Broome County Office of Risk Management
Broome County **Office** Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-2402 Fax: (607)778-2918

Requirements for Coverage under 207-C
Sheriff's Office Only
Law Enforcement

1. **APPLICATION INSTRUCTIONS** – to apply for benefits under 207-C Municipal Law, you must complete this packet in it's entirely including the page named **"Application for Benefits Under Section 207-C of the General Municipal Law"**

2. **FILE WITHIN 5 DAYS**. The Risk and Insurance department must be made aware of the injury within 5 days and all paperwork must be received within 7 days.

3. **COMPLY WITH REQUESTS FROM THE RISK & INSURANCE DEPARTMENT.** If you apply for coverage for lost time, you will receive correspondence from the Risk & Insurance department noting approvals, denials or requests for further information, which you must comply with to receive benefits.

4. **THE BROOME COUNTY PHYSICIANS REPORT MUST BE COMPLETED INCLUDING THE DATE OF YOUR VISIT, NEXT APPOINTMENT AND ABILITY TO PERFORM MODIFIED DUTIES FOR ALL LOST TIME COVERAGE.**

5. **PRE-TAX BENEFITS CEASE WHILE RECEIVED 207-C BENFITS.** You are not eligible to receive pre-tax benefits while receiving non taxable pay so you are unable to participate in our Deferred Compensation Program while out on 207-C.

6. **IF YOUR 207-C APPLICATION IS DENID DUE TO FOLLOWING THE REQUIRED PROCEDURE YOUR CLAIM WILL STILL BE CONSIDERED UNDER WORKERS' COMPENSATION**.

CLAIMS MUST FIRST BE SUBMITTED TO YOUR SUPERVISOR AND SUBMITTED TO RISK AND INSURANCE VIA FAX (607) 778-2918 or EMAIL
bcworkerscomp@co.broome.ny.us

Broome County Office of Risk Management
Broome County **Office** Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-2402 Fax: (607)778-2918

Workers Compensation Packet and Instructions Effective January 1, 2024

PINK PACKET

1. **Instructions** – to be read by employee (claimant) and supervisor and **retained by employee.**

2. **WC Form 1 Claimant's Statement** – to be completed and signed by claimant.

3. **WC Form 2 Supervisor's Statement** – to be completed and signed by Supervisor and provided to the Department Head for signature.

4. **WC Form 3 Witness Statement** – to be completed by any and all witnesses of the reported accident/incident. Each witness must complete a separate statement.

5. **WC Form 4 Authorization to Release Records** – to be completed and signed by the claimant.

6. **WC Form 5 Notice to Claimant** – to be signed by the claimant.

7. **WC Form 6 Treating Physicians Report** – to be retained by the claimant and taken to each physician visit.

8. Please note: There is a seven day waiting period before wages can be picked up under workers' compensation.

WC Form 1, WC Form 2, WC Form 3 (all copies), WC Form 4, and WC Form 5 must be submitted to Risk & Insurance

Please Submit the packet via fax (607) 778-2918 or email to bcworkerscomp@co.broome.ny.us

colleen.capwell@broomecountyny.gov

Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-6474 Fax: (607)778-2918

Procedure for Reporting a Workers' Compensation Injury

Employee Responsibilities:

1. Notify your supervisor of the accident/incident immediately.
2. The packet must be completed in full (Incomplete packets may be returned), signed and returned to Risk & Insurance within 5 days. Please call 778-6474 for questions regarding claims.
3. **Retain this Instruction form, WC From 6-Physicians report and a copy of the packet** for your records. The Treating Physicians report must be taken to each doctors' visit.
4. **Billing Information (You are responsible for giving this information to your Physician and Providers):**

TRIADGROUP
400 Jordan Road Troy, NY 12180
Tel: 800-337-7419
www.triadgate.com
PLEASE PROVIDE INFORMATION TO YOUR PHYSICIAN

