Workers' Compensation Claims Process

Workers' compensation is an insurance that provides medical coverage and/or cash benefits to workers who become injured or ill as a direct result of their employment.

The Hudson City School District participates in the RCG Workers' Compensation Consortium through Questar. The Consortium does not require employees to contribute to the cost of compensation. Medical expenses and/or cash benefits are paid by the School District, as directed by the New York State Workers' Compensation Board. The Workers' Compensation Board is a New York State Agency that analyzes, processes, and approves legitimate claims. The Consortium utilizes PMA as its' third-party administrator, who assists districts that participate in the consortium with processing all claims under workers' compensation.

In a workers' compensation case, there is no fault assigned to the School District or the employee. The District has an obligation to process all claims in a timely fashion. This will ensure that all claims are analyzed appropriately, and if approved, compensation and coverage for medical expenses can begin as soon as possible. **The Workers' Compensation Board decides on valid claims based on medical documentation provided directly to Workers' Compensation (via PMA) by the treating provider.** A claim is paid if the employer agrees that the injury or illness is work-related. If the employer disputes the claim, PMA will investigate, and in some cases, a law judge will decide if the claim is compensable.

The employee has an obligation to report the injury or illness to their direct supervisor first, and then to notify Human Resources within twenty-four (24) hours of the injury or illness. Next, the employee must complete the **Employee Accident and Illness Form** and submit it to their immediate supervisor. The immediate supervisor will then submit the form to Human Resources. In the case where emergency medical treatment is sought outside of the contractual workday, notification shall be made to Human Resources the next regular business day.

The steps for processing a claim are attached. **If you have any questions, please contact Human Resources.**

For more information, visit: https://www.wcb.ny.gov/content/main/Workers/what-is-workers-compensation.jsp

Workers' Compensation Steps for Claim Processing

If you are injured on the job:

1. Immediately report your injury to your immediate supervisor and seek medical attention from the school nurse. The School Nurse will evaluate you and instruct you to notify Human Resources (within 24 hours) of your work-related injury. It is the employee's responsibility to follow up with Human Resources.

2. Fill out the **Employee Accident and Illness Form, sign it,** and submit it to your supervisor. It is your supervisor's responsibility to sign the acknowledgement page and forward the completed report to Human Resources. Please complete the form, including the social security number and mailing address, sign the form, and attach any medical documentation as appropriate. Incomplete forms will be returned, which will result in a delay in processing.

3. The District will work with PMA Companies to process your claim. You will receive an acknowledgment letter from PMA that they have received your information. You may also be asked to fill out additional paperwork from PMA, including but not limited to a Medical Authorization Form. This will allow PMA to pay your medical bill(s), obtain medical records related to your injury, and allow for a prompt determination of your eligibility for benefits under New York State Workers' Compensation Law.

4. A claims representative from PMA will review all the relevant documentation provided and investigate your claim. They may contact you directly to discuss your claim and answer any questions that you have regarding the process. PMA is bound to the same privacy laws as medical personnel.

5. If you are unable to work as a result of your injury or illness, please provide medical documentation to Human Resources within twenty-four (24) hours of your doctor's visit. Please also notify your immediate supervisor of your absence. The Doctor's note(s) should specify that you are unable to work due to a work-related injury and the date of the incident.

6. During your period of absence, you will be using your personal sick leave accruals. If you are entitled to workers' compensation benefits, a portion of your sick leave will be reimbursed to you in accordance with New York State Workers' Compensation Law and your applicable Collective Bargaining Agreement. Please note that if you are out of work

seven (7) days or less due to your illness or injury, there will be no reimbursement of time used. The Workers' Compensation Board will decide if you will be reimbursed for your sick leave accruals based on the medical documentation submitted by your treating medical provider.

7. It is up to you to know your Collective Bargaining Unit language regarding Workers' Compensation and the use of other paid time off (floating holidays, personal days, and vacation days). Employees may be required to ask their treating medical provider to complete a Family Medical Leave Act application. This will give the employee health insurance and employment protection.

8. When you are ready to return to work, you will first need to submit medical documentation to Human Resources, authorizing you to return to your position with no restrictions, or indicating that you have a disability and need an accommodation. If you are requesting an accommodation, the medical documentation needs to indicate the disability, the accommodation requested, and the date you anticipate being able to come back to work with no restrictions and/or accommodations. Please submit documentation to Human Resources, as soon as you receive it. As stated previously, the documentation should include the specific date in which you are cleared to return to work. You should also notify your immediate supervisor directly.

9. If your medical documentation has restrictions or accommodations, please send a copy to Human Resources and schedule an appointment to meet with Melissa Noblin, Personnel Clerk. You can do this by contacting her at extension 2115. Please note that any restrictions in job function as directed by your doctor must be specific and directly related to your position and duties in the District. The District reserves the right to determine whether or not the accommodation requested is reasonable and can be provided on a case-by-case basis. An interactive discussion will take place to explore all options related to the employee's return to work.

