AccentCare
6900 Dallas Parkway, Suite 450
Plano, TX 75024
P: 888-978-6099
F: 888-978-6118

December 10, 2021

Yoely Vilorio
101-52 99th street
Ozone Park, NY 11416

Dear Yoely,

We were recently notified of your need for a leave of absence beginning **1/24/2022** for reasons that may qualify under the Family and Medical Leave Act (FMLA).

Please do the following:

- **FMLA Certification of Health Care provider form**- You meet the eligibility requirements for FMLA job protection consideration. Please have this form completed by your doctor and return to me at 888-978-6118 or email daccentcare@lockton.com. The forms are due within 15 days after your leave starts for FMLA job protection consideration. (Please let me know if you have any issues getting this completed by the healthcare provider.)

- **Disability pay- Please see the last pages of this packet for the Arch disability forms.**

    1. Please complete **Part A** (Claimant Statement)
    2. Take to your doctor and have them complete **Part B** (Health Care Provider's Statement)
    3. **Send completed ARCH forms *directly* to ARCH at ARCHdbl@visit-aci.com or fax to 610-977-3216 (If you send them anywhere else it will delay your claim)**
    4. If you have questions about your pay after your claim has been submitted, you can call Arch at (877) 369-0979 (press 5 for Spanish)

MEDICAL CERTIFICATION
If you fail to provide medical certification within this fifteen (15) day period, your leave may be denied, and you will be considered on an unapproved leave of absence and subject to disciplinary action. Given the current COVID-19 situation, please reach out to me if you have any problems obtaining medical documentation from your provider.

PTO
Your Paid Time off (PTO) accrual will be suspended while you are on leave and will resume upon your return to work.

BENEFIT CONTINUATION
While on leave of absence, you are responsible for your portion of your Health and Welfare benefits. You will receive a separate notification from our benefits department about payment information. For more information about your benefits, please call 855-849-4238 to speak to a benefit representative.

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RETURN TO WORK
Prior to your return to work, please present a release to return to work completed by your Health Care Provider. If you have difficulty getting this documentation completed due to COVID, please let me know.

JOB REINSTATEMENT
AccentCare will attempt to provide the same or an equivalent position with the same pay, benefits, and terms and conditions upon your return to work. You meet the minimum eligibility standards for a protected leave of absence; therefore, you are guaranteed job reinstatement. FMLA leave status also does not exempt your position from being affected by actions such as reclassification, job modification, layoff or job elimination that would have otherwise occurred in the normal course of business. If, due to business operations necessities, your position has been filled or otherwise eliminated, you will receive a separate notification from your Human Resource Department.

DEPENDENT ADDITION
If your absence is due to the birth of your child and you would like to add your newborn to your medical insurance coverage, you must notify our benefits department **within 31 days** of the date of birth.

STATE OR MUNICIPAL LEAVE The following leaves types will run concurrently with all FML leaves if applicable and will count against any state entitlement.

Blood Donation – employer grants either three hours of time per year to donate blood or two times per year to donated blood without the use of accrued time.
Bone Marrow Donation –Time off work to undergoes a medical procedure to donate bone marrow. Not to exceed 24 work hours.
Domestic Violence- An employee who was the victim of domestic violence may be granted time off work.
New York Paid sick time- Employers must provide 40 hours of paid sick time or PTO to care for spouse, child, parent, or domestic partner
Family Military Leave- Allowed 10 day of unpaid leave if an employee's spouse is on leave from deployment to a military conflict.

While on leave, you are **required** to keep in contact with me regarding your return to work.

For FMLA questions: Please call me at 888-978-6099 Option 2.

For Pay questions: Please call Arch Insurance @ (877) 369-0979 for NY disability pay.

Sincerely,

Nayeli Leon
Absence Management Specialist

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FMLA Certification of Health Care Provider Forms

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number 1235-0003
Expires 08/31/2021

SECTION I: For Completion by the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertification, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: **Accent Care 888-978-6099** **FAX THIS FORM BACK TO 888-978-6118**

SECTION 2: For Completion by the EMPLOYEE INSTRUCTIONS to the EMPLOYEE:

Your name: _____
First Middle Last

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

SECTION 3: For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

As an employer, AccentCare understands the time that it takes to administer this paperwork and your cooperation is greatly appreciated. Our employees will have less worry and frustration when all paperwork is completed and his/her leave commences. This makes for a healthier workplace and in turn, a healthier community.

