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

Volunteer Fire and Ambulance Packet and Instructions Effective January 1, 2024

PINK PACKET

1. **Instructions** – to be read by volunteer and Chief and **retained by the volunteer.**
2. **WC Form 1 Claimant's Statement** (2 pages)– to be completed and signed by the volunteer.
3. **WC Form 2 Supervisor's Statement** – to be completed and signed by the Chief.
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 volunteer.
6. **WC Form 5 Notice to Claimant** – to be signed by the volunteer.
7. **WC Form 6 Treating Physicians Report** – to be retained by the volunteer and taken to each physician visit.

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

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Procedure for Reporting a Workers' Compensation Injury

Employee Responsibilities:

1. Notify your supervisor/Chief 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 (607-778-6474) 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

NEW YORK STATE | Workers' Compensation Board

VOLUNTEER AMBULANCE WORKER'S CLAIM FOR BENEFITS

SEE REVERSE FOR FILING INSTRUCTIONS

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one) ☐ Yes ☐ No

W.C.B. CASE NO. (if known)	CARRIER CASE NO. (if known)	CARRIER CODE NO.	DATE OF INJURY	SOCIAL SECURITY NO.

	First Name	Middle Initial	Last Name	Address (Give Number and Street, City, State, Zip Code)	Apt. No.
1. VOLUNTEER AMBULANCE WORKER					
2. AMBULANCE COMPANY					
3. POLITICAL SUBDIVISION					

INFORMATION, REGULAR WORK

4. (a) Marital Status _____ (b) Gender ☐ M ☐ F ☐ X (c) Date of Birth _____ (d) Tel. No. _____
5. Describe in detail your duties in regular employment _____
6. Your work week at time of injury was (check one) ☐ 5 days ☐ 6 days ☐ 7 days ☐ Other _____
7. Employer's name and address _____

INJURY

8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? ☐ Yes ☐ No
(b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision _____

PLACE AND TIME

9. Address where injury occurred _____ County _____
10. Date of injury _____ at _____ o'clock _____ M

NATURE AND EXTENT OF INJURY

11. State full nature and cause of injury _____
12. Has injury resulted in amputation? ☐ Yes ☐ No If yes, describe _____
13. On what date did you stop work because of this injury? _____
14. Have you returned to work? ☐ Yes ☐ No If yes, give date _____
15. (a) Does injury keep you from work? ☐ Yes ☐ No (b) Have you done any work during your disability? ☐ Yes ☐ No

MEDICAL CARE

16. (a) Did you receive medical care? ☐ Yes ☐ No (b) Are you now receiving medical care? ☐ Yes ☐ No
17. (a) Are you now in need of medical care? ☐ Yes ☐ No (b) Name and address of attending doctor _____
18. If you were treated in a hospital, give name and address _____

VOLUNTEER AMBULANCE WORKERS' BENEFITS

19. Have you received volunteer ambulance workers' benefits payments for the injury reported above? ☐ Yes ☐ No
20. Are you now receiving volunteer ambulance workers' benefits payments? ☐ Yes ☐ No
21. Do you claim further volunteer ambulance workers' benefits payments? ☐ Yes ☐ No If yes, explain _____

NOTICE

22. Have you given Notice to Liable Pol. Subdivision of Vol. Ambulance Worker's Injury or Death (Form VAW-1) to the political subdivision liable for the payment of your vol. ambulance workers' benefits? ☐ Yes ☐ No If yes, was such Notice delivered personally? ☐ Yes ☐ No or sent by Registered Mail? ☐ Yes ☐ No If yes, to whom was Notice delivered/sent _____
_____ Date _____
Name of Officer and Political Subdivision

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

I certify that copy of this was filed with _____
Name of Officer Title of Officer

_____ on _____
Political Subdivision or Ambulance Service Liable for Benefits

Dated _____ Signed by _____ or
Volunteer Ambulance Worker

Signed _____
A person on their behalf, or in case of death, by any one or more of their dependents, or person on their behalf. Relationship Telephone No.

VAW-3 (6-22)

THIS CLAIM SHOULD BE FILED WITH THE CHAIR, WORKERS' COMPENSATION BOARD, AS SOON AS POSSIBLE AFTER INJURY IS INCURRED. DO NOT DELAY FILING THIS CLAIM.

