



Ohio Department of Natural Resources

JOHN R. KASICH, GOVERNOR

JAMES ZEHRINGER, DIRECTOR

Dear Employee:

We are sorry that you are unable to work due to non-work related health reasons. This packet contains all the necessary information for you to apply for the State of Ohio's Disability Leave Program administered by the Department of Administrative Services (DAS).

If you are permanent full-time employee or a part-time employee who has worked more than 1500 hours in the previous 12 months, you may be eligible for disability leave. In order to apply for disability leave you must complete the **Application for Disability Leave Benefits (ADM4310)** form in its entirety. Page 1 contains instructions that describe the forms and process for completing them. You must complete pages 2 & 3 and your doctor must complete pages 3 & 4. You should ask your doctor to attach any medical records that document your disability.

You may utilize accrued sick, vacation and personal leave or compensatory time to supplement the 67% disability wages up to a combined total of 100% of your regular rate of pay. On page 3 indicate if you wish to use accrued leave to supplement your disability pay from 67% to 100%.

If your illness is mental health related, you must seek care from a licensed mental health provider. If you are enrolled in the state's health plan, contact United Behavioral Health (UBH) at 1-800-852-1091 for a referral to a mental health clinician. You should provide your clinician with the Statement of Psychiatric Disability (ADM4316) and return it to DNR HR Payroll/Benefits within 20 days of your last day worked. **You do not need to fill this form out if your illness is not mental health related.**

Pages 2-5 of the **Application for Disability Leave Benefits (ADM4310)** (and the Statement of Psychiatric Disability, if applicable) must be filed within 20 calendar days of your last day worked. Make a copy of the completed forms for your records and

- mail the original completed forms to the below address, Attention: Payroll/Benefits OR
- scan/email the forms to DNR ODNR Payroll and Benefits OR
- fax them to 614-265-7051

If your claim is approved you must serve a mandatory 14 consecutive calendar day waiting period before you can receive disability leave benefits. During this time, you may use your leave time (sick, personal, vacation or comp time) to receive pay during the waiting period. This time will not be restored.

If you are going to be hospitalized or have outpatient surgery, you must also complete the **State of Ohio Hospitalization or Outpatient Surgery Certification** form as soon as possible so your sick leave can be paid at 100% during the waiting period instead of 70%.

Any questions can be addressed to Leita Cook, ODNR Absence Management Coordinator, 614-265-6436 or email them to leita.cook@dnr.state.oh.us. Additional information about the program is available at www.das.ohio.gov/Divisions/HumanResources/BenefitsAdministration/Disability

**INSTRUCTIONS FOR COMPLETION OF ADM4310
INITIAL APPLICATION FOR DISABILITY LEAVE BENEFIT APPLICATION**

This form is used only for an initial filing for Disability Leave Benefits. If you are filing supplemental information for an extension of disability benefits, use form ADM4311.

COMPLETION OF FORMS

- Type or print legibly
- All sections of application must be completed
- You are responsible for completing the Employee Statement, pages 2 and 3
- Your physician is responsible for completing the Attending Physicians Statement, pages 4 and 5
- You are responsible for returning **all five (5) pages** of the disability form to your agency within **twenty (20) calendar days of your date last worked***
- 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

WAITING PERIOD

- If approved for benefits, you must serve a **mandatory 14-day** waiting period** before receiving benefits

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

- Claim 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

PHYSICIAN INSTRUCTIONS

- Type or print legibly
- Complete pages 4 and 5 without expense to the state of Ohio
- Complete each section as thoroughly as possible
- Attending physician should retain a **copy** of all 5 pages of the form
- The employee is responsible for returning the entire form to their personnel office within twenty (20) calendar days of the date the employee last worked. *** 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

** Contract exceptions for filing - FOP 46 & FOP 48 please refer to your contract.*

*** Contract exceptions for length of waiting period - Attorney General, FOP 46 and FOP 48, Refer to your contract.*

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

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

Application for Disability Leave Benefits

Employee Statement

Please read instructions on page 1 of the application before completing this application

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

Employee Name		Date of birth	State of Ohio User ID	
Address	Street	City	State	Zip
Telephone (area code)	Home ()	Work ()	Cell ()	
E-mail				
Agency		Job Title		
Date accident or illness began		Date became disabled	Date last worked	Date of first treatment
Date of most recent treatment			Date of next appointment with physician(s)	
Describe your disability				
Was disability due to an injury?		If yes, date of injury	How and where did accident happen?	
Yes ___ No ___				
List of all physicians treating you for this condition				
Name		Specialty	Telephone (area code)	Fax (area code)
Have you been hospitalized for this illness?		If yes, give name of hospital & city	Date(s) of confinement	
Yes ___ No ___				
Additional hospitalizations/urgent care/emergency room visits/dates for this illness (Please provide medical reports from these visits)				

Employee Name		State of Ohio User ID
Was your current illness/injury received in the course of and arising out of your employment with the State of Ohio or any other employer? Yes ___ No ___		
Have you ever applied for workers' compensation benefits involving the same part of body as your current illness/injury or for a condition in any way related to your current illness/injury? Yes ___ No ___ If yes, provide:		
BWC claim Number (s) _____		
Date (s) of illness/injury (s) _____		
Is your current illness/injury a recurrence of a previous illness/injury listed above? Yes ___ No ___	If yes, did you receive any lost time wages or other compensation from BWC? Yes ___ No ___ If yes, provide type of compensation and timeframe:	
Have you filed a BWC claim for your current condition? Yes ___ No ___	Are you filing a BWC claim for your current condition? Yes ___ No ___	
Have you returned to work?	If yes, give date	If no, what date do 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, name of employer:		
Address:	Phone:	Your position:
Would you like to supplement disability by utilizing available leave time? Yes ___ No ___		
If yes, list type of leave you want to use		
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 representative 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 (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>		
This authorization will be valid for 180 days from date of signature.		
Date	Employee 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.

