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INJURED ON THE JOB?

An Employee's Guide to Worker's Compensation in New York State

Workers' Compensation Board

New York State Workers' Compensation Board

Table of Contents

What is Workers' Compensation?.. 2
How to File a Claim…………………………………………………………………. 2
Who Is and Isn't Covered?.. 3
A Worker's Responsibilities……………………………………………………. 3
Medical Care……………………………………………………………………………… 4
Rehabilitation and Social Work……………………………………………… 5
Occupational Disease ……………………………………………………………. 5
Wage Replacement (Cash) Benefits………………………………………… 6
Reduced Earnings Benefits ………………………………………………… 6
Disability Classifications……………………………………………………… 7
Resolving Disputed Claims…………………………………………………… 8
Disability Benefits During a Dispute……………………………………… 8
Death Benefits…………………………………………………………........... 9
Social Security Benefits…………………………………………………………… 9
Discrimination……………………………………………………………………………… 9
A Timeline for Your Case…………………………………………………… 10
Common Questions……………………………………………………………… 10-11
Directory of WCB Board Offices…………………………………………… 12

The C-3 and C-3.3 forms follow the text of this document.

This pamphlet is a general, simplified presentation of workers' compensation provisions and procedures. It is not a substitute for the law or legal advice.

The Workers' Compensation Board does not discriminate on the basis of race, color, national origin, sex, religion, age, disability, or sexual preference when providing services or in employment.

Workers' compensation fraud is a felony, punishable by fines and up to seven years imprisonment. To report fraud, call 1.888.363.6001.

What is Workers' Compensation?

Workers' Compensation is a form of insurance. Most employers must carry this insurance for workers injured or who become ill because of their jobs. It provides for medical care and wages you lose because your ability to work is affected. Employers pay for this insurance carrier or by the employer if it insures itself. Benefits are paid according to the law, and the Workers' Compensation Board ensures they are correctly provided.

The Workers' Compensation Board is a state agency that oversees how employers and insurers handle injured workers' claims. A claim is paid if the insurer agrees the incident is work-related or if the Board orders it. An employer or its insurer can dispute the claim. If that happens, the Board will try to resolve the dispute within 90 days. For example, the insurer may believe the incident didn't occur at work. It may not even agree that it covered your employer when you were hurt. Other issues may also arise. Whatever the reason, the Board will try to resolve it as quickly as possible.

You don't need to lose time from work to file a claim. No one needs to be found at fault for you to receive benefits. Claimants don't receive less if they were careless, nor do they receive more if the employer is at fault. However, a worker loses the right to benefits if the injury results solely from using drugs or alcohol or from trying to injure themselves or someone else.

HOW TO FILE A CLAIM

You must report the injury, in writing, to your employer within 30 days of the accident. **The Board must be notified of your case within two years of the accident.** You must also file a compensation claim as soon as possible.

You may file the Form C-3, Employee's Claim for Compensation, in one of three ways:

1. Online, go to www.wcb.ny.gov and click **Workers** to complete the form.
2. Complete a paper C-3 and mail it to the nearest Board office. A C-3 is in the center of this pamphlet, and Board addresses are on the back.
3. Call 1.866.396.8314. A Board representative will complete it with you.

You will be notified by mail if a hearing is necessary.

Who Is Covered?

- Workers in all for-profit businesses.
- County and municipal employees.
- Public school aides, including New York City aides. New York City shop teachers are covered; other New York City teachers are covered in another system.
- Employees of the state of New York, including some volunteer workers.
- Domestic workers employed 40 or more hours per week by the same employer. This includes full-time sitters, companions, and live-in maids.
- Farm workers whose employers paid $1,200 or more for farm labor in the previous calendar year.
- Anyone else the Board determines is an employee.

Religious, educational or charitable nonprofit entities may voluntarily cover their clergy and teachers. Domestic workers employed fewer than 40 hours a week and not living in the employer's residence may also be covered voluntarily by their employer. It isn't mandatory.

Who Isn't Covered

- Volunteers at nonprofit organizations.
- Clergy and members of religious orders who are performing religious duties.
- People working at educational, religious, or charitable institutions who teach or perform nonmanual labor.
- People covered by federal workers' compensation laws. This includes postal workers, certain maritime trades, interstate railroad, and federal employees.
- Anyone doing yard work or casual chores at a one-family, owner-occupied home. (A minor handling power-driven machinery, including a power lawnmower, is covered.) There may be limited coverage under a homeowner's policy.
- Certain foreign government employees.
- New York City police officers, firefighters, teachers, and sanitation workers are covered by another system. Other uniformed police and firefighters may also be excluded.
- Certain real estate salespeople, insurance agents and media sales representatives who sign contracts stating that they are independent contractors.
- Sole proprietors, partners, and certain one/two-person corporations without employees. They may cover themselves.

A Worker's Responsibilities

1. Try to return to work as soon as you're physically capable. Your employer may have transitional or light duty work for you.
2. You're responsible for looking for work within your physical abilities. This may mean working outside your previous occupation.
3. Respond to all inquiries and documents from the Board and the insurer in a timely manner.
4. Advise the Board and other parties of address changes.
5. Attend all hearings and appointments. Arrive on time.
6. Answer questions thoroughly and honestly.
7. Participate actively in your case. Don't let events happen around you.
8. Understand any agreements you make.
9. Ask questions of your representative and the Board.

Medical Care

A worker who is injured on the job or becomes ill from his work will have his health care for that condition paid under a workers' compensation claim. This care is covered whether or not you lose time from work. It is also paid in addition to any benefits you get for missed wages.

Health care providers must be authorized by the Board to see workers' compensation patients. The Board has lists of providers who are authorized to treat you. You can find a doctor on www.wcb.ny.gov under **Health Care Information,** or by calling 1.800.781.2362. You can receive care from any of these providers, or from your own doctor, if he or she is registered. The providers will send the bills directory to the insurer and the Board. **Do not pay any bills unless the Board disallows your case.** You may also receive reimbursement for travel to and from a health care provider's office.

If specific medical services are disputed, the insurer must pay any undisputed portion. It must also explain in writing why the services were not paid, and request any information needed to pay them. Your doctors may ask you to sign Form A-9. This states you'll pay the bills if the Board does not allow your claim, or if you drop your case before it's accepted.

Types of Services Covered

Medical
Osteopathic
Dental
Podiatric
Psychological *(by referral)*
Chiropractic Treatment
Surgery
Hospital Care

Laboratory Tests
Prescribed Drugs
Nursing Services
Surgical Appliances
Prosthetic Devices

Preauthorization is sometimes required.

Preferred Provider Organizations

If the insurer has a network of providers to care for injured workers, you must use those providers. This is called a Preferred Provider Organization (PPO). The insurer must notify you of this. If you aren't satisfied with the care you receive from the PPO, you may select an authorized provider outside the PPO after 30 days of treatment.

Diagnostic Networks

Insurers may also require you to use its network of facilities for diagnostic tests. Tell your doctors and other providers if the insurance carrier requires you to use its network for a diagnostic test.

Pharmacy Charges

You can go to any pharmacy unless the insurer uses a network. Ensure the pharmacist knows you have a workers' compensation case because many will bill the carrier directly rather than you. However, the pharmacy can ask you to pay for the prescription upfront. The insurer must reimburse you within 45 days. The pharmacy can only charge you the amount specified by law, so you will be fully reimbursed even if you pay in advance. You're not responsible for any charges. If you must use an insurer's network pharmacy, the insurer must tell you how you should use it. Those pharmacies are paid directly. You will not be responsible for any charges.

Exceptions

1. *Testing:* The insurer may not demand you use a network provider for a diagnostic test in a medical emergency. It may not require you to use a network that does not have a provider or facility within a *reasonable distance, one mile from your home or employment in an urban setting, and ten miles in a suburban or rural location.*
2. *Pharmacy:* The insurer may not demand you use network pharmacies if it is not reasonably possible in a medical emergency. *You don't need to use network pharmacies if they don't offer mail order or aren't located a reasonable distance from you, either.*

Rehabilitation and Social Work

Rehabilitation services help people return to work and lead full and active lives. Specific services are explained below.

Medical rehabilitation helps people reach maximum independence and functioning. It provides workers with information and helps them obtain medical care, physical accommodation, or other special needs. Only a physician may recommend medical rehabilitation, so talk to your doctor. This service is arranged outside the Board.

Vocational rehabilitation helps people whose disability prevents them from returning to their usual job. Counselors help injured workers find employment that fits their abilities. They also help develop a plan to return to work. This may include vocational counseling and referrals for training and selective job placement.

Social workers assist people when family or financial problems interfere with returning to work. In addition, social workers help people cope with their disability and discuss their concerns about rehabilitation. They can also help workers prepare to return to work.

The Board has counselors, social workers, and claims examiners who coordinate and monitor other services. If you could benefit from these services, contact the Board. The office telephone numbers are on the back of this pamphlet.

Occupational Disease

An occupational disease is contracted as the result of your work. It arises from a specific aspect of the work that you perform. For example, people who remove asbestos may contract asbestosis. People who work on computers may suffer from carpal tunnel syndrome.

You may be disabled by an occupational disease even if you don't lose time from work.

The rules governing the time limits for filing an occupational disease claim are complex. You should file as soon as you know you're ill, or suspect that you have an occupational disease.

People disabled by occupational diseases receive the same benefits they would for an on-the-job accident. In the case of death, the dependents must file within two years of the date of death.