BE SURE TO TELL YOUR PHARMACIST
Rx prescriptions processed through
AWPRx
BIN: 610237
PCN: AWPRX
GROUP: TRD999
Pharmacist Assistance (888)700-0922
Claimant Customer Service (888)700-0185
Radiological testing, xray, MRI, CT scan, scheduled through **One Call Medical**
(800) 872-2875
Call them to schedule an appointment at a facility near you

Supervisor Responsibilities:

- Notify Risk and Insurance immediately (778-6474) and provide the employees name, brief injury description, employees contact information and treatment facility, if applicable.
- Review the packet as submitted by the employee and ensure it is completed in full and signed where appropriate. Ensure all forms are returned, including:
  - ✓ WC Form 1 – Claimant's Statement of Accident
  - ✓ WC Form 2 – Supervisor Statement
  - ✓ WC Form 3 – Witness Statement
  - ✓ WC Form 4 – Authorization
  - ✓ WC Form 5 – Notice to Claimant
  - ✓ WC Form 6 – Treating Physicians Report (Can be turned separately, if necessary)
- Notify Risk & Insurance immediately via phone or email with any change in work status and fax all physicians reports or doctors notes to (607) 778-2918. If you have any questions regarding this paperwork or any additional information regarding this claim, please call 778-6474.

Instructions

Broome County Office of Risk Management

Broome County Office Building
60 Hawley Street, P.O. Box 1766, Binghamton, NY 13902
Main Office: Phone (607)778-6474 Fax: (607)778-2918
Email: BCWorkerscomp@broomecountyny.gov www.gobroomecounty.com

CLAIMANT'S STATEMENT

Person Injured _____ Social Security# _____

(Last Name) (First Name) (Initial)

Gender ☐Male ☐ Female ☐ Unknown Date of Birth ___/___/___ Phone Number (___) _____

Home Address _____

(Street) (City) (State) (Zip Code)

Employer/Dept _____ Job Title _____ Date of hire ___/___/___

Employment Status ☐Full time ☐ Part Time ☐Seasonal ☐Volunteer Employer Phone # (___) _____

What is your gross pay (before taxes)per pay period? $ _____ How often are you paid? ☐Weekly ☐ Biweekly ☐ Other

INJURY/ILLNESS INFORMATION

Date of Accident _____ Hour began work _____ AM PM Time of Injury _____ AM PM

Where did the injury occur? (e.g. 1 Main Street, front door, etc) _____

Property/Equipment Involved? (e.g., hammer, forklift, vehicle) _____

Body Part Injured (**Be specific to right or left**) _____

What were you doing when injured? (e.g., unloading truck, patient care, carrying boxes, etc.) _____

How did the injury/illness happen? (e.g., tripped over object, slipped getting out of truck, etc.) _____

Explain full nature of injury/illness? (e.g., twisted left ankle, cut forehead, bruised leg, etc.) _____

Witnesses to Incident Witness Department Witness Contact information

Attach additional pages if needed

Broome County Office of Risk Management

Broome County Office Building
60 Hawley Street, P.O. Box 1766, Binghamton, NY 13902
Main Office: Phone (607)778-6474 Fax: (607)778-2918
Email: BCWorkerscomp@broomecountyny.gov www.gobroomecounty.com

CLAIMANT'S STATEMENT
MEDICAL TREATMENT FOR THIS INJURY

Date of first treatment ___/___/___ ☐None Received ☐On Site ☐Emergency Room ☐Urgent Care/Walk-In

☐Hospitalization Stay over 24 Hours ☐Doctor's Office

Name and Address where you were first treated: _____

_____ Phone Number (___)_____

Are you still being treated for this injury? ☐ Yes ☐ No Doctors's Name _____

Doctor's Address _____ Phone Number (___)_____

Have you ever had another injury to the same body part or similar illness? ☐ Yes ☐ No

If Yes, please provide names and addresses of Doctors who treated you: _____

_____

WORK STATUS

Did you stop work because of your injury/illness? ☐ If yes, on what date? ___/___/___ ☐ If No, go to signature

Have you returned to work? ☐ Yes ☐ No If yes, on what date? ___/___/___ ☐Regular Duty ☐ Light Duty

Are you employed anywhere else? ☐ If yes, please list employer: _____

Have you returned to work with your other employer? ☐ Yes ☐ No If yes, on what date? ___/___/___

Illness Cases Only ☐ **Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case**

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that that this document will be presented to an insurer and become a part of the records of Broome County.