MEDICAL FACTS to support this certification (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment
such as the use of specialized equipment): _____

Date condition commenced: _____/____/____ Duration of the condition _____

Was this the result of a workplace illness or injury ___No ___Yes?

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No___ Yes
If so, dates of admission: _____/_____/_____

Date(s) you treated the patient for condition: _____/_____/_____, _____/_____/_____, _____/_____/_____

Will the patient need to have treatment visits at least twice per year due to the condition? ____No ___ Yes
Was medication, other than over-the-counter medication, prescribed? ___No ___Yes
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No ___Yes
If so, state the nature of such treatments and expected duration of treatment:

Is the medical condition pregnancy? ___No ___Yes If so, expected delivery date: _____/____/____

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CERTIFICATION OF HEALTHCARE PROVIDER FORM CONTINUED:

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes

If yes, identify the job functions the employee is unable to perform: _____

Will the employee be incapacitated for a single continuous period due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

First date the employee was unable to work _____/_____/_____ Est. date the employee may return to work _____/_____/_____

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) month(s) _____

Estimate the part-time or reduced work schedule the employee needs, if any: from _____/____/____ through ____/_____/____

_____ hour(s) per day; _____ days per week

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No Yes____.

Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No Yes____ If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of **flare-ups** and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) month(s) _____ **Duration:** _____ hours or ___ day(s) per episode

Thank you very much for your assistance and if we can help in any way please feel free to contact us at 888-978-6099

_____ _____/_____/_____
Signature of Health Care Provider Date

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____Fax :(_____) _____

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AccentCare of New York
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Employees Name: _____

RETURN TO WORK

Section 4: Please complete and sign the employee section of this form and then give this form to your Healthcare Provider to complete. To assist your doctor in completing this information please obtain a copy of your Job description from your supervisor. **The signed and completed form must be returned to your supervisor and to the Absence Management Specialist prior to you returning to work.** Por favor completar y firmar la sección de empleado de esta forma y luego dar esta forma a su proveedor de salud para completar. Para ayudar a su médico para completar esta información por favor obtenga una copia de su descripción de trabajo de su supervisor. El formulario firmado y completado debe devolverse a su supervisor y a los especialistas de gestión ausencia antes que regresar al trabajo.

Employee section

Patient's Authorization
To All Healthcare Providers: I hereby authorize AccentCare to verify the noted information and, if applicable, obtain any additional medical information to substantiate this return to work certification. I authorize you to return completed forms directly to AccentCare via Fax number listed below.
Employee signature: **Date:**

Healthcare Provider Section

Our employee has informed us of their intent to return to work. AccentCare is requesting that you, the Provider, complete sections listed below in their entirety (as applicable) to assist us in clearing the employee to return to work.

Fax completed Return to Work form to 888-978-6118 or email to daccentcare@lockton.com

Please complete the following information on this return to work form:

1. Based on present occupation, on what date will the patient will be able to return to work.	_____/_____/_____
2. Are any modification or restrictions going to be necessary for them to return to work on that date?	**Please circle one:** **YES** **NO**

3. **If the answer on question 2 is "yes"** please complete the following

3 a. In an 8-hour workday, how many hours can this employee

Sit_____ Stand_____ Walk_____

3 b. Other Capabilities

Lifting Maximum _____ pounds

Pushing/Pulling Maximum _____pounds

Able to drive vehicle for work purposes (circle) Yes No

	None 0%	Occasionally 1-33%	Frequently34-64%	Constantly65-100%
Reaching above shoulder R / L				
Kneeling:				
Bending Stooping:				
Squatting:				
Computer work/Keyboarding				

4. Please list any other restrictions if applicable

5. **If the answer on question 2 is "yes"** Release to full duty without restrictions	_____/_____/_____
Physician Signature:	**Date signed:**

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DERECHOS DEL EMPLEADO
SEGÚN LA LEY DE AUSENCIA FAMILIAR Y MÉDICA

DIVISIÓN DE HORAS Y SALARIOS DEL DEPARTAMENTO DE EE. UU.