Occupational Hearing Loss

The law states a different time period to file a claim for occupational hearing loss than other disabilities. A waiting period must pass before you file a claim. That period is your choice of:

- Three months after leaving the employment where you were exposed to the harmful noise, or
- Three months from the date you're removed from the harmful noise in the workplace. Removal can include wearing protective gear, so ask for it at work. You can contact OSHA at 1.800.321.OSHA for help if necessary.

The Board will consider the last day of whichever period you choose as the date of disability in determining when your benefits begin.

Occupational hearing loss claims have different time limits. You may file beyond the typical two-year limit if you do it within 90-days of learning the hearing loss is job-related.

Wage Replacement (Cash) Benefits

Claimants who are totally or partially disabled for more than seven days receive benefits for lost wages. The amount you receive is based on your average weekly wage for the 52-weeks prior to the date of injury, including overtime. It’s based on your gross earnings, not your take-home pay. The Board will use two-thirds of your average weekly wage, and then adjust it by the extent of your disability:

2/3 x average weekly wage x % of disability = weekly benefit

The weekly maximum benefit is two-thirds your average weekly wage. If you suffer a total disability, you get two-thirds your weekly wage, up to the maximum (see below.) For example, if you earn $750 per week and are totally (100%) disabled as of today, you receive two-thirds of $750, or $500 per week. You’re 100% disabled, so you receive all of the benefit.

If you’re 50% disabled and earned $750 per week, your benefit is $250. To calculate it: two-thirds your $750 average weekly wage equals $500. Then, because you are 50% disabled, your benefit is half of $500, or $250.

The benefit rate is computed the same way, whether you are temporarily or permanently disabled. The maximum weekly wage benefit is based on accident date. It does not increase as maximum benefits increase.

Schedule of Benefits:

	Weekly Maximum	
Date of Accident:	**Total:**	**Partial:**
July 1, 2023 – June 30, 2024	$1,145.43	$1,145.43
July 1, 2022 – June 30, 2023	$1,125.46	$1,125.46
July 1, 2021 – June 30 2022	$1,063.05	$1,063.05
July 1, 2020 – June 30, 2021	$966.78	$966.78
July 1, 2019 – June 30, 2020	$934.11	$934.11
July 1, 2018 – June 30, 2019	$904.74	$904.74
July 1, 2017 – June 30, 2018	$870.61	$870.61
July 1, 2016 – June 30, 2017	$864.32	$864.32
July 1, 2015 – June 30, 2016	$844.29	$844.29
July 1, 2014 – June 30, 2015	$808.65	$808.65
July 1, 2013 – June 30, 2014	$803.21	$803.21

	Weekly Maximum	
Date of Accident:	**Total:**	**Partial:**
July 1, 2012 – June 30, 2013	$792.07	$792.07
July 1, 2011 – June 30, 2012	$772.96	$772.96
July 1, 2010 – June 30, 2011	$739.83	$739.83
July 1, 2009 – June 30, 2010	$600	$600
July 1, 2008 – June 30, 2009	$550	$550
July 1, 2007 – June 30, 2008	$500	$500
July 1, 1992 – June 30, 2007	$400	$400
July 1, 1991 – June 30, 1992	$350	$350
July 1, 1990 – June 30, 1991	$340	$340
July 1, 1985 – June 30, 1990	$300	$300

If you’re disabled more than 14 days, you may get wage benefits from the first day. Otherwise, the first 7 calendar days of the disability are not covered. Medical care for your injury is provided as long as it’s needed, as determined by the Board.

Note: If the insurer disputes your case, it may withhold your wage replacement benefit until the Board directs it to pay for you.

Reduced Earnings Benefits

If you can return to work but your injury keeps you from earning the same wages you once did, you may be entitled to a benefit that will make up two-thirds of the difference. These are reduced earnings benefits.

Disability Classifications

Your doctor will state how much your injury disables you. The insurer may disagree with that judgment. That insurer can require you to see a doctor for an *independent medical exam.* The Board will decide how disabled you are (the *degree of disability)* from among those opinions. Your lost wage benefit is based on the degree of disability. These are the four classes:

Temporary Total Disability: You cannot work and earn wages, but only on a temporary basis. You're entitled to the full allowable wage benefit.

Temporary Partial Disability: You've temporarily lost some ability to work and earn full wages. You'll receive a percentage of your salary equal to the percentage of disability. For example, if you're 25% disabled, you'll get 25% of your award for the time you're disabled.

Note: All injuries, even those later found *permanent*, are first *temporary*. All benefits are also subject to the maximum weekly amount.

Permanent Total Disability: You completely lost the ability to work and earn wages. **There's no limit on the number of weeks of benefits.**

Permanent Partial Disability, Nonschedule Loss: You lost some part of your ability to work. If you were injured before March 13, 2007, you can get benefits as long as the disability results in wage loss. Injuries after then may receive up to 10 years of benefits, as shown below. (You can apply for reclassification, and additional benefits, after that period.) Even if the disability doesn't impact wages, medical care is always paid.

Permanent Partial Disability, Schedule Loss: This category involves loss of an arm, hand, finger, leg, foot, and toe or their use, and loss of eyesight or hearing. The law specifies the number of weeks in benefits you receive for this loss.

Disfigurement: People whose faces, heads or necks are permanently disfigured may get up to $20,000, depending upon the extent of injury and date of the accident.

Resolving Disputed Claims

Insurers will often accept a claim and promptly begin paying benefits. However, an insurer can dispute a claim, for various reasons. For example, it may not agree you were injured; it may not believe the injury occurred while it provided insurance or any number of other situations. Board claims examiners and conciliators first attempt to resolve issues. If they can't, the Board will hold hearings in front of a workers' compensation law judge. The judge takes testimony, reviews your medical records and wages. Then, the judge decides the issue and sets the award amount.

Either side may appeal that decision. This must be done in writing within 30 days of the decision. Three Board commissioners review appealed cases. They may agree, change part of a decision, or reject it. They may also return the case for more hearings. Insurers don't have to pay lost wage benefits while the three commissioners are reviewing the case. An insurer can accept part of a case and appeal another. In that instance, it must pay the accepted part of the award while the case is reviewed. The insurer must pay your wages and medical bills if your award is upheld by those commissioners, even if it appeals further.

Either side may appeal that decision to the full Board of workers' compensation commissioners. If the entire Board takes the case, it will agree, change or overturn the decision.

Appeals from Board decisions may be taken within 30 days to the Appellate Division, Third Department, Supreme Court of the State of New York. That decision may be appealed in the Court of Appeals.

You always have the right to an attorney or licensed representative. That person may not ask for or take a fee from you. The Board determines the fee for legal services.

That fee is deducted from the lost wages award.

Disability Benefits During a Dispute

If you aren't receiving benefits because your claim was disputed, you may get disability benefits in the meantime. You can file a DB-450 form, available from www.wcb.ny.gov and click **Workers,** or by calling 1.800.353.3092. You pay back any disability payments from your lost wage benefits.

Death Benefits

There is a benefit for the family of workers who die from an injury or illness suffered on the job. The benefit is payable whether the worker dies right after an injury or later.

The worker's spouse and children will receive two-thirds of the employee's average weekly wage, up to the weekly maximum amount. The spouse and children share that weekly benefit; they do not each receive the full benefit. Children receive the benefit until age 18, or until 23 if they attend college. If a child is blind or physically disabled, he or she will receive the benefit for life. The spouse receives the benefit until remarriage. If the spouse remarries, he or she gets a final payment equal to two years of benefits.

The benefit is payable first to a spouse and minor children or dependent grandchildren. If there are no other dependents, then a different benefit is paid. The surviving parents of the deceased worker's estate may be entitled to $50,000. Funeral expenses may also be paid. That benefit is up to $6,000 in metropolitan New York counties, and up to $5,000 in all others.

Social Security Benefits

Your injury or illness may entitle you to Social Security Disability benefits and workers' compensation. People with a permanent disability or a disability that lasts at least 12 months may qualify. Contact a Social Security Office to learn more.

Discrimination

An employer may not fire you or hold it against you if you file a workers' compensation claim. You're also protected from retaliation for testifying in a workers' compensation case. Employers may not discriminate against you in hiring, too. You have two years to make a discrimination complaint. File Form DC-120 with the Board. You can call a Board office for the form, or find it at www.ny.gov and click **Forms.**

If the Board finds that a worker was improperly fired, it will order the employee restored. The employee will also receive back pay lost by that discrimination.

AMERICANS WITH DISABILITIES ACT

The 1990 Americans with Disabilities Act prohibits discrimination against people with disabilities in employment. It ensures equal access to government services, public accommodations, transportation, and telecommunications. This law can help injured employees who want to return to work. Call the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities at 1.800.949.4232 for more information.

A Timeline for Your Case

Immediately: Get medical treatment. Tell your supervisor about the accident and how it occurred. You must also notify your employer of the accident, in writing, within 30 days. You should file a C-3 form with the Board, too.

Within 48 hours of treatments: Your doctor files a medical report with the Board. Copies must also be sent to your representative and the employer or its insurance carrier.

Within 10 days of the accident: The employer reports the injury to the Board and the insurer.

Within 14 days of receiving the accident notification: The insurer gives you a written statement of your legal rights within 14 days of learning of the accident or with the first check, whichever is earlier. If you must use its provider network, the insurer must also give you that contact information.

Within 18 days of the accident: The insurer must accept your claim or explain why it disputes it. It must inform you, any representative, and the Workers' Compensation Board. If you didn't notify the employer promptly, it must act within 10 days of learning of the accident. If the case is disputed and you're losing time from work, file for disability benefits.

Every 2 weeks: The insurer pays lost wage benefits to you (if the case is accepted.) It will pay your healthcare providers directly. The insurer must notify the Board if it stops or modifies your benefits.

