WARREN COUNTY SELF-INSURANCE DEPARTMENT
1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249
email: warrencountyinsurance@warrencountyny.gov

Work Related Injury Report Procedure

Warren County DPW

This packet should be provided to any employee that sustains a work related injury requiring medical care or time off from work. If there is no medical care or time off from work, record the incident on a separate incident only form.

Employee Responsibilities:

1. Complete "Employee Injury Report"
2. Complete "Authorization to Obtain Information"
3. Complete "Warren County DPW Incident Report Form"

   Give the 3 forms above to your supervisor immediately.

4. This packet contains forms that you will need to take with you to the treating provider & pharmacy.

   a. Take a copy of "Workers' Compensation Medical Visit Encounter Form" with you to each doctor visit.

   b. Ask your medical providers to send all bills to Warren County Self-Insurance, 1340 State Route 9, Lake George NY 12845. Be sure to mark the date of injury clearly on all correspondence.

   c. If you require pharmaceuticals for this injury, take the "Temporary Prescription Form" page with you to the pharmacy.

5. Provide your supervisor with proper medical documentation if time away from work is recommended.

Supervisor Responsibilities:

1. If the injury is serious or the employee is expected to be out of work more than one (1) day, call Self-Insurance immediately to alert them to the claim. Follow up with the paper work as soon as possible.
2. Confirm that the employee has completed and given you the forms:

   "Employee Injury Report", "Authorization to Obtain Information" and the "Warren County DPW Incident Report Form"

3. Advise and confirm that the employee has retained forms:

   "Claimant Information Packet"

   "Workers' Compensation Medical Visit Encounter Form"

   The list of pharmacies

4. Complete the Employer Instructions section on the "Temporary Prescription Form" page and return that page to the employee.
5. Investigate the incident to determine the root cause. Complete the "Warren County DPW Incident Report Form" page 2 and also complete the "Supervisors Report of Incident Investigation".
6. If there were witness(es) to the accident, obtain statements from each one about the incident.
7. Forward completed Employee forms (3), the completed Supervisors form and any witness statements to the DPW OFFICE as soon as possible. Timely filing is very important to avoid penalties. The DPW Office will complete Form C-2F and email all forms to Self-Insurance. Original forms should be sent to Self-Insurance via interoffice mail.
8. Notify Self-Insurance when employee returns to work OR if the employee's condition changes.

EMPLOYEE INJURY REPORT

This form should be completed by any employee that has sustained a work related injury and is seeking medical treatment or will miss time from work due to injury.

PLEASE PRINT CLEARLY

Employee Name:_____ Date of Birth: _____Phone:_____

Employee Address:_____

Last 4 digits of Social Security #: xxx-xx-_____ What municipality do you work for?_____

DATE OF INJURY: _____Time of injury: _____am pm Time you began work that day: _____am pm

Where were you working when the injury happened?

What were you doing when you got injured and how did the injury happen?

Explain fully the nature of your injury; list body parts affected and if right or left:

Are you going to seek medical attention for this injury? _____ If so, where? _____

Are you out of work due to this injury? _____ If so, what date did you stop working?_____

When do you expect to return to work?_____

How could this incident have been prevented?

Did anyone witness the injury?_____
If so, please list names:_____

Have you ever injured the same body part before, at work or at home?_____ If so, give details below:

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employees Signature:_____Date:_____

Please give this form to your immediate supervisor as soon as possible.

AUTHORIZATION TO OBTAIN INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE
OF INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize Warren County Self-Insurance to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Person(s) / organizations authorized to use or disclose the information:

   Any medical facility that has treated me in the past.

2. Person(s) / organization to whom the requested use or disclosure may be made:

   Warren County Self-Insurance and/or its agents.

3. Specific description of information that may be used or disclosed:

   Copies of medical records including, but not limited to, patient questionnaires, patient intake sheets, referral forms, patient history forms, office notes, reports, charts, x-ray or other films, etc., and/or copies of hospital and medical records relating to services rendered to me for the following medical condition(s):

   Any condition except those excluded below.

   Excluding (1) any and all confidential HIV and AIDS related information protected under Article 27-F of the New York Public Health Law and (2) any and all confidential mental health records protected under Section33.13 of the New York Mental Hygiene Law.