DE LOS DERECHOS DE LA LICENCIA

Los empleados elegibles que trabajan para un empleador sujeto a esta ley pueden tomarse hasta 12 semanas de licencia sin sueldo sin perder su empleo por las siguientes razones:

- El nacimiento de un hijo o la colocación de un hijo en adopción o en hogar de crianza;
- Para establecer lazos afectivos con un niño (la licencia debe ser tomada dentro del primer año del nacimiento o la colocación del niño);
- Para cuidar al cónyuge del empleado, al hijo, o al padre que tenga un problema de salud serio que califique;
- Debido a un problema de salud serio del mismo empleado que califique y que resulte en que el empleado no pueda realizar su trabajo;
- Por exigencias que califiquen relacionadas con el despliegue de un miembro de las fuerzas armadas que sea cónyuge del empleado, hijo o padre.

Un empleado elegible que es cónyuge, hijo, padre o familiar más cercano del miembro de las fuerzas armadas que está cubierto, puede tomarse hasta 26 semanas de licencia bajo la Ley de Ausencia Familiar y Médica (FMLA, por sus siglas en inglés) en un periodo de 12 meses para cuidar al miembro de las fuerzas armadas que tenga una lesión o enfermedad seria.

Un empleado no tiene que tomarse la licencia de una sola vez. Cuando es medicamente necesario o de otra manera permitido, los empleados pueden tomarse la licencia de forma intermitente o en una jornada reducida.

Los empleados pueden elegir, o un empleador puede exigir, el uso de licencias pagadas acumuladas mientras se toman la licencia bajo la FMLA. Si un empleado sustituye la licencia pagada acumulada por la licencia bajo la FMLA, el empleado tiene que respetar las políticas de pago de licencias normales del empleador.

BENEFICIOS Y PROTECCIONES

Mientras los empleados estén de licencia bajo la FMLA, los empleadores tienen que continuar con la cobertura del seguro de salud como si los empleados no estuvieran de licencia.

Después de regresar de la licencia bajo la FMLA, a la mayoría de los empleados se les tiene que restablecer el mismo trabajo o uno casi idéntico, con el pago, los beneficios y otros términos y otras condiciones de empleo equivalentes.

Un empleador no puede interferir con los derechos de la FMLA de un individuo o tomar represalias contra alguien por usar o tratar de usar la licencia bajo la FMLA, oponerse a cualquier práctica ilegal hecha por la FMLA, o estar involucrado en un procedimiento según o relacionado con la FMLA.

REQUISITOS DE ELEGIBILIDAD

Un empleado que trabaja para un empleador cubierto tiene que cumplir con tres criterios para poder ser elegible para una licencia bajo la FMLA. El empleado tiene que:

- Haber trabajado para el empleador por lo menos 12 meses;
- Tener por lo menos 1,250 horas de servicio en los 12 meses previos a tomar la licencia*; y
- Trabajar en el lugar donde el empleador tiene al menos 50 empleados dentro de 75 millas del lugar de trabajo del empleado.

*Requisitos especiales de "horas de servicio" se aplican a empleados de una tripulación de una aerolínea.

PEDIDO DE LA LICENCIA

En general, los empleados tienen que pedir la licencia necesaria bajo la FMLA con 30 días de anticipación. Si no es posible avisar con 30 días de anticipación, un empleado tiene que notificar al empleador lo más pronto posible y, generalmente, seguir los procedimientos usuales del empleador.

Los empleados no tienen que informar un diagnóstico médico, pero tienen que proporcionar información suficiente para que el empleador pueda determinar si la ausencia califica bajo la protección de la FMLA. La información suficiente podría incluir informarle al empleador que el empleado está o estará incapacitado para realizar sus funciones laborales, que un miembro de la familia no puede realizar las actividades diarias, o que una hospitalización o un tratamiento médico es necesario. Los empleados tienen que informar al empleador si la necesidad de la ausencia es por una razón por la cual la licencia bajo la FMLA fue previamente tomada o certificada.