Periodically: See your doctor and get treatment as recommended. The doctor will submit progress reports to the Board and insurer.

Common Questions About the Law

Q: What is covered under Workers' Compensation Law?
A: Injuries on the job and work-related illnesses, and occupational diseases.

Q: What if I don't file a claim for workers' compensation?
A: You may lose the right to benefits for lost wages and medical care. You should file a C-3 reporting your injury or illness, even though your employer's insurer must notify this Board when it accepts or disputes your case.

Q: How is the cash benefit for temporary total disability determined?
A: The temporary total disability benefit is two-thirds of the average weekly wage you earned in the year before the accident. There is a maximum amount you can receive per week (see page 6.) Your maximum benefit is set by what is in effect **on the date of the injury.**

Q: Is medical care provided even if no time is lost from work?
A: Yes. Medical care is provided for your condition even if no time is lost from work.

Q: Must I wait for medical care?
A: No, but physicians must request authorization to perform procedures that cost more than $1,000 each. This $1,000 threshold pertains to each procedure, not the total cost of care. Insurers must respond to the request within 30 days. Authorization is not necessary in case of an emergency.

Common Questions About the Law (cont.)

Q: May a doctor treat me if the insurer does not answer a request for approval?
A: Yes. Insurers have 30 days to reply to an authorization request. If the insurer does not reply in 30 days, the provider may perform the services. If the service is a diagnostic test and the carrier requires claimants to use its network, the test must still be obtained from a network provider.

Q: Are prescription medications covered under the law?
A: Yes. Once your claim is established, pharmacies may bill the insurer directly. You may receive a card or document you can show a pharmacy stating you have coverage. If the carrier has a pharmacy network, it will tell you, and you must use those pharmacies. The only exceptions are in a medical emergency, or if the pharmacies don't offer mail order and there isn't a location reasonably close to you. You may have to pay the pharmacy for service before your claim is established. The carrier must then pay you when the case is established. There is no copayment.

Q: What happens when an insurance carrier contests a claim?
A: To contest a claim, a carrier must notify the Board within 18 days of the disability, or within 10 days of learning of the accident, whichever is later. The carrier must explain why it disputes the claim. You are then entitled to present your case to the Board. You will be notified of a pre-hearing conference. The Board seeks to resolve most cases within 90 days.

Q: Must I have a medical examination when the employer or insurer requests it?
A: Yes. The insurer may have you examined by a qualified provider who is authorized by this Board, within a reasonable distance for you to travel. Refusing this exam may affect your claim.

Q: May an insurer suspend or change the cash benefit?
A: Yes, but you are then entitled to a hearing. A carrier must submit evidence for the change to the Board, and the Board decides. A carrier may not change your benefit after the Board decides it without the Board's approval.

Q: Do I have to use an attorney?
A: No, but an attorney can be helpful in disputed and complex cases. You may represent yourself, or use an attorney or a licensed representative (see www.wcb.ny.gov for a list of licensed representatives.) Fees are approved by the Board and deducted from your award. **Do not pay your counsel directly.**

Q: What can I do if I disagree with the Board's decision?
A: You may appeal in writing within 30 days of the filing date of the decision. You must explain why you disagree with the decision. Three Board commissioners will review your case. If you disagree with that review, you can appeal to the full Worker's Compensation Board of Commissioners. They may or may not consider it.

Q: What can I do if I'm not satisfied with the outcome of the appeal?
A: You may appeal to the Appellate Division, Third Department, within 30 days after a decision is served.

Q: Are there penalties for falsehood in claims?
A: It's a felony to willfully misrepresent a case to obtain benefits. Penalties include up to seven years imprisonment and fines. You may also lose the right to benefits. It's also a felony for an insurer to raise a false issue in an attempt to deny a worker benefits it knows the worker is entitled to receive.

Directory of WCB Services and Board Offices

Board Services

Customer Service
1.866.750.5157

Fraud Referral Hotline
1.888.363.6001

Advocates for Injured Workers
1.800.580.6665

Disability Benefits
1.800.353.3092

Health Care Provider
1.800.781.2362

Board Offices

Albany District Office
100 Broadway – Menands
Albany, NY 12241
1.866.750.5157

Binghamton District Office
State Office Building, 44 Hawley Street
Binghamton, NY 13901
1.866.802.3604

Brooklyn District Office
111 Livingston Street
Brooklyn, NY 11201
1.800.877.1373

Buffalo District Office
Ellicott Square Building
295 Main Street – Suite 400
Buffalo, NY 14203
1.866.211.0645

Long Island District Office
220 Rabro Drive, Suite 100
Hauppauge, NY 11788-4230
1.866.681.5354

Manhattan District Office
215 W. 125th Street
New York, NY 10027
1.800.877.1373

Peekskill District Office
41 North Division Street
Peekskill, NY 10566
1.866.746.0552

Queens District Office
168-46 91st Avenue
Jamaica, NY 11432
1.800.877.1373

Rochester District Office
130 Main Street West
Rochester, NY 14614
1.866.211.0644

Syracuse District Office
935 James Street
Syracuse, NY 13203
1.866.802.3730

Please send claims-related mail to:
PO Box 5205 • Binghamton, NY • 13902-5205

DOES YOUR INJURY ENTITLE YOU TO AN ADDITIONAL AWARD?

Understanding Your Schedule Loss of Use Award

New York State Workers' Compensation Board

1.877.632.4996

www.wcb.ny.gov

What is a Schedule Loss of Use Award?

A Schedule Loss of Use Award (known as a SLU) is an additional cash payment. It pays you for an injury that leaves you with less ability in a body part than you had before the injury. If you don't get back the same level of use in the injured body part, because you now have a permanent disability, you may be eligible for a SLU payment.

This award is made after you've healed from your work-related injury. The point when you're as well as will get is called *Maximum Medical Improvement*. If you reach the point with less use of a body part than you had before the incident, you may receive a SLU award. You can receive this money even if you never missed time from work or if you've already returned to work.

Who deserves a Schedule Loss of Use Award?

You may deserve an award if one or more of these body parts doesn't fully heal to where it was before the injury:

- Arm
- Food
- Eye (Vision Loss)
- Leg
- Toe
- Ear (Hearing Loss)
- Hand
- Face (Scar)/Neck/Scalp
- Finger

Body parts may also include the wrist, elbow, shoulder, ankle, knee, and hip. Permanent injury to a body part may include: fractures, amputations, surgeries, tears, dislocations, second and third degree burns, crush injuries, and severe nerve damage.

How much is a Schedule Loss of Use Award?

The law states how many benefit weeks you'll receive. It's based on the body part and how much it was damaged. You'll get a certain number of weeks of payment to make up for the permanent injury. For example:

1. The law allows 312 weeks for an arm injury.
2. You lost 25% of the use of your arm
3. 25% of 325 weeks = 78 weeks
4. You earn $900 weekly. Two-thirds your average weekly wage (your workers' compensation rate) is $600.
5. $600 a week for 78 weeks = $46,800 to you.

How do I get a Schedule Loss of Use Award?

A doctor's opinion is needed. Ask your doctor when you've reached maximum medical improvement. If your injury is permanent, your doctor will state how much less you can use that body part. It'll be a percentage: 25%, 50%, and so on. The doctor will file that opinion with the Board.

What happens after my doctor submits a report?

Make sure your doctor sends a report to the Board. The Board reviews all medical reports. If your doctor sends a report to the Board. The Board reviews all medical reports. If your doctor and the insurer's doctor agree on the amount of loss you suffered, that becomes the number of weeks of payment you'll get.

If the Board gets only one medical opinion, it will write to you and the insurer, asking for the other. You have 60 days to get a report. If we don't get the other medical report from you in 60 days, or from the insurer in 90 days, the Board will decide based on the one medical report in your file. Be sure your doctor sends a report to the Board.

What if the doctors disagree on my health?

If your doctor and the insurer's doctor disagree, the Board will decide. You may be asked for more documents, and you may have a hearing. (You'll receive a notice with the date, time, and place of the hearing.) There, the judge will try to resolve the dispute or schedule a trial.

In either case, the judge will render a decision. The insurer has 10 days to pay the award after the final decision.

How are Awards paid?

If your award is worth more than the payments you already received for that injury, a SLU award is paid one of two ways:

1. You'll get your regular workers' compensation checks until the SLU award is fully paid, or
2. You can write to the Board and ask for the rest of the SLU payment in a lump sum. The Board will direct the insurer to pay you the rest of the money in one check.

