation Unit will review and confirm the information.

Upon completion and return of all forms:

- Lost time and general medical information details will be sent to your Supervisor/ Manager & Human Resources Representative.

Remember,
Safety Begins
with You!