Application for Disability Leave Benefits - Attending Physician Statement

Instructions for completing this form are on page 1 of this 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 _____																		
Date patient rendered disabled from working _____	Ever had same or similar condition: If yes, when and describe Yes ____ No ____																				
Is condition arising out of employment? Yes ____ No ____																					
Date first consulted you for this condition _____		Additional dates of treatment including the most recent visit _____																			
Frequency of visits: Weekly ____ Monthly ____ Other ____			Referrals _____																		
Date of most recent visit _____	Next scheduled appointment _____	EDC _____																			
Diagnosis of disabling condition(s)																					
Diagnosis _____	ICD-9 _____																				
Diagnosis _____	ICD-9 _____																				
Diagnosis _____	ICD-9 _____																				
Dates of Hospitalization _____		Name of Hospital _____																			
Reason for hospitalization and/or type of surgery performed _____	If surgery performed, give date Mo ____ Day ____ Yr ____	If pregnancy, provide delivery date Mo ____ Day ____ Yr ____																			
Complications or other factors contributing to disability (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) 																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Medications</th> <th style="width: 33%;">Dosage</th> <th style="width: 33%;">Date initiated</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>				Medications	Dosage	Date initiated	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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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.

Employee Name		
Plan of treatment for a return to work		
What restrictions are placed on patient's work activities?		
What job duties is the employee unable to perform?		
1. In an 8-hour workday, person can: (Circle full capacity for each activity)		
TOTAL (hours)	Sit 0 1 2 3 4 5 6 7 8	Stand 0 1 2 3 4 5 6 7 8 Walk 0 1 2 3 4 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(s) prevents them from working:		
Temporary ___ 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 ___	
___ For part-time basis	Mo ___ Day ___ Yr ___	
part-time schedule: hours per day ___ days per week ___		
___ For suitable work activities within the limitations listed above	Mo ___ Day ___ Yr ___	
Additional Remarks		
Name (attending physician) Please print		Specialty
Street Address		Fed ID#
City	State	Zip Code
Telephone (area code)	Fax (area code)	E-mail address
Date form received	Date signed	Signature

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**STATE OF OHIO
HOSPITALIZATION OR OUTPATIENT SURGERY CERTIFICATION**

(Please Print)

Employee's Name (First/Middle/Last):	Employee ID:
Employee's Job Title:	Agency:
Home Address:	City: State: Zip:
Telephone (W): ()	Telephone (H): ()

1. This information is being provided by: Physician Practitioner Another provider of health services

Name Title Phone Number

INSTRUCTIONS: Please complete only one of the two sections that follow.	
<p><u>SECTION I: HOSPITALIZATION</u></p> <p>2. Patient Information:</p> <p>_____</p> <p><i>(Name)</i></p> <p>_____</p> <p><i>(Relationship to Employee (if applicable))</i></p> <p>3. Dates of Hospitalization: _____</p> <p>4. Patient was hospitalized overnight? Yes or No</p> <p>5. Hospital: _____</p> <p>_____</p> <p>_____</p> <p><i>(Facility Name/Address)</i></p>	<p><u>SECTION II: OUTPATIENT SURGERY</u></p> <p>6. Patient Information:</p> <p>_____</p> <p><i>(Name)</i></p> <p>_____</p> <p><i>(Relationship to Employee (if applicable))</i></p> <p>7. Date of Surgery: _____</p> <p>8. Hospital: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><i>(Facility Name/Address)</i></p>

Physician's Certification

I certify that the information contained in this form is true to the best of my knowledge.

Attending Physician/Heath Care Provider Signature *Date*

Employee's Authorization and Certification

I voluntarily authorize the State of Ohio to contact my health care provider for the limited purpose of clarifying the information contained in this certification. Employee's initials: _____

I certify that the information contained in this form is true to the best of my knowledge and understand any misrepresentation on my part may result in a denial of full payment for sick time and may subject me to discipline.

Employee's Signature *Date*

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**DEPARTMENT OF ADMINISTRATIVE SERVICES
STATEMENT OF PSYCHIATRIC DISABILITY**

Patient's Name (Please Print)

Disability Claim Number

AUTHORIZATION: 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's 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 representative 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.

(Signature) This authorization will be valid for 180 days from date of signature.

(Date)

NOTE TO TREATMENT PROVIDER: Please complete the following questions as thoroughly as possible. Failure to do so may result in a denial of your patient's benefits. Any cost for completion of this report is your patient's responsibility.

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.

1. DSM diagnostic code, with symptomology. _____

2. Please include interpretive results of MMPI or other psychological testing if done. _____

3. Provide dates of treatment. _____

4. List medications, changes in medications with dates changed, any side effects from medication, and lab results. _____

5. Describe patient's mood and affect. _____

6. Comment on patient's ability to carry out daily activities and follow instructions. _____

7. Describe patient's behavior or any changes in behavior. _____

8. Is there any evidence of a thought disorder? Please comment. _____

9. Comment on patient's judgment and ability to concentrate. _____

10. Is there any impairment in memory? Please comment. _____

11. Has patient been referred to another treatment source? If so, please provide name, address, and copy of evaluation, if available. _____

12. Comment on how the combined symptoms and intensity interfere with job performance. _____

13. Plan of treatment toward return to work with expected date of return. _____

14. Patient's condition prevents them from working:

Temporarily

Permanently

For longer than 12 months

15. 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. _____

Name (treatment provider) Please Print		Specialty	Federal ID #
Street Address, City, State, Zip			
Telephone (area code)	Fax (area code)	E-mail Address	
Date form received	Date signed	Signature	