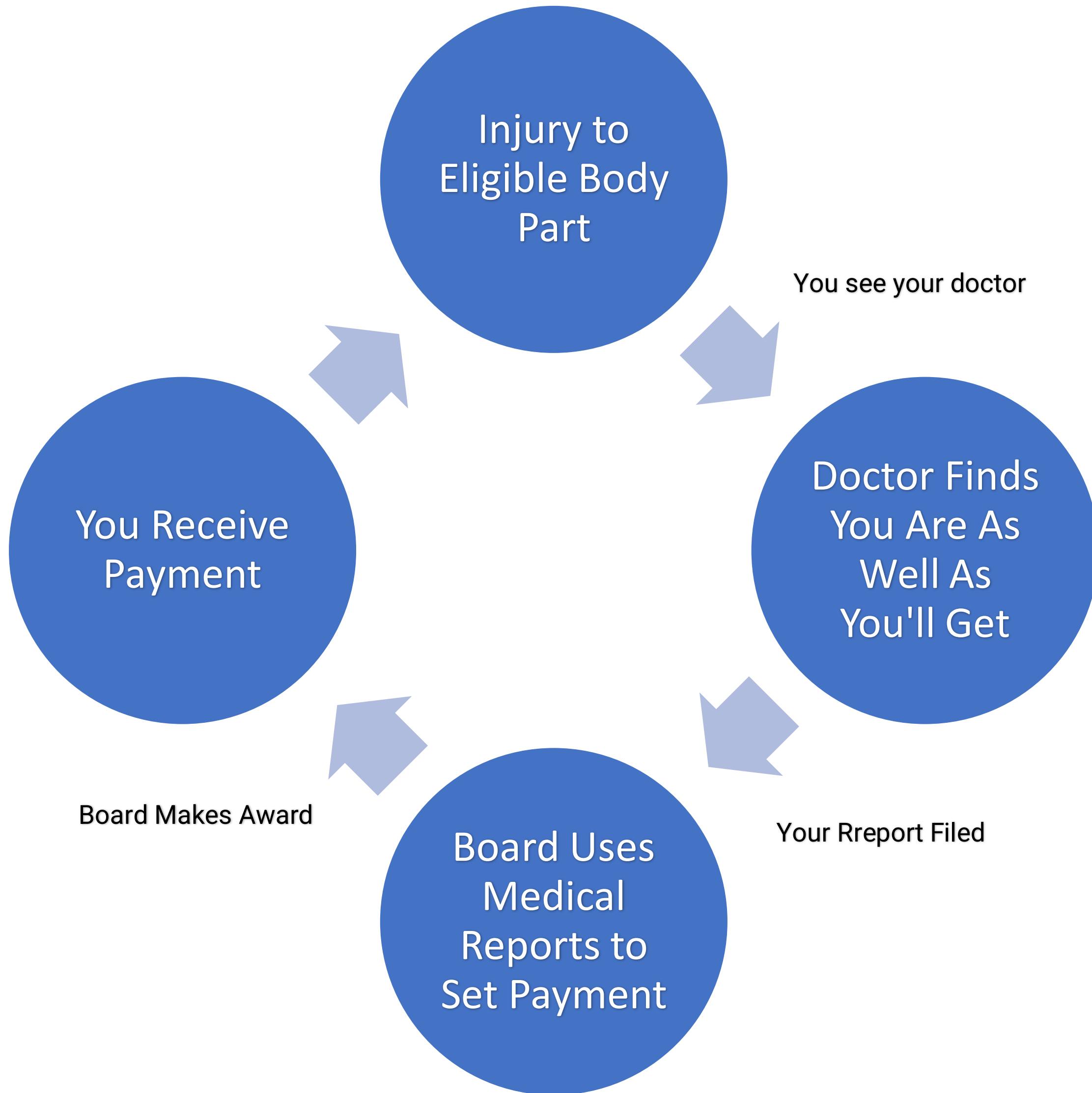
Speaking up for you: The Advocate for Injured Workers

The Advocate for Injured Workers helps injured workers get the benefits they deserve under the law. This office will help you with your case and can explain a schedule loss of use claim. When calling the Advocate, please have:

- Claimant's Name
- Claimant's Board Case Number
- Telephone Number, with Area Code
- Brief Description of the Issue
- Any Documents or Letters Received

To reach the Advocate, call 1.800.580.6665.

Here's What Will Happen



Maximum Possible Compensation

Member Lost	Weeks of Compensation
Arm……………………………………	312 / $351,143.52
Leg…………………………………….	288 / $324,132.48
Hand…………………………………	244 / $274,612.24
Foot…………………………………..	205 / $230,719.30
Eye…………………………………….	160 / $180,073.60
Thumb……………………………..	75 / $84,409.50
First Finger………………………	46 / $51,771.16
Second Finger…………………	30 / $33,763.80
Third Finger……………………..	25 / $28,136.50
Fourth Finger…………………..	15 / $16,881.90
Great Toe………………………..	38 / $42,767.48
Other Toe………………………..	16 / $18,007.36

Questions?

Call the NYS Workers' Compensation Board at 1.877.632.4996.

We're available:
Monday | 8:30am – 6:00pm
Tuesday, Wednesday | 8:30am – 6:00pm
Thursday, Friday | 8:30am – 4:30pm

www.wcb.ny.gov
General_Information@wcb.ny.gov

How to File a Claim

If you are injured on the job, you should complete the Board's form Employee Claim (C-3) as soon as possible to ensure your benefits are not delayed or interrupted. You must also notify your employer in writing of when, where, and how you were injured or became ill.

There are several ways to file the Employee Claim (C-3) form:

- Complete the web version of the Employee Claim (C-3) form.
- Call 1.866.396.8314, and someone from the Board will help you fill out the form.
- File a paper Employee Claim (C-3) form.
    - You may obtain a paper Employee Claim (C-3) form by visiting any Customer Service Center or District Office; by printing the Employee Claim (C-3) form; or by calling 877.632.4996, and the Board will mail you one.
    - If you submit a paper form, please mail the completed Employee Claim (C-3) form to the District Office nearest you.

You will be notified by mail of any action regarding your claim.

Remember: You must file a claim within two years of the accident. You must also notify your employer if you are hurt on the job.

Death Claims

When a claimant has passed away at work or due to an existing work injury/illness, the Next of Kin should file a C-62 (with the appropriate documentation) to the Board. The C-64 form would need to be filed by the last treating physician stating how the deceased death is causally related to work (or the previous work injury.) The C-65 form would be completed by the funeral home.

Why File for Social Security Disability Benefits?

I am frequently asked similar questions from people inquiring about Social Security Disability (SSD) benefits, for instance:

- Why bother filing, won't I just be denied?
- Don't you have to be completely bed-ridden to get approved for SSD?
- I was out of work for only 2 years, I don't qualify for benefits, rights?
- Don't I have to wait a year before filing for SSD benefits?
- I don't want to be on welfare, this is welfare, right?
- I can't afford a lawyer to represent me, so I can't file, right?
- Doesn't this affect my benefits at age 65?
- If awarded, what do I get for me and my family?

Invariably, the same people that ask these questions end up filing for SSD benefits and many end up receiving vital monthly compensation for themselves and their families. The fact is, Social Security Disability is a tremendous resource for injured workers and should be utilized by the disabled in the event of serious injury. So, the following represents some of the common Social Security answers that you can relay to your members when they are injured.

Why Bother Filing, Wont' I Just Be Denied?

It is true that many people who file SSD applications are denied on the initial application. It is also true that it is more likely that you will be denied on an application is you are less than 50 years old. However, this should never stop anyone from filing an application for SSD. First, as is a common adage in the law, every case is individual and no one should assume approval or denial based on other people's cases. Second, although the majority of cases are denied on the application, a very high percentage of those same cases are approved on appeal before a Social Security judge. SSD judges are well versed in the law and medicine involved in your case and with the right legal arguments, your case can be won.

Don't You Have to Be Completely Bed-Ridden to get Approved for SSD?

No. Social Security Disability requires that a claimant be "unable to perform substantial gainful activity"; simply put, you have to unable to work. So, the question isn't "are you unable to do anything because of your disability?; but instead is "are you unable to work due to your disability?" An inability to work can be proven even if you are able to perform many normal activities of daily living. Judges and lawyers look for very specific symptoms and limitations in attempting to prove your ability to work; you do not have to be "bed-ridden" to get SSD benefits.

Can I Get SSD Benefits If I Was Only out of Work for 2 Years?

Yes. Social Security requires that a claimant be out of work, or be expected to be out of work, for at least 12 months to be eligible for SSD benefits. That means that if a claimant is out of work for at least twelve months but goes back to work, they can still be eligible for a lump sum of disability benefits for the time they were out of work. This is known as a “Closed Period” claim. For example, assume one of your members was out of work for 16 months due to a back injury, but did return to work in a full duty capacity thereafter. That member would be entitled to collect SSD benefits for the time they were out of work regardless of their current work status. For many workers, this year of past due benefits could approximate $20,000. Bottom line, a claimant can receive “Closed Period” SSD benefits even if they are back to work.

Don’t I Have to Wait a Year Before Filing for SSD?

No. If you have a serious injury that is expected to keep you out of work for at least one year you can, and should, file for SSD as early as possible. In New York it may take as long as 2 years to see a judge; filing an application early can save the claimant from severe economic hardship.

Isn’t SSD a Welfare Benefit?

No. SSD is a federally secured retirement plan for people who accumulate enough work credits during their career but are unable to continue work due to disability. Your tax dollars have helped fund this retirement package. Although Social Security does have a welfare component for people who haven’t worked, known as Supplemental Security Income (SSI), SSD is not a welfare benefit.

I Can’t Afford a Lawyer to Represent Me, So I Can’t File, Right?

Wrong. Attorneys representing claimants in SSD are paid on a contingency fee basis, meaning they only get paid if they win your case. In fact, all SSD attorneys are mandated by the Social Security Act to charge the same fee. And, to ensure an attorney is paid the right amount, Social Security pays the attorney directly from a claimant’s past due benefits. You never even have to write a check to your lawyer. All claimants can afford an attorney in a SSD case.

If I Receive Benefits Now, Does it Affect my Benefits at Age 65?

No. If a claimant continues to receive SSD benefits up until their full retirement age they will continue to receive the increased disability rate after age 65. If a claimant receives a “Closed Period” of benefits, such benefits will have no impact on their “old age” retirement benefits upon retirement.

What Type of Benefits Will I Receive?

Depends. Your disability benefit depends on how much you have paid into the system over the years. Those figures are then placed into a mathematical equation written into the Social Security Act and a number is generated. What is certain is that if you have any minor children, they are entitled to ½ your benefit amount in addition to your benefit, up to a “household maximum.” For example, if a claimant is entitled to $1,500 per month from SSD and has one child under 18, they would be entitled to $2,250 per month in SSD benefits.

