INSTRUCTIONS FOR COMPLETION OF ADM4311
SUPPLEMENTAL REPORT FOR DISABILITY LEAVE BENEFITS

This form is to be used to request an extension of your disability leave claim. If you are filing for initial disability benefits, use form ADM4310

File online by going to: MyOhio>MyWorkspace>myBenefits>Create/Extend a Disability Claim.

COMPLETION OF FORMS

- Print legibly
- All sections of application must be completed
- You are responsible for completing the Employee Statement, Page 2
- Your physician is responsible for completing the Attending Physician Statement, Pages 3 and 4 (Employees are prohibited from completing this section of the application)
- You are responsible for returning both sections of the form to your agency by the deadline date given in the last decision letter sent by Benefits Administration Services **If there will be a delay in getting the Attending Physician Statement submitted, please return the Employee Statement to your agency human resources office by the deadline date given in the last decision letter**

PERSONAL DATA

- You must notify your supervisor of your absence and the expected date of your return to work
- Print legibly

RETURN TO WORK

- To return to work on a part-time basis, you must have the approval of your agency and a return to work release
- Only employees receiving full-time benefits or those who are returning part-time immediately following the mandatory 14-day waiting period are eligible to receive part-time benefits
- You must return to work in a Transitional Work Program if recommended by your attending physician and your agency can provide such a program

WORK RELATED CLAIMS

- You are **required** to file a claim for lost time wages directly with the Ohio 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

- Claims must be submitted to your agency personnel office
- 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

DISABILITY RETIREMENT

- If your condition is permanent or will last greater than 12 months, you may be required to file for disability retirement benefits to continue receiving disability leave benefits

PHYSICIAN INSTRUCTIONS

- Complete the Attending Physician Statement, Section B, Pages 3 & 4 without expense to the State of Ohio
- Attending physician should retain a copy of pages 3 & 4 of the form
- The employee is responsible for returning the entire form to his or her personnel office within a specified time frame. **Failure to do so may result in denial of your patient's benefits**

BEHAVIORAL HEALTH CONDITIONS

Optum, the State's behavioral health care provider, manages disability claims for State of Ohio employees who are enrolled in the State's medical plan.

To request a disability assessment, an employee may contact Optum directly at 1-800-852-1091 or the Ohio Department of Administrative Services Employee Assistance Program (EAP) at 1-800-221-6327

- To be eligible for disability leave benefits for a behavioral health condition, the following must apply:
  - The employee must have a behavioral health/ substance use condition that prevents the employee from working for longer than fourteen (14) calendar days
  - The employee must be in treatment with a behavioral health/substance use specialist licensed to practice in the State of Ohio, and
  - The employee must follow the treatment plan prescribed by their provider

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Disability benefits for State employees are authorized in Administrative Rules 123:1-33-01 through 123:1-33-11 and the bargaining unit contracts

Information about the Disability Leave Program is available on the benefits website:
http://das.ohio.gov/Divisions/HumanResources BenefitsAdministration/Disability.aspx

Supplemental Report
Disability Leave Benefits Employee Statement

Please read the instructions on Page 1 before completing this application.
This form must be submitted to your agency within 20 calendar days from the ending date of approved benefits; FOP 46 and FOP 48 please refer to your contract.
File online by going to: MyOhio>MyWorkspace>myBenefits>Create/Extend a Disability Claim.

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

Employee's Name	State of Ohio User ID	Date of Birth

Street Address	City	State	ZIP Code

Telephone (area code) Home:	Personal Email:
Work: Cell:	Work Email:

Have there been any changes in your condition since your original claim? Yes ____ No ____ If yes, please explain

Any conditions that have become disabling that were caused by or resulting from your job? Yes ____ No ____
If yes, please describe

Have you been hospitalized since your original claim? Yes ____ No ____	If yes, give dates of confinement
Name of Hospital	Reason for confinement
Have you returned to work? Yes ____ No ____ If yes, give date:	If no, what date to 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, did you receive compensation? Yes ____ No ____

Place of Employment: Address:
Telephone: Provide dates worked: Your position:

If your claim was not as an advancement of workers' compensation, have any conditions become disabling that were caused by or resulting from your job? Yes ____ No ____
If yes, please describe:

EMPLOYEE CERTIFICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the State's mental health vendor, Optum, 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 Ohio Department of Administrative Services (DAS) or its representatives 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, Optum, 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, Optum, 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.

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.

This authorization will be valid for 18 months from date of signature. I understand, that I have the right to revoke this authorization at any time prior to its expiration by providing written notice to the Disability Unit for the Ohio Department of Administrative Services, 30 East Broad Street, 27th Floor, Columbus, Ohio 43215. However, I understand, that I may not revoke any action taken by DAS in reliance on this authorization prior to the date DAS receives my written notice of revocation. Additionally, I understand that revoking this authorization may impair further processing of my claim or result in my claim being discontinued.

Date:	Employee Signature

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.

Supplemental Report
Attending Physician Statement

Please read the instructions on Page 1 before completing this application.
This form must be submitted to your agency within 20 calendar days from the ending date of approved benefits; FOP 46 and FOP 48 please refer to your contract.
File online by going to: MyOhio>MyWorkspace>myBenefits>Create/Extend a Disability Claim.

PLEASE ATTACH COPIES OF OFFICE NOTES, EVALUATIONS AND TESTING RESULTS
INSUFFICIENT AND/OR ILLEGIBLE MEDICAL EVIDENCE MAY RESULT IN THE DENIAL OF BENEFITS

EMPLOYEE: Section A (Employee complete this section before giving the form to your provider)

Employee Name	Date of Birth	State of Ohio User ID

ATTENDING PHYSICIAN/TREATING PROVIDER: Section B
(Employee is prohibited from completing any portion of this form beyond this point)

Diagnosis of disabling condition(s)
Primary Diagnosis _____ ICD-10 _____
Secondary Diagnosis _____ ICD-10 _____
Tertiary Diagnosis _____ ICD-10 _____

Date rendered disabled

Treatment dates since last report	Date of next appointment
Has patient been hospitalized since initial claim Yes ____ No ____	Dates of hospitalization
Reason for hospitalization	Name of Hospital

If surgery performed, provide date and type of surgery Mo. _____ Day _____ Yr. _____
Sugery_____

Complications or other factors delaying recovery (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)

List any **change** in medication since onset of disability

Medications	Dosage	Date initiated

Plan of treatment for a return to work

What restrictions are placed on patient's work activities?

Attending Physician/Treating Provider - Section B
(Employee is prohibited from completing any portion of this form beyond this point)

Employee Name

What job duties is the patient unable to perform?

1. In an 8-hour workday, person can: (mark 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 prevents them from working:

Temporarily _____ **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. _____

_____ 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. _____

Additional Remarks

PLEASE PRINT Name (treatment provider)	Specialty	Fed ID#
Street Address City State ZIP Code		
Telephone (area code)	Fax (area code)	Email address
Date form received	Date signed	Signature