_____ _____

Signature and title of person preparing report **Date**

SUPERVISOR/DEPARTMENT HEAD STATEMENT

Please attach additional pages, if necessary

Injured Employee's Name _____ Supervisors name _____

Date notified of Injury _____ Time notified _____ AM PM

Did you witness the Accident/Injury? ☐ Yes ☐ No

If yes, please describe the incident/accident in detail as witnessed along with employee's condition after injury _____

If No, please state the claimant's account of the injury and your observation of their condition at the time of reporting (i.e limping, cut, bruised, etc)

Do you agree with the claimant's statement of injury? ☐ Yes ☐ No

If you do not agree with the statement of injury, please explain: _____

Was Personal Protective Equipment required ☐ Yes ☐ No If Yes, was it used properly ☐ Yes ☐ No

Please list any unsafe conditions or hazards that caused/contributed to this incident _____

Please note any precautions that should be taken to prevent a similar injury in the future _____

SIGNATURE OF SUPERVISOR **DATE**

SIGNATURE OF DEPARTMENT HEAD **DATE**

Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-2402 Fax: (607)778-2918

WITNESS STATEMENT

(Each witness must complete a separate statement)
Attach additional pages, if necessary

Injured Employee's Name _____

Date of Accident/Incident _____ Time of Incident_____ AM PM

Location of Incident _____

Witness Name_____ Witness Job Title_____

Witness Department_____ Witness Phone Number_____

Witness Description of Incident (Include as much detail as possible): _____
(attach an additional page if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

_____ _____
Witness Signature Date Signed

Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-6474 Fax: (607)778-2918

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MUST BE SIGNED FOR PAYMENT OF MEDICAL BILLS

I, _____ authorize the use and disclosure of Health Information as described in this authorization.
Print Name

Specific person/organization or class of persons authorized to provide information:

Licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer.

Specific person/organization authorized to receive and use information:

Broome County and legal representatives, Triad Group (or current TPA) and Corporate Care Management, Inc (or current Nurse Case Management Firm)

Specific and meaningful description of the information:

Any and all office notes, diagnostic test results, x-rays, employment records and hospital records.

Purpose of the request:

To evaluate the claim for Workers' Compensation Benefits, to determine causal relationship and/or apportionment.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time by notifying Broome County Office of Risk & Insurance, P.O. Box 1766, Binghamton, NY 13902 in writing. I understand that this revocation is only effective after it is received and logged in by Broome County Office of Risk & Insurance or the current TPA. I understand that this revocation will not apply to any use or disclosure made prior to its activation by Broome County.

I understand that after this information is disclosed, federal law may not protect it and the recipient may re-disclose it for the purposes stated above.

I understand that failure to sign this authorization could result in delayed processing of my claim and the Carrier's inability to pay related medical expenses.

I understand that I may receive a copy of this authorization.

I understand that this authorization will remain in effect for the entire period of my Workers' Compensation claim unless revoked.

Signature of Claimant: _____ Date of Birth: _____

Department employed by: _____ Date: _____

Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-6474 Fax: (607)778-2918

NOTICE TO EMPLOYEES APPLYING FOR WORKERS' COMPENSATION BENEFITS

If you are applying for or are receiving workers' compensation benefits (including advanced payments of workers compensation in the form of sick, vacation or any other benefit time), you must immediately report any other earnings you receive to the Broome County Office of Risk & Insurance and the Workers' Compensation Board including but not limited to:

1. If you return to any form of work
2. If you held employment of any kind with any other employer at the time of your injury
3. If you are self employed
4. If you receive income from any other sources such as rental property, online sales, etc.
5. If you perform any services in exchange for other goods or services, including volunteer work
6. If there is a change in your contact information including phone number and address
7. If you are participating in any type of educational classes or vocational rehabilitation programs

Failure to report earnings as defined will subject you to criminal prosecution and civil liability, including the suspension or forfeiture of your benefits.