For a rough estimate of a claimant’s disability benefit amount, look at their annual statement from the Social Security Administration. If a claimant has minor children, be sure that they look under the “Family Household Maximum” amount to find out the maximum monthly benefit that Social Security will pay.

If you have any questions,
please don’t hesitate to contact us at any time at: 631.665.0609

SOCIAL SECURITY DISABILITY & THE NEW FIREARM POSSESSION/PURCHASING RULES

By: Sean Patrick Riordan, Esq.

I have received several calls and inquiries regarding the "new Social Security Administration Regulations" regarding firearm possession/purchase for those receiving Social Security Disability (SSD) benefits. To that effect, the Social Security Administration has implemented, as of December 19, 2016, new regulations regarding gun possession/purchase by ***some*** SSD recipients. As many of my clients are retired uniformed personnel who retain weapons into retirement, I certainly understand the anxiety that hearing this news has caused. HOWEVER, Social Security's new regulations affect very few SSD recipients and will not interfere with the large majority of retired officers' ability to retain their weapons while receiving Social Security Disability benefits.

The background of the new Social Security regulations is important to understand. The Brady Handgun Violence Prevention Act (Brady Act) was passed in 1994, and called for the US Attorney General to set up the National Instant Criminal Background Check System (NICS), allowing for the immediate background check of those wishing to purchase a firearm. However, in 2007, Congress determined that the NICS program was not operating properly and passed the NICS Improvement Amendments Act (NIAA). The NIAA required federal agencies that had "any record demonstrating" that a person fits into one of the restricted categories of the Brady Act; such agencies must provide the Attorney General with its information.

Relevant to the Social Security Administration (SSA) and our discussion here, the Brady Act prohibits ***"a person who has been adjudicated as a mental defective or who has been admitted to a mental institution" from "possessing, shipping/transporting or receiving any firearm or ammunition."*** Therefore the SSA was charged with determining whether it had any information regarding individuals who had been "adjudicated as a mental defective." Clearly, the SSA does, within the confines of its disability programs, make decisions regarding whether individuals are capable of performing "substantial gainful activity." Often, as part of these disability determinations, SSD applicants raise psychological impairments which they believe impact their ability to work. However, a mere finding that a psychological impairment has an impact on one's ability to work does not mean they have been determined to be a "mentally defective" individual. Therefore, the SSA came up with a reasonable system in which it meets its obligations under NIAA, while not reporting every SSD recipient with a psychological impairment to the Attorney General. That system is encapsulated in its new rules.

Under its new rules the SSA will report those individuals that meet the following criteria to the Attorney General in accordance with its mandate under the NIAA:

1. The individual is a SSD or Supplemental Security Income (SSI) recipient;
2. The individual was found to meet or equal a Psychological Listing under 12.00 of the Social Security Act;
3. The individual was determined by the SSA to be unable to manage his/her own economic benefit and therefore a Representative Payee has been assigned to manage the individuals benefit on their behalf.

Based on these parameters, the impact of this new reporting system on most SSD recipients is extremely limited. First, an individual must be determined to "meet a Listing within Section 12.00" of the Social Security Act. Legally, this means that the individual's psychological impairment, in and of itself, was determined by the SSA to be so severe that no other factor was considered during the determination of whether the individual could perform work activities. This is not applicable to the majority of SSD cases involving uniformed personnel; generally, a recipient had other factors considered during the SSD adjudication process. Such factors as an applicant's other disabilities, age, education level, previous work experience, and transferable skills are commonly evaluated to determine the individual's work capability. Where these factors were considered in addition to the psychological impairment, these individuals are not subject to the new reporting rules. In other words, only those that have been found to suffer from such a severe psychological disability that nothing else was considered during the SSD process will be reported to the Attorney General under these new firearm possession rules.

Second, the SSA further limits the number of SSD recipients it will report to the Attorney General with the additional criteria that the individual must also have been found incapable of managing their own funds and the SSA appointed a Representative Payee to receive the economic benefit on the recipients behalf. This means that not only does the individual have to meet or equal a Social Security Act Listing but they also have to be found incapable of managing their own funds. This additional criteria further limits the amount of SSD recipients that are affected by the new rules and greatly limits the amount of uniformed personnel that should be concerned with these new provisions.

I do have one concern with the new rules, and it is a concern that is coming to fruition. The SSA has indicated that they will send out, to the SSD recipient, a notification of potential reporting to the Attorney General under the new rules when it is determining whether a SSD recipient is in need of a Representative Payee. A Representative Payee determination is sparked when the SSA has information that the SSD recipient may have a psychological illness that affects their ability to manage their own funds. It is my fear that this notice of potential reporting will go to all SSD recipients being considered for a Representative Payee, rather than those that also meet the Listing criteria noted above. Therefore, some who clearly do not meet the criteria for reporting to the Attorney General may still receive a letter saying that they *might* be referred to the Department of Justice. In fact, we have already fielded calls from clients saying that they received notification that they may be reported despite the fact that they clearly do not meet the criteria discussed above, so it does appear that my fear is in fact reality. This will cause undue stress for many who receive SSD benefits and retain their weapons post their retirement form their law enforcement position. If you, or any of your members, receive this letter you should immediately consult with your attorney to weigh the likelihood of being reported.

Overall, the impact of the new Social Security Security regulations are extremely limited as they relate to our law enforcement clientele. If you or your members have any questions, please do not hesitate to reach me anytime, 212.612.3198 or sean@nycomplaw.com.

WTC-12

- Background and deadline extension
- Notice of participation form
- Filing WTC-Related Workers' Compensation Claims

State of New York
WORKERS' COMPENSATION BOARD

REGISTRATION OF PARTICIPATION IN WORLD TRADE CENTER RESCUE, RECOVERY AND/OR CLEAN-UP OPERATIONS
(Sworn Statement Pursuant to Workers' Compensation Law 162)

BACKGROUND

1. On August 14, 2006, Workers' Compensation Law (WCL) Article 8-A was enacted to expand the time for a "participant" in World Trade Center rescue, recovery and/or clean-up operations who suffers, or may suffer in the future, from a "qualifying condition" to file a claim for workers' compensation lost wage and medical benefits and to permit the Board to reopen such claims previously denied as untimely. Article 8-A was recently amended to change the definition of "qualifying condition" and to extend the registration deadline.
2. A "Participant in World Trade Center rescue, recovery, or cleanup operations" (referred to as "participant") is defined in WCL 161(1) as any:
   (a) **employee** who within the course of employment, or (b) volunteer upon presentation to the Board of evidence satisfactory to the Board that he or she:
      i. participated in the rescue, recovery, or cleanup operations at the World Trade Center site between September 11, 2001 and September 12, 2002, or
      ii. worked at the Fresh Kills Land Fill in New York City between September 11, 2001 and September 12, 2002, or
      iii. worked at the New York City morgue or the temporary morgue on pier locations on the west side of Manhattan between September 11, 2001 and September 12, 2002, or
      iv. worked on the barges between the west side of Manhattan and the Fresh Kills Land Fill in New York City between September 11, 2001 and September 12, 2002.

3. "World Trade Center site" is defined as "anywhere below a line starting from the Hudson River and Canal Street; east on Canal Street to Pike Street; south on Pike Street to the East River; and extending to the lower tip of Manhattan."
4. A "qualifying condition" is defined as "any of the following diseases or condition resulting from a hazardous exposure during participation in World Trade Center rescue, recovery, or clean-up operations:
   a. Diseases of the upper respiratory tract and mucosae, including conditions such as conjunctivitis, rhinitis, sinusitis, pharyngitis, laryngitis, vocal cord disease, upper airway hyper-reactivity, and trachea-bronchitis, or a combination of such conditions;
   b. Diseases of the lower respiratory tract, including but not limited to: bronchitis, asthma, reactive airway dysfunction syndrome, and different types of pneumonitis, such as hypersensitivity, granulomatous, or eosinophilic;
   c. Diseases of the gastroesophageal tract, including esophagitis and reflux disease, either acute or chronic, caused by exposure or aggravated by exposure;
   d. Diseases of the psychological axis, including post-traumatic stress disorder, anxiety, depression, or any combination of such conditions; or
   e. New onset diseases resulting from exposure as such diseases occur in the future including cancer, chronic obstructive pulmonary disease, asbestos-related disease, heavy metal poisoning, musculoskeletal disease and chronic psychological disease.
5. In order for the claim of a participant in World Trade Center rescue, recovery, or cleanup operations to come within the application of Article 8-A of the Workers' Compensation Law, <u>the participant is required to register</u> with the Workers' Compensation Board ("Board".) The registration form (WTC-12) must be filed not later than September 11, 2018.
6. To register, this Sworn Statement must be accurately and truthfully completed and the original filed with the Board District Office or Downstate Central Mailing Center (see addresses below) no later than September 11, 2018. **NYS Workers' Compensation Board Centralized Mailing Address:** P.O. Box 5205, Binghamton, NY 13902.

INSTRUCTIONS

A. If you were a "participant" in World Trade Center rescue, recovery, and/or cleanup operations, as that term is defined above, you are required to provide information requested by the Board in the accompanying Sworn Statement if you were exposed to hazardous conditions which cause you to suffer, or may cause you to suffer in the future, from a "qualifying condition" for which you will or may file or have filed a claim for workers' compensation benefits.