Los empleadores pueden exigir un certificado o una recertificación periódica que respalde la necesidad de la licencia. Si el empleado determina que la certificación está incompleta, tiene que proporcionar un aviso por escrito indicando qué información adicional se requiere.

RESPONSABILIDADES DEL EMPLEADOR

Una vez que el empleador tome conocimiento que la necesidad de la ausencia del empleado es por una razón que puede calificar bajo la FMLA, el empleador tiene que notificar al empleado si él o ella es elegible para una licencia bajo FMLA y, si es elegible, también tiene que proporcionar un aviso de los derechos y las responsabilidades según la FMLA. Si el empleado no es elegible, el empleador tiene que brindar una razón por la cual no es elegible.

Los empleadores tienen que notificar a sus empleados si la ausencia será designada como licencia bajo la FMLA, y de ser así, cuánta ausencia será designada como licencia bajo la FMLA.

CUMPLIMIENTO

Los empleados pueden presentar un reclamo ante el Departamento de Los empleados Los Los empleados pueden presentar un reclamo ante el Departamento de Trabajo de EE. UU., la División de Horas y Salarios, o pueden presentar una demanda privada contra un empleador.

La FMLA no afecta a ninguna ley federal o estatal que prohíbe la discriminación ni sustituye a ninguna ley estatal o local o convenio colectivo de negociación que proporcione mayores derechos de ausencias familiares o médicas.

Para información adicional o para presentar un reclamo:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

Departamento de Trabajo de los EE.UU. | División de Horas y Salarios

WHD DIVISIÓN DE HORAS Y SALARIOS

WH1420 SPA REV 04/16

Revised 2020

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AccentCare of New York
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NEW YORK STATE | Workers' Compensation Board

DECLARACIÓN DE DERECHOS
BENEFICIOS POR DISCAPACIDAD DEL ESTADO DE NUEVA YORK

ANDREW M. CUOMO, Gobernador

SI USTED NO PUEDE TRABAJAR POR CAUSA DE UNA ENFERMEDAD O LESIÓN NO-OCUPACIONAL, USTED PODRÍA TENER DERECHO A BENEFICIOS POR DISCAPACIDAD

1. Por ley, su empleador debe facilitarle el pago de beneficios por discapacidad a sus empleados.

2. Las prestaciones estatutarias por discapacidad son pagaderas para cualquier lesión o enfermedad no-ocupacional relacionada (incluyendo discapacidad por embarazo) comenzando al 8vo día consecutivo de discapacidad. Los beneficios son pagaderos por hasta 26 semanas. La cantidad total de pago combinado por licencia por discapacidad o familiar que un empleado puede recibir dentro de un periodo de 52 semanas consecutivas no puede exceder las 26 semanas. Los pagos por beneficios se basan en su salario semanal promedio de las ocho semanas inmediatamente antes de su discapacidad, y están sujetos al máximo permitido por la ley vigente en el primer día de la discapacidad. Su empleador o sindicato puede ofrecer diferentes beneficios que sean por los menos igual de favorables que los beneficios estatutarios bajo un Plan o Acuerdo de Beneficios por Discapacidad.

3. PARA RECLAMAR BENEFICIOS usted debe someter una notificación por escrito y prueba de discapacidad (Formulario de reclamos DB-450) a su empleador o proveedor de seguros indicado a continuación dentro de los 30 días después del primer día de su discapacidad. En ningún caso usted debe esperar más de 26 semanas después de esa fecha para someter un reclamo. Usted puede obtener un Formulario DB-450 con su empleador, su proveedor de seguros, su proveedor de cuidados de salud o contactando la Junta de Compensación Laboral. (Vea la dirección y número de teléfono indicados a continuación.) **No asuma** que su empleador ha sometido un reclamo de parte suya; **someter el reclamo es su responsabilidad.**

4. Usted tiene derecho a ser tratado por cualquier médico, quiropráctico, dentistas, enfermera-partera, podólogo o psicólogo de su preferencia. A diferencia de la compensación de empleados, sus facturas médicas **no** serán pagadas por su empleador o proveedor de seguros, a menos que su empleador y/o sindicato provea el pago de facturas médicas bajo un Plan o Acuerdo de Beneficios por Discapacidad aprobado.