Your endorsement on a benefit check, or deposit of the check into an account, is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

_____ _____

Date **Claimant Signature**

_____

Print Name

Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-6474 Fax: (607)778-2918

Treating Physician's Workers' Compensation Report

To the employee: You must give this form to your physician at each visit

EMPLOYEE NAME _____

DEPT. AND DIVISION _____

DATE OF INJURY

For Physician use only

- In your medical opinion is this injury related to the individual's job? ☐ Yes ☐ No
- Current degree of disability ☐ Mild (25%) ☐ Moderate (50%) ☐ Marked (75%) ☐ Total (100%)
- Taking into consideration the degree of disability you identified the employee:

☐ Can return to work without restrictions ___/___/___ ☐ Cannot return to work until ___/___/___

☐ Return to work with restrictions indicated below effective ___/___/___ through ___/___/___

Broome County has a comprehensive modified duty program & can accommodate most restrictions. The information provided in this form will be utilized to temporarily assign county employees to modified duty. Please explain in detail in the "Additional Comments" the nature of your patient's limitation in terms of Hours / Weight. / Range of Motion, etc.

				Additional Comments
☐ NO	☐ LIMITED	☐ UNRESTRICTED	PUSHING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	PULLING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	BENDING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	STOOPING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	SITTING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	STANDING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	TWISTING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	CLIMBING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	KNEELING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	LIFTING	_____ Lbs. Max.
☐ NO	☐ LIMITED	☐ UNRESTRICTED	**OVERHEAD** LIFTING	_____ Lbs. Max.

Additional restrictions:

Authorization for the following treatment/test is hereby requested:
Requests can be faxed to (607) 778-2918 Attn: Colleen _____

Date of this Exam: _____ Date of Next Appointment: _____

Physician Signature, Address and Phone Number: _____

I acknowledge and agree to the restrictions as marked above: _____
CLAIMANT'S SIGNATURE REQUIRED

APPLICATION FOR BENEFITS UNDER
SECTION 207{C} OF THE GENERAL MUNICIPAL LAW

I _____

Of _____

DO HEREBY MAKE FORMAL APPLICATION FOR BENEFITS PROVIDED UNDER SECTION 207{C} OF THE GENERAL MUNICIPAL LAW ON THE BEHALF OF _____.

MY RELATIONSHIP TO THE APPLIANT IS:

Self { } Legal Counsel { } Other Authorized person { }

IT IS UNDERSTOOD THAT NO 207{C} BENEFITS WILL BE PROVIDED TO THE APPLICANT PENDING DETERMINATION OF ELIGIBILITY BUT THAT SHOULD ELIGIBILITY BE FOUND REIMBURSEMENT WILL BE MADE FROM THE DATE OF DISABILITY.

THIS APPLICATION PERTAINS TO AN ACCIDENT OCCURRING ON _____
{DATE}

AT _____
{Address of incident}

IT IS ALSO UNDERSTOOD THAT THE APPLICANT MUST PROVIDE A PHYSICIAN'S STATEMENT CONCERNING THE INJURY AND DISABILITY WITHIN TEN {10} DAYS FROM THE DATE OF THIS APPLICATION. FAILURE TO PROVIDE MEDICAL DOCUMENTATION WILL RESULT IN A DENIAL OF BENEFITS.

IT IS ALSO UNDERSTOOD THAT MY FAILURE TO COOPERATE WITH THE RISK MANAGER MAY RESULT IN A DENIAL OF MY BENEFITS.

Date _____ _____
Signature of employee

Employee #_____ _____
Town/Village/Department