B. Please complete the Sworn Statement by providing the following information:
   a. **Item 1 –** Give your current residential address, including apartment number (if applicable), street number, street name, city, state, and zip code. Give mailing address if different from the residential address provided. Be sure to include your telephone number. Please provide your Social Security Number and your date of birth by month/date/year.
   b. **Item 2 –** This sentence just states that you participated in the World Trade Center rescue, recovery, and cleanup operations between September 11, 2001, and September 12, 2002, at the World Trade Center site, the Fresh Kills Land Fill, the New York City morgue or temporary morgue, or the barges between the west side of Manhattan and the Fresh Kills Land Fill.
   c. **Item 3 –** State whether you participated in the World Trade Center rescue, recovery, and/or cleanup operations as an employee (in the course of your employment for pay) or as a volunteer (not in the course of your employment, but upon your own initiative without pay);
   d. **Item 4 –** List with a brief description any evidence of your activities as a volunteer, for example, badge, letters, statements, pictures, accommodations, etc.;
   e. **Item 5 –** Fill in the table. Specify the dates and locations of your participation in World Trade Center rescue, recovery and/or cleanup operations, and if applicable, and you know, the name of your employer's insurance carrier; and
   f. **Item 6 –** Indicate whether you previously filed a workers' compensation claim with the Board relating to your participation in World Trade Center rescue, recovery, and/or cleanup operations. If you have, you must include the date the claim was filed and the WCB case number.
   g. **Item 7 –** This item states your understanding that filing the Sworn Statement, and thereby registering as a "participant," is not the same as filing a claim for workers' compensation benefits. To file a claim for benefits, you must timely submit to the Board Form C-3 or Form WTCVol-3.

h. **Item 8 –** This item states that you understand that the law penalizes those who submit false written documents to the Board and for making false statements.

C. After you complete the Sworn Statement, please review it to insure that it is truthful and accurate.

D. Sign the Sworn Statement in front of a notary public. Your signature on the Sworn Statement must be notarized of the comparable process for the jurisdiction in which you are located when signing this Statement. Do not sign the Sworn Statement until you are in the presence of the notary public. PLEASE NOTE: by signing this statement, you swear and affirm that the information provided and statements therein are true under penalty of perjury. You are also stating that you understand that the law prescribes penalties for perjury, for willfully making false statements in connection with an insurance claim, and for submitting a false instrument for filing.

E. You must file the original Sworn Statement with the Board no later than September 11, 2018 to the Board's Centralized Mailing Address: P.O. Box 5205, Binghamton, NY 13902.

ADDITIONAL INFORMATION

F. Filing this Sworn Statement with the Board is **NOT** considered the filing of a claim for workers' compensation benefits. In order to file a claim for workers' compensation benefits, you must submit a Form C-3 (Employee's Claim for Compensation) or WTCVol-3 (World Trade Center Volunteer's Claim for Compensation) to the Board in a timely manner.

G. **PLEASE NOTE:** If you previously filed a claim for workers' compensation benefits relating to your participation in World Trade Center rescue, recovery and/or cleanup operations, which was disallowed by the Board because you did not give timely notice to your employer or did not file a claim with the Board within the time allowed, the Board will reopen and reconsider such claim PROVIDED your Sworn Statement is filed with the Board no later than September 11, 2018.

H. **PLEASE NOTE:**

a. "participant" must register by filing a Sworn Statement with the Board no later than September 11, 2018, in order for the extended claim filing period to apply to his/her claim.

b. If a "participant" has already filed a claim for workers' compensation benefits for a "qualifying condition" which was disallowed as untimely and now fails to timely file a Sworn Statement with the Board, the "participant's" claim will not be reopened and reconsidered by the Board. Except that a claim by a participant in the World Trade Center rescue, recovery, or cleanup operations whose disablement occurred between September 11, 2012 and September 11, 2015, shall not be disallowed as barred by Section 18 or Section 28 of this chapters if such claim is filed on or before September 11, 2018. Any such claim by a participant in the World Trade Center rescue, recovery, or cleanup operations whose disablement occurred between September 11, 2012 and September 11, 2015, and was disallowed by Section 18 or 28 of this chapter shall be reconsidered by the Board.
c. The extended period in which to file a claim will only apply to the claim of a "participant" who registers by filing a Sworn Statement with the Board no later than September 11, 2018.

Registration of Participation in World Trade Center Rescue, Recovery, and/or Clean-up Operations

(Sworn Statement Pursuant to Workers' Compensation Law 162)

REGISTRATION IS NOT THE FILING OF A CLAIM FOR WORKERS' COMPENSATION BENEFITS

In the Matter of the Registration of ________________________________ , Participant
(Your first name, middle initial, and last name)

Regarding Participation in World Trade Center Rescue, Recovery, and/or Clean-up Operations.

State of ____________________________________
(State/province where you have this notarized)

County of ____________________________________
(County, or country – if outside of the USA, where you have this notarized)

I, ____ being duly sworn, depose and say:
(*Print first name, middle initial, and last name)*

1. I am the above named Participant, and I reside at ____
   ______________ *(Provide street number and name, city, state, zip code, and country if not USA)*

2. I was a participant in World Trade Center rescue, recovery, and/or clean-up operations as that term is defined in Workers' Compensation Law 161 (1). *(See instruction page for complete definition)*

3. I participated in the World Trade Center rescue, recovery, and/or clean-up operations as defined in Workers' Compensation Law 161 (1) as *(specify whether you participated as an **employee** or **volunteer**)* ____
   (A person participated as an employee if he/she was in the course of his/her employment and was paid. A person participated as a volunteer if it was not part of his/her employment he/she was not directed to participate by the employer and he/she was not paid for the services performed.)

4. I have the following evidence of my activities as a **volunteer**

   ____

   ____

   (If you did not participate as a volunteer, cross out this paragraph.)

5. The date(s) and location(s) where I worked as a participant, a description of the work I performed, the name and address of my employer while a participant or the name of the agency or entity that directed my volunteer participation, and the insurance carrier, if applicable, and/or known for my employer are as follows:

Date(s) Participated:	**Location(s) Where Participated**	**Description of Work Performed**	**Name of Employer / Rescue Entity or Agency**	**Address of Employer / Rescue Entity or Agency**	**Name of Employer's Insurance Carrier *(if known)***

6. I (state whether you **have or have not)** ________________ filed a claim with the Workers' Compensation Board (hereinafter referred to as "Board") relating to my participation in World Trade Center rescue, recovery, and/or clean-up operations as defined in Workers' Compensation Law 162 (1). I filed my claim on ____________ (date claim was filed with the Workers' Compensation Board) and the "WCB Case No." for the claim filed is ____________________(eight digit number assigned by the Workers' Compensation Board.)

7. I understand that by filing this Sworn Statement with the Board, I am not filing a claim for benefits and the Board will not create a case file. I understand that to file a claim, I must timely submit to the Board Form C-3, Employee's Claim for Compensation, or Form WTCVol-3, World Trade Center Volunteer's Claim for Compensation.

8. I understand that the law prescribes penalties for perjury, for knowingly making false statements in a written instrument for filing with a public entity such as the Board, and

for willfully making false statements in connection with an insurance claim. By signing my name below, I swear and affirm under penalty of perjury, that the information and statements I have made herein are true.

____
Complete Signature
(ink only – use blue ballpoint pen if possible)

Sworn to before me this ____________ day
Of____________ , 20_____
____
Notary Public

The information below is provided to give City employees a basic understanding of how WTC-related Workers' Comp claims are handled by the NYC Law Department and the NY State Workers' Compensation Board. It is not exhaustive; City employees who file claims also should visit the NY State Workers' Compensation Board website at www.wcb.state.ny.us for more comprehensive information.

Ways to Speed the Processing of Your Workers' Compensation Claim:

- ⇒ File your claim directly with the New York City agency for which you worked during WTC rescue and recovery operations rather than with the NY State Workers' Compensation Board.
- ⇒ Submit detailed medical evidence and any other information requested by the Board in a timely manner. If possible, submit medical evidence when you submit your claim.
- ⇒ Appear for any independent medical exams required by the City on the dates scheduled.
- ⇒ Attend any hearings scheduled at the Workers' Compensation Board.

Step #1

Register with the NY State Workers' Compensation Board using a WTC-12 form by September 11, 2014. This will preserve your right to file a WTC-related claim in the future, even if you are not experiencing any health problems related to your rescue and recovery work at present.

Please Note: Submitting a WTC-12 form prior to September 11, 2014 is NOT the same as filing a WTC-related Workers' Comp claim. These are two different steps. To find out if you already have submitted a WTC-12 form, please call 877.632.4996 or visit www.wcb.state.ny.us.

Step #2

If you believe that you now are experiencing disabling health problems related to your participation in WTC rescue and recovery operations, file a Workers' Comp claim with the City agency that employed you during that time. Ask the human resources department of the City agency for a "Notice of Injury" form. Be as specific as you can about what kind of health problem you are experiencing and when you first became sick. Providing this information will ensure that your claim is processed more quickly. Please submit medical records and, if possible, a letter from your doctor stating that

your illness or injury is related to your work during the WTC rescue and recovery operations.

Step #3

Once you have filed a "Notice of Injury" form, your human resources department will send it to the NYC Law Department. You will likely receive a letter or some form of communication from the NYC Law Department notifying you that your claim has been received and either accepted or controverted. (Claims may be controverted because the information to make a final determination regarding compensability. Remember, taxpayer dollars are used to pay claims and it is the responsibility of New York City government to ensure that these funds are spent appropriately.

This is only the first step in the process. A controverted claim requires further action by the Workers' Compensation Board. Before a final determination can be made, a judge at the Workers' Compensation Board will determine the answers to several important questions, which may include:

- Whether or not you participated in the WTC rescue and recovery operations as defined by the law while you were employed by New York City;
- Whether or not your particular health problem is disabling and the correct date of disablement; and
- Whether or not this health problem is WTC-related.