5. Los beneficios por discapacidad serán pagados directamente a usted por el proveedor de seguros, **no a través de su empleador**, a menos que su empleador sea un asegurador aprobado.

6. **Si su empleador o proveedor de seguros le disputa que usted no tiene derecho al pago de beneficios por discapacidad, ellos deben enviarle una Notificación de Rechazo, dentro de 45 después de haber sometido su reclamo, informándole las razones por las cuales los beneficios no se les están pagando. Si usted no está de acuerdo con su rechazo, usted tiene el derecho legal** de solicitar una revisión del rechazo ante la Junta de Compensación Laboral. **IMPORTANTE:** Si usted no ha recibido beneficios dentro de 45 días después de haber sometido su reclamo y no recibe una Notificación de Rechazo (Formulario DB-451), contacte rápidamente a la Junta de Compensación Laboral llamado al siguiente número de teléfono.

7. Si su discapacidad es el resultado de un accidente automovilístico y usted ha sometido un reclamo para beneficios por no-culpa, usted debe también someter un reclamo (Formulario DB-450) para beneficios por discapacidad. **Si usted no solicita los beneficios por discapacidad, el asegurador por no-culpa puede reducir sus pagos de no-culpa. IMPORTANTE**: En tale casos, si usted no tiene derecho a beneficios por discapacidad, notifique inmediatamente a su proveedor de seguros de no-culpa.

8. Su empleador no le puede pedir que renuncie a su derecho de beneficios por discapacidad ni tampoco puede deducirle más de 60 centavos a la semana (a menos que la contribución adicional sea parte de un plan aprobado) de su salario para contribuir al pago de primas de seguros de beneficios por discapacidad. **Usted no puede ser despedido ni discriminado por someter un reclamo para beneficios por discapacidad.**

SI TIENE ALGUNA DIFICULTAD PARA OBTENER UN FORMULARIO DE RECLAMO O NECESITA AYUDA PARA LLENARLO, O SI TIENE CUALQUIER OTRA PREGUNTA O DUDA ACERCA DE UNA ENFERMEDAD O LESIÓN NO-OCUPACIONAL RELACIONADA, CONTACTE A CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN LABORAL.

Esta información es una presentación resumida de sus derechos según las provisiones de la Sección 229 de la Ley de Beneficios de Baja Familiar Remunerada e Discapacidad. El proveedor de seguros de beneficios por discapacidad de su empleador es:

Inserte el Nombre, Dirección y Número de Teléfono

Estipulado por el Presidente,
Junta de Compensación Laboral

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Arch Insurance Company c/o Administrative Concepts, Inc.
P.O Box # C1024 Southeastern, PA 19398-1024
Phone: 877-369-0979/ Fax: 610-977-3216
E-mail: archdbl@visit-aci.com

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Use this form if you became disabled **while employed** or if you became disabled **within four (4) weeks after termination of employment** OR if you became **disabled after having been unemployed for more than four (4) weeks.** Please answer all questions in Part A and questions 1 through 3 in Part B. Read all instructions on this form carefully. Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: _____ First Name: _____ MI: ___

2. Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip: _____ Country: _____

3. Daytime Phone #: _____ 4. Email Address: _____

5. Social Security #: ___ - ___ - _____ 6. Date of Birth: ___ - ___ - _____ 7. Gender: ☐ Male ☐ Female

8. My disability is (if injury, also state how, when and where it occurred): _____

9. I became disabled or became ineligible for Unemployment Insurance because of this disability on: ___ / ___ / _____

I worked on that day: ☐ Yes ☐ No

Have you recovered from this disability? ☐ Yes ☐ No If Yes, what was the date you were able to work: ___ / ___ / _____

Have you since worked for wages or profit? ☐ Yes ☐ No If Yes, list dates: _____

10. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER			PERIOD OF EMPLOYMENT		Average Weekly Wage (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