10. **Most importantly…Please take care of yourself during this process!!!**

Workers' Compensation Claims Process

If any Hudson City School District employee experiences a work-related injury or illness, please follow the process below to ensure that required reporting and recordkeeping are met.

- Immediately Report the injury to your Supervisor.
- See the School Nurse for evaluation, if possible.
- Notify Human Resources of your work-related injury within 24 hours.
- Complete the Employee Accident and Illness Form.
- Make sure both you and your Supervisor fill out and sign the forms.
- Your Supervisor will send the form to Human Resources
- Human Resources will work with PMA to process your claim to the Workers' Compensation Board.
- PMA will send the employee an acknowledgement letter and may request additional medical information. Please work directly with PMA to ensure medical privacy.
- If you cannot come to work, you must provide medical documentation to Human Resources. Please do not submit medical documentation regarding your work-related injury to any other District employee. This will protect your medical privacy.
- Medical documentation needs to specify that you are unable to work due to a work-related injury and the date of the injury. The documentation must have contact information for the medical provider.
- Enter your time in Wincapweb as sick time. If a substitute is required, contact the corresponding Sub Caller.
- When the Workers' Compensation Board reimburses the District for your paid time used, you will be reimbursed the amount that Workers' Compensation indicates.
- It is your responsibility to know your Collective Bargaining Agreement regarding the use of other leave accruals when your sick time is exhausted.
- FMLA paperwork may be required.
- PMA will answer any specific questions regarding Workers' Compensation Law.

If you have any questions, please contact
Human Resources

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CITY SCHOOL DISTRICT

Employee Accident and Illness Report

Please answer *ALL* questions and sign to ensure proper processing.

Employee Name:_____Date of Birth:_____

Date of Accident:_____ Job Title: _____ SS#: _____

Work Location: _____ Location of Accident: _____

Employment Status: ☐FT ☐PT Date of Hire:_____ Time of Accident:_____

Employee Mailing Address: _____

Best Phone Number to be Reached: _____ ☐Home ☐Cell

Have you had a prior injury to the affected body part? ☐Yes ☐No

If Yes, Approximate Date: _____ and please explain: _____

_____

Have you had prior medical treatment to the affected body part? ☐Yes ☐No

If yes, please explain: _____

_____

Primary Care Physician: _____ Telephone Number: _____

What were you doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material that you were using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry," etc.:

_____

_____

What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time," etc.:

_____

_____

What was the injury or illness? Tell us the part of the body that was affected and how it was affected. Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome," etc.:

_____

_____

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What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, indicate N/A.

_____

_____

Was Medical Treatment provided by the School Nurse? ☐Yes ☐ No

Was an EMT or Ambulance Service Used? ☐Yes ☐ No

Did you go to a Hospital or Physician for treatment? ☐Yes ☐ No

If Yes, please provide the name of the Hospital or Treating Physician and date when treatment was received.

_____

_____

Employee's Statement:

Please provide a detailed statement of how the accident occurred. Please include date, time, exact location of the accident, witness names, any body parts injured, etc. (May submit additional pages for explanation if needed)

_____

_____

_____

Employee's Signature: _____ Date: _____

If all questions are not answered, the form may be returned to you and delay the claims process.

******Supervisor Must fill out the Principal/Supervisor's Statement and attach to this report before submission to Human Resources******

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Principal/Supervisor's Statement

The Principal/Supervisor must fill out his/her portion of the form, and secure witness statements (if applicable) prior to submission to Human Resources.

What date was this accident first reported to you? _____

Who reported this accident to you? _____

Did you personally observe the accident? ☐Yes ☐ No

Did the employee seek medical treatment immediately following the accident?

☐Yes ☐No

Did the employee continue to work after the accident? Please provide details:

☐Yes ☐No

_____

Are you aware of any potential witnesses to the accident? If so, please provide names and contact information. ☐Yes ☐No

_____

Principal/Supervisor's Signature: _____ Date: _____

ORIGINAL, COMPLETED AND SIGNED FORM MUST BE SENT TO:

ATTENTION: HUMAN RESOURCES

Hudson
CITY SCHOOL DISTRICT

Witness Statement

To be completed by the witness to the accident

Please answer ALL questions and sign to ensure proper processing

Witness Name: _____ Date:_____

Work Location:_____

Witness Mailing Address: _____

Best Phone Number to Reach You: _____ ☐Home ☐Cell

Accident Details:

Name of the injured employee: _____

Date of Accident: _____ Approximate Time of the Accident: _____

Do you know the injured party? ☐Yes ☐ No If Yes, please explain:

_____

Witness Statement:

Please provide a detailed statement of how the accident occurred. What did you observe? What did you do? Where was the accident? Who else was present? (May submit additional pages for explanation if needed)

_____

_____

_____

Witness Signature: _____ Date: _____

ORIGINAL, COMPLETED AND SIGNED FORM MUST BE SENT TO:

ATTENTION: HUMAN RESOURCES