You may retain an attorney at no charge to represent you in these proceedings (the NY State Workers' Compensation Board can provide you with the referral.) In the event that your claim is accepted and you receive compensation, the attorney's fees will be deducted from the award.

Step #4

You may receive a letter from the NY State Workers' Compensation Board asking for medical evidence to support your claim if you have no already provided it.

Your doctor can submit this evidence on C4 forms that are provided by the NY State Workers' Compensation Board on its website or in the form of a letter. It is your doctor's responsibility to submit written evidence in support of your claim. At a minimum, it should include the following information:

- the health problem for which you are seeking Workers' Compensation

- how this health problem is related to your participation in WTC rescue and recovery operations
- if you had this condition before September 11, 2001, how your participation in WTC rescue and recovery operations made the condition worse
- whether the condition prevents you from working

By providing as much evidence as possible from the outset, your doctor can hasten the processing of your claim. If your doctor fails to provide proper medical evidence, the process will be delayed.

Please Note: Even if you physician does submit all the information indicated above, this does not guarantee that your claim will be established.

Step #5

Once you provide medical evidence in support of your claim, the NY State Workers' Compensation Board usually schedules a hearing before a judge at a location and time that are convenient for you. The hearing can be scheduled whether or not you have an attorney. Depending on the specifies of your case, there can be more than one hearing to help the judge determine the facts.

The NYC Law Department may request that you undergo a medical examination with a doctor selected by the Law Department to verify your medical condition. The examining doctor will file a medical report and send copies to you, the Board, and the NYC Law Department. The judge will review this report along with the evidence that you have submitted. Disagreement can occur regarding any fact (see bullets in *Step #4.)* The judge can rule on different aspects of your case before making a final ruling. You have the right to appeal these decisions and the final ruling.

Step #6

If the medical report of the doctor who examines you doesn't agree with the evidence that you and your doctor have submitted, the judge will schedule a trial. In this event, both doctors may be required to testify and answer questions. After both sides have testified, the judge makes a ruling based on the evidence and testimony that have been presented. The judge can issue this ruling immediately or send it in writing to you and the NYC Law Department some time afterwards.

The rates of compensation are determined by the NYS Workers’ Compensation Board. They cover the medical costs to treat your disabling condition and may include some replacement for lost wages based on a percentage of your income when you became disabled and other factors.

Step #7

Both you and the NYC Law Department have the right to appeal the judge’s ruling by filing and application for board review. A panel of three NY State Workers’ Compensation commissioners reviews the same evidence as the judge before issuing an independent written decision.

BUREAU OF JUSTICE ASSISTANCE

FACT SHEET

PUBLIC SAFETY OFFICERS' BENEFITS PROGRAM

The Bureau of Justice Assistance's PSOB Office is honored to review the more than 1,000 claims submitted each year on behalf of America's fallen and catastrophically disabled public safety heroes and their loved ones.

A unique effort of the U.S. Department of Justice; local, state, federal, and tribal public safety agencies; and national organizations, the Public Safety Officers' Benefits (PSOB) Program provides death benefits to the survivors of law enforcement officers, firefighters, and other first responders whose death (or catastrophic injury) was the direct and proximate result of an injury sustained in the line of duty. To determine these claims, the PSOB Office works closely with survivors, injured officers, and agencies to obtain the required documentation to comply with the PSOB law and its implementing regulations. While some claims are straightforward and clearly meet the criteria, others present significant factual and legal complexities that must be resolved before a determination can be made.

The PSOB Office collaborates with national law enforcement, firefighter, and first responder groups to provide a range of PSOB training and technical assistance, from one-to-one mentoring to conferences and online resources.

PSOB Programs

Death Benefits

PSOB provides a one-time benefit to eligible survivors of public safety officers whose deaths were the direct result of an injury sustained in the line of duty on or after September 29, 1976.

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Disability Benefits

PSOB provides a one-time benefit to eligible public safety officers who were permanently and totally disabled as a result of a catastrophic injury sustained in the line of duty on or after November 29, 1990. Injuries must permanently prevent officers from performing any gainful work in the future.

Education Benefits

PSOB provides support for higher education to eligible spouses and children of public safety officers who died in the line of duty or were catastrophically disabled in the line of duty.

PSOB Claims Process

The PSOB Office recently launched PSOB 2.0, a web-based claims portal designed to streamline the application submission and claims review process for PSOB Program applicants.

- A **PSOB Death Benefits** application consists of two parts—a Part A application completed by the applicant or authorized representative, and a Part B application completed by the public safety agency. The web-based application will generate a customized set of questions and required documents for each individual application; a sample PSOB Death Benefits application can be viewed by visiting www.psob.gov/benefits.

- A **PSOB Disability Benefits** application consists of two parts—a Part A application completed by the officer or authorized representative, and a Part B application completed by the public safety agency. The web-based application will generate a customized set of questions and required documents for each individual application; a sample PSOB Disability Benefits application can be viewed by visiting www.psob.gov/benefits.

- **PSOB Education Benefits** (PSOEA) are available to public safety officers' spouses and children for 45 months of full-time education or training or for a proportional period of time for a part-time program. The first step in filing for PSOEA benefits is the submission and approval of an initial prescreen application, which confirms program eligibility. After the prescreen application is approved, an initial payment application is submitted along with additional documents and information. To view sample PSOEA applications, visit www.psob.gov/benefits.

Below are the key steps in the review of a PSOB claim:

1. Survivors/officers/representatives create an online account and submit an application (Part A) in PSOB 2.0. The agency also submits its application (Part B) in PSOB 2.0.

2. PSOB reviews the applications for completeness and contacts applicants regarding any missing documents.

3. Once all required documents are submitted, a claim number is assigned, the case is reviewed, and a determination is prepared.

4. The determination and documentation undergo a Senior Benefits Specialist, PSOB Director, and legal review.

5. When a decision is final, PSOB mails a copy of the determination and notification letters to the survivors/officer and to the agency.

6. If approved, the benefit is paid by the U.S. Department of the Treasury via direct deposit. If not approved, detailed information is provided regarding the appeal process.

Appeals

The Public Safety Officers' Benefits Program allows claimants whose claims are denied at the PSOB Office level to appeal the decision at two levels of administrative appeal: the Hearing Officer level and the Bureau of Justice Assistance (BJA) Director level. Claimants have 33 days to appeal their initial denial, as well as 33 days to appeal to the BJA Director.

PSOB Performance

Providing nearly $2 billion in assistance since 1976, PSOB has recently determined many claims for law enforcement officers and other responders whose deaths and disabilities are linked to exposure to harmful chemicals during cleanup efforts following September 11, 2001.

Contact PSOB

The PSOB website is found at psob.bja.ojp.gov. To speak with a Customer Resource Specialist, please call 1-888-744-6513 8:00 a.m. to 4:30 p.m., eastern time, or email AskPSOB@usdoj.gov.

ABOUT BJA

BJA helps to make American communities safer by strengthening the nation's criminal justice system: its grants, training and technical assistance, and policy development services provide state, local, and tribal governments with the cutting-edge tools and best practices they need to reduce violent and drug-related crime, support law enforcement, and combat victimization. To learn more about BJA, visit bja.ojp.gov or follow us on Facebook (www.facebook.com/DOJBJA) and Twitter (@DOJBJA). BJA is a component of the Department of Justice's Office of Justice Programs.

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PUBLIC SAFETY OFFICERS' BENEFITS
DEATH BENEFITS PROGRAM

Required Documents

FILING A PSOB DEATH CLAIM

U.S. Department of Justice

Death Benefits Application - Part A - Survivors

Collect and upload the following required documents regarding the officer's surviving family and potential beneficiaries.

For officers with surviving children, use the "Children At-A-Glance" chart on the back of this checklist for the documents to include with the application.

- ☐ Death Benefits Application Part A completed and electronically signed by the survivor(s) or authorized representative.
- ☐ Divorce decrees for all the officer's and current spouse's previous marriages, including references to physical custody of any children, *if applicable*.
- ☐ Officer's current marriage certificate, *if applicable.*
- ☐ Death certificates for all the officer's and current spouse's previous marriages, if any of the marriages ended in death, *if applicable.*

Death Benefits Application - Part B - Agency

Collect and upload the following required documents regarding the officer's line-of-duty death from agency records.

- ☐ Death Benefits Application Part B completed and electronically signed by the head of the public safety agency or designee.
- ☐ Incident and/or Accident Reports.
- ☐ Death Certificate.
- ☐ When the cause of death is a heart attack, stroke, or vascular rupture, all incident and/or accident reports for the officer's on-duty activities in the 24 hours prior to his or her heart attack, stroke, or vascular rupture.
- ☐ A copy of any of the rulings related to other benefits (workers' compensation, state line of duty, September 11th Victim Compensation Fund) that were applied or related to the officer's death.
- ☐ Volunteer Fire Departments (VFD), Rescue Squad, Ambulance Crew Only: Supporting documentation of department's volunteer status, *if applicable*.
  - If VFD, Rescue Squad, or Ambulance Crew is a nonprofit/chartered corporation, a statement on letterhead, signed by an elected official such as a mayor, county commissioner, etc., which states:

    "The [insert name of VFD, Rescue Squad, or Ambulance Crew] is legally organized and is authorized by the [insert name of government agency] to act on its behalf by providing [*fire services* or *rescue activities*, or *emergency medical services*] as its primary function, to the community of [insert name of jurisdiction]."

SUBMIT

Submit the above information via PSOB 2.0. Keep a complete copy for your records.