11. My job is or was: _____ (Occupation) 12. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)

13. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No

If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits after LAST DAY WORKED, explain reasons fully: _____

14. For the period of disability covered by this claim:

A. Are you **receiving** wages, salary or separation pay: ☐ Yes ☐ No

B. Are you **receiving** or **claiming**:

1. Workers' compensation for work-connected disability: ☐ Yes ☐ No
2. Paid Family Leave: ☐ Yes ☐ No
3. No-Fault motor vehicle accident (check box): ☐ Yes ☐ No or personal injury involving third party (check box): ☐ Yes ☐ No
4. Long-term disability benefits under the Federal Social Security Act for this disability: ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 14, COMPLETE THE FOLLOWING:

I have: ☐ received ☐ claimed from: _____ for the period: ___ / ___ / _____ to: ___ / ___ / _____

15. In the year (52 weeks) **before** your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No

If "Yes", fill in the following: Paid by: _____ from: ___ / ___ / _____ to: ___ / ___ / _____

16. In the year (52 weeks) **before** your disability began, have you received Paid Family Leave? ☐ Yes ☐ No

If "Yes", fill in the following: Paid by: _____ from: ___ / ___ / _____ to: ___ / ___ / _____

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. If my disability began while I was unemployed, I certify that I had been unemployed for more than four (4) weeks. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's Signature Date

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of Claimant Address Relationship to Claimant

AccentCare
6900 Dallas Parkway, Suite 450
Plano, TX 75024
P: 888-978-6099
F: 888-978-6118

AccentCare of New York
Home Care • Nursing • Personal Care

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 9. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: _____ First Name: _____ MI: ___

2. Gender: ☐ Male ☐ Female 3. Date of Birth: ___ / ___ / ___

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's symptoms: _____

b. Objective findings: _____

5. Claimant hospitalized?: ☐ Yes ☐ No From: ___ / ___ / ___ To: ___ / ___ / ___

6. Operation indicated?: ☐ Yes ☐ No a. Type _____ b. Date ___ / ___ / ___

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ (Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) _____ Licensed or Certified in the State of _____ License Number

_____ Health Care Provider's Printed Name _____ Health Care Provider's Signature _____ Date

_____ Health Care Provider's Address _____ Phone #

Employer's Statement

Employer's Name: _____ Policy Number: _____
Employer's Address: _____ Telephone Number: _____
Employer's Email Address: _____
Employee's Name and Address: _____
Is Employee: ☐ Union ☐ Non-Union ☐ Other: _____
Was the employee provided with the Statement of Rights (Form DB271S) ☐ Yes ☐ No If "Yes", date _____
Is Employee a ☐ Member ☐ Owner ☐ Partner ☐ Spouse Employee's Occupation _____
Date of Employment: _____ ☐ Full time worker ☐ Part time worker Social Security Number _____
Normal work week: (check boxes to show usual days worked) ☐ Sun. ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.
Date Employee Last Worked: _____ Date Employee Wages Ceased _____
Has Employee returned to work? ☐ Yes ☐ No If "Yes," date: _____
Has employment terminated? ☐ Yes ☐ No If "Yes," why? _____
Are regular weekly wages and/or sick pay being continued during disability? ☐ Yes ☐ No
If "yes," does employer request reimbursement? ☐ Yes ☐ No
Was employee on job when disability occurred? ☐ Yes ☐ No
Has claim been filed for Workers' Compensation? ☐ Yes ☐ No
Name of Workers' Compensation carrier: _____
Is Employee member of a union that provides for payment of weekly cash benefits? ☐ Yes ☐ No
If "yes," give name, address and telephone number of union: _____
Does employee contribute to cost of this insurance? ☐ Yes ☐ No
If "yes," is employee contribution the maximum permitted by law? ☐ Yes ☐ No
Other: $ _____ per _____

Earnings 8 weeks prior to disability; include weekly value of board, lodging and tips.

	WEEK ENDING Mo.	Day	Year	NO. DAYS WORKED	GROSS AMOUNT
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.				TOTAL	$

Employer tax ID: _____ Signed: _____ Title: _____ Date: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.