WHAT EVERY VOLUNTEER AMBULANCE WORKER SHOULD KNOW IN CASE OF INJURY IN LINE OF DUTY

A. The law requires every county, city, town, village or ambulance district to:

1. Provide Volunteer Ambulance Workers' Benefits in case of accident or injury in the line of duty.
2. Post a notice of compliance:(a) Giving the name of the insurance carrier, if the community is insured, or (b) Stating that the community is self-insured. *(Look for this notice at your ambulance company headquarters. Advise the Workers' Compensation Board if it is not posted in a conspicuous place. Note: Ambulance Services unaffiliated with a political subdivision are not required to provide coverage under the VAWBL. However, if coverage is provided, a notice of compliance must be posted.)*

B. What You Must Do

1. You must give written notice of injury on Form VAW-1 or this Form VAW-3 by personal delivery or registered mail WITHIN NINETY DAYS after injury to the designated officer of the political subdivision liable for benefits as follows:

If the political subdivision liable for benefits is a	Then deliver to
a. County	a. Clerk of Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	e. Secretary

   If a political subdivision is not liable for benefits, file this form with the head of the unaffiliated ambulance service. The home county, city, town, village or ambulance district is liable for the payment of benefits, regardless of whether service was rendered for the home area or for another area under contract or in response to a call for assistance.
2. Form VAW-1 is only a notice of injury or death and not a claim for benefits.
   In order to claim benefits, you must file this Form VAW-3 no later than two years after injury with: (a) Chair, Workers' Compensation Board (see address below) and (b) The same officer to whom a notice of injury was sent (item B1 above). If you file Form VAW-3 WITHIN NINETY DAYS, it serves as both a notice of injury and a claim for benefits, and you do not need to file Form VAW-1.
3. You should secure medical attention promptly (see item 2 below regarding choice of doctor).
4. Attend the hearing on your case if you are notified to appear before the Workers' Compensation Board.
5. Go back to work as soon as you are able.

C. Your Rights

1. As a volunteer ambulance worker, you are entitled to benefits if you suffer injury in the line of duty.
2. Generally, you are entitled to be treated by a doctor of your choice, provided they are authorized by the Board. If the ambulance service or political subdivision is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the certified preferred provider organization which has been designated to provide health care services for volunteer ambulance workers' injuries.
3. You are entitled to be paid for drugs, crutches or any apparatus such as belts, if they are prescribed by your doctor; also for carfares and other necessary expenses going to and from your doctor's office or hospital. You are to secure a bill or receipt for such expenses and present it to the clerk of the county's board of supervisors, comptroller or chief financial officer of the city, clerk of the town or village, secretary of the ambulance district or to the ambulance service which is liable for providing volunteer ambulance workers' benefits, or its insurance carrier for payment. If payment is refused, the bill or receipt should be sent to the Workers' Compensation Board with a statement of fact that payment has been refused.
4. You may be entitled to benefits from the first day of disability if your injury results in a loss of earning capacity,or leaves you with impaired eyesight or hearing, serious facial scars, or any permanent injury or stiffness of a finger, hand, toe, foot, leg or arm.
5. You are entitled to an opportunity to be heard on your claim before the Workers' Compensation Board.
6. You are entitled to the repair or replacement of prosthetic devices which are damaged as a result of services performed in the line of duty as a volunteer ambulance worker. Prosthetic devices include an artificial limb, artificial eye, eyeglasses, contact lens, hearing aid, denture or dental appliance or any surgical appliance required to be worn or used by the volunteer ambulance worker, but does not include articles considered to be ordinary wearing apparel.

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).
The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

INSTRUCTIONS: Claims should be sent directly to the Workers' Compensation Board at the address listed below:

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Line: 877-632-4996

IF YOU HAVE QUESTIONSOR NEED ADVICE ABOUT YOUR CLAIM,YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.	SI TIENE PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.

BE SURE TO NOTIFY THE APPROPRIATE OFFICE OF THE WORKERS' COMPENSATION BOARD OF ANY CHANGE IN YOUR ADDRESS.

Broome County Office of Risk Management

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VOLUNTEERS'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

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VOLUNTEER'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 Volunteer'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 CHIEF **DATE**

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WITNESS STATEMENT

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

Injured Volunteer'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

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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 Volunteer: _____ Date of Birth: _____

Volunteer Department:

_____ Date: _____

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NOTICE TO VOLUNTEERS APPLYING FOR VOLUNTEER BENEFITS

If you are applying for or are receiving volunteer fire/ambulance benefits, 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 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 **Volunteer Signature**

_____

Print Name

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Treating Physician's Volunteer Fire/Ambulance Report

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

VOLUNTEER'S NAME _____

FIRE/AMBULANCE DEPT _____

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