☐ File online at www.psob.gov

Because every PSOB case is unique, additional information may be requested to clarify or establish the eligibility of claims and beneficiaries according to the PSOB Act and its regulations.

While the PSOB Office hopes that no agency or family ever requires our services, we stand ready to assist you throughout the claim process. Do not hesitate to contact the PSOB Office toll free at 1–888–744–6513 between the hours of 8 a.m. and 4:30 p.m. Eastern Standard Time or by email at AskPSOB@usdoj.gov for assistance with any part of the PSOB claim.

PUBLIC SAFETY OFFICERS' BENEFITS

"CHILDREN" AT-A-GLANCE

	Birth Certificate	Signature on PSOB Claim Form	Statement from child that he/she was capable of self-support when the officer passed away	Statement from school confirming child's status as a full-time student for the term when the officer passed away	Statement from child's parent that, when the officer passed away: • the child's principal residence was the home of the officer, OR • the child did not live at the officer's home but was dependent on the officer's income for more than one-half of the child's support, OR • the officer accepted the child as his/her own (include affidavits from two non-family members stating such).
Natural child, age 18 or under when the officer passed away?	✓	Parent or Guardian of Child			
Stepchild, age 18 or under when the officer passed away?	✓	Parent or Guardian of Child			✓
Natural child, age 19–22, and a full-time student when the officer passed away?	✓	Child		✓	
Natural child, age 19–22, and not a full-time student when the officer passed away?	✓	Not Required	✓		
Stepchild, age 19–22, and a full-time student when the officer passed away?		Child		✓	✓
Stepchild, age 19–22, and not a full-time student when the officer passed away?		Not Required	✓		
Natural or stepchild over the age of 22 when the officer passed away?		Not Required			

BJA
Bureau of Justice Assistance
U.S. Department of Justice

PUBLIC SAFETY OFFICERS' BENEFITS OFFICE
U.S. Department of Justice • Office of Justice Programs • Bureau of Justice Assistance
810 Seventh Street NW., Fourth Floor, Washington, DC 20531
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NCJ248819

PUBLIC SAFETY OFFICERS' BENEFITS
DISABILITY BENEFITS PROGRAM

Checklist

FILING A PSOB DISABILITY CLAIM

U.S. Department of Justice

IMPORTANT: In general, Public Safety Officers' Benefits (PSOB) claims must be filed within 3 years of the public safety officer's disability. To discuss claims that fall outside of this filing period, please call the PSOB Office directly at 1–888–744–6513.

Medically retired officers, or their representatives, and their former employing public safety agency must submit the following documents concerning the line-of-duty injury to file a disability claim with the PSOB Office:

- ☐ **Report of Public Safety Officer's Permanent and Total Disability Claim Form:** This form must be completed and signed by the disabled officer (or representative) and the head of your former employing agency.

- ☐ **Benefits Provider Information:** A letter or affidavit from the agency's benefits provider stating the disabled officer is receiving the maximum allowable disability compensation for public safety officers in the agency. This must be on the provider's letterhead and signed by an authorized official. The benefits provider may be a retirement fund or a government workers' compensation office. Please note that, for purposes of the PSOB Disability Program, Social Security does not qualify as a benefits provider, even though the officer may be receiving funds from that source.

- ☐ **Circumstances of Injuries:** A statement signed by the head of the former employing agency, on agency letterhead, that includes the officer's name and title, when and where the incidents occurred, what initiated them, and the nature of the injuries. This statement must also indicate the date on which the officer was medically retired from the agency.

- ☐ **Agency Investigation (Accident/Collision/Reconstructive) Reports:** These reports should contain information relevant to each incident and injury that contributed to the officer's permanent and total disability. If these reports are unavailable, a statement to that effect must be signed and submitted by the head of the former employing agency.

- ☐ **Official Toxicology Catastrophic Reports:** If available, these reports must be signed by the official who performed the toxicology analysis immediately following each injury. If a toxicology analysis is not available, a statement to that effect must be signed and submitted by the head of the former employing agency.

- ☐ **Tax Returns:** A copy of each state, local, and federal tax return filed by or on behalf of the public safety officer from the year before the injury to the current year.

- ☐ **Medical Documentation:** Medical documentation must include admission and discharge summaries from each medical facility in which the officer was treated for each of the injuries, as well as a final medical diagnosis.

- ☐ **Claimant Statement:** A brief statement signed by the disabled officer or representative must also be submitted, that addresses the following questions:

  1. What is the highest educational level the disabled officer achieved? Has the disabled officer completed any special training or courses, including military training?
  2. Has the disabled officer received any formal vocational evaluations or vocational rehabilitative treatment? If so, what is their current status?
  3. Has the disabled officer worked at any job following the injuries? If so, where?

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EDUCATIONAL ASSISTANCE PROGRAM

U.S. Department of Justice

The Federal Law Enforcement Dependents Assistance (FLEDA) Act was enacted in October 1996 to enhance the appeal of service in civilian federal law enforcement agencies by providing financial assistance for higher education to spouses and children of federal law enforcement officers killed in the line of duty. Congress and the President amended the Act in 1998 to provide educational assistance to spouses and children of police, fire, and emergency public safety officers killed in the line of duty, thus creating the Public Safety Officers' Educational Assistance (PSOEA) Program. The PSOEA Program also makes assistance available to eligible spouses and children of public safety officers permanently and totally disabled by catastrophic injuries sustained in the line of duty.

Background

By amending the FLEDA Act, Congress and the President extended educational assistance to include not only the families of federal law enforcement officers but all public safety officers. In so doing, they made an important statement about how vital our public safety officers are to our nation's safety.

The PSOEA Program recognizes that the benefits available to these families through the Public Safety Officers' Benefits (PSOB) Program, administered by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, are often consumed by basic needs and are not sufficient to support the costs of higher education. For many families, however, access to higher education is instrumental in their ability to move forward in the aftermath of a line-of-duty tragedy.

PSOEA Program Benefits

The PSOEA Program provides an educational assistance allowance to eligible survivors of public safety officers whose deaths or permanent and total disabilities are the direct and proximate result of an injury sustained in the line of duty.

PSOEA benefits may be used to defray educational expenses, including tuition, room and board, books, supplies, and education-related fees. The amount of assistance is determined by the length of the term and whether the student attends school as a full-time, three-quarter-time, half-time, or less-than-half-time student.

Also, the amount of assistance is subject to change consistent with the current computation of the educational assistance allowance set forth in Title IV of the Higher Education Act, Section 3532 of Title 38, United States Code.

Assistance under the PSOEA Program is available to both public safety officers' spouses and children for 45 months of full-time education or training or for a proportional period of time for a part-time program.

PSOEA Program Effective Dates

Under the PSOEA Program, the families of federal, state, local and tribal police, fire, and emergency public safety officers are covered for line-of-duty deaths that occurred on or after January 1, 1978. The effective date for families of permanently and totally disabled federal law enforcement officers is October 3, 1996. Families of state and local police, fire, and emergency public safety officers are covered for line-of-duty permanent and totally disabling injuries that occurred on or after November 13, 1998. Families of Federal Emergency Management Agency (FEMA) personnel and state, local, and tribal emergency management and civil defense agency employees are covered for such injuries sustained on or after October 30, 2000.

Eligibility for PSOEA Benefits

The PSOEA Program stipulates that PSOEA benefits are to be provided directly to students who attend a degree or certification program at an institution of higher learning and are the spouses or children of federal, police, fire, and emergency public safety officers whose deaths or permanent and total disabilities are covered by the PSOB Program (34 U.S.C. 10281 et seq.). While public safety officers' children are generally no longer eligible for assistance for classes attended after their 27th birthday, there is no age restriction as to when they can apply for assistance for those classes.

Required Documents

For more information about the PSOEA Program, and the documents required to submit a PSOEA claim, please visit www.psob.gov.

PUBLIC SAFETY OFFICERS' BENEFITS
DISABILITY BENEFITS PROGRAM

Required Documents

FILING A PSOB DISABILITY CLAIM

U.S. Department of Justice

IMPORTANT: In general, Public Safety Officers' Benefits (PSOB) claims must be filed within 3 years of the public safety officer's disability. To discuss claims that fall outside of this filing period, please call the PSOB Office directly at 1–888–744–6513.

Disability Benefits Application - Part A and B

Collect and upload the following required documents regarding the officer's line-of-duty injury.

- ☐ Disability Benefits Part A application completed and electronically signed by the disabled officer or authorized representative.
- ☐ Disability Benefits Part B application completed and electronically signed by the head of the former employing agency or designee.
- ☐ Agency Accident or Incident Report containing information relevant to each incident and injury that contributed to the officer's disability.
- ☐ Statement signed by the disabled officer or authorized representative that addresses the following questions:
  - What is the highest educational level the disabled officer achieved? Has the disabled officer completed any special training or courses, including military training?
  - Has the disabled officer received any formal vocational or functional capacity evaluation or vocational rehabilitative treatment? If so, provide a copy of the report.
  - Has the disabled officer worked at any job following the injuries? If so, where?
- ☐ IRS "Wage and Income Transcript" for the past three years. These documents are available without charge from the IRS by mail or online at https://www.irs.gov/individuals/tax-return-transcript-types-and-ways-to-order-them.
- ☐ Medical Documentation, including admission and discharge summaries from medical facilities, as well as a final medical diagnosis for each injury.
- ☐ Volunteer Fire Departments (VFD), Rescue Squad, Ambulance Crew Only**:** Supporting documentation of department's volunteer status, *if applicable*.
  - If VFD, Rescue Squad, or Ambulance Crew is a nonprofit/chartered corporation, a statement on letterhead, signed by an elected official such as a mayor, county commissioner, etc., which states:

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