4. Purpose of the requested use or disclosure:

   For the use in a pending Workers' Compensation claim brought by me.

5. I understand that I may revoke this authorization at any time by giving written notice to the person / organization that is providing the information I no longer want to be used or disclosed, except to the extent that action has already been taken in reliance on this authorization.

6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

7. This authorization expires upon the final closure of the Workers' Compensation claim brought by the individual.

8. Photocopies and electronic copies of this authorization should be accepted as original.

_____	_____	_____
Signature of Individual Authorizing Use/Disclosure	Date	Printed Name of Individual

For Office Use: Date of Injury:_____ Carrier Case #_____ WCB#_____

Warren County DPW Incident Report Form

A copy of this form must be completed by all employee(s) and witness(s) involved in the incident.

Date of incident:_____ **Time:**_____

1. What was the task or job just before the incident occurred, include who was on site or involved? (i.e. I was replacing a culvert at 123 Route 5 Pottersville with Carter and Tiffany)

2. What was the incident / near miss? (While lifting the culvert with the loader the chain broke and culvert fell on Carter)

3. Were there any injuries? (Note: employee injuries require additional employee injury report forms.)

4. Was there any damage to property or equipment? (Note: auto & property damage may require additional forms.)

Fleet Manager: Estimated amount of damage:		Will damage be repaired?
Date:	Comment:	Initial:

5. What was the ROOT cause(s) of the incident? (ask "why" until root cause(s) is determined)

6. What actions will / should be taken to eliminate future repeats of the incident? (i.e. training, use PPE, other equipment)

7. Finish and Initial

ATTACH PICTURES and drawings of area where incident happened and damage
By initialing below you are stating that this is an accurate representation of the events that occurred.
Completed by (print your name) Your Initials: Today's Date:
Check one**:** ☐ Employee ☐ Witness ***Return this form to your immediate supervisor.***

Routing, complete and forward to the next individual or send to all at the same time:

1. Immediate Supervisor Name (print)_____

Initial and date when reviewed_____

Comments:_____

2. Confidential Assistant to DPW Superintendent

Initial and date when reviewed_____

Comments:_____

3. Highway Manager

Initial and date when reviewed_____

Comments:_____

_____

3. DPW Safety Officer

Initial and date when reviewed_____

Comments:_____

_____

4. DPW Superintendent

Initial and date when reviewed_____

Comments:_____

5. Self-Insurance / County Safety

Initial and date when reviewed_____

Comments:_____

Claimant Information Packet

WARREN COUNTY SELF-INSURANCE DEPARTMENT
1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249
Email: warrencountyinsurance@warrencountyny.gov

You were injured at work. What now?

If you've suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek the medical care that is necessary.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Report injuries as soon as possible but always within 30 days of the injury.
- Medical reports are necessary for your case. Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the NYS Workers' Compensation Board and with Warren County Self-Insurance, your employer's insurance carrier. Ask that your doctor complete the "Workers' Compensation Medical Visit Encounter Form" and fax it back to Warren County Self-Insurance. This may help expedite your claim. If your case is disputed, the Workers' Compensation Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, they must notify the Warren County Self-Insurance Department by filing a C-2f form. You should file an "Employee Injury Report" form reporting your injury as soon as possible. You should complete the "Authorization to Obtain Information" and give it to your employer immediately.

Additionally, you may file a C-3 Employee Claim with the NYS Workers' Compensation Board, there are two ways to do it.

- Visit www.wcb.ny.gov to complete the form
- Call 1-877-632-4996. A Workers' Compensation Board employee will assist you.

Health Care Benefits

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Workers' Compensation Board disallows your case. If your case is disputed, the providers are paid when the Workers' Compensation Board decides your case. If the Workers' Compensation Board decides against you, or if you don't pursue a case, you will have to pay the doctor or hospital.

Warren County Self-Insurance covers medically necessary drugs and equipment that your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. Make sure that you obtain receipts for those expenses, and submit them to Warren County Self-Insurance on a Claimants Record of Medical and Travel Expenses and request for Reimbursement (Form C257).

Generally, you can choose any health care provider authorized by the Workers' Compensation Board. You can search for an authorized provider on the Board website, wcb.ny.gov. Warren County participates in the ONECALL MEDICAL diagnostic radiology network, therefore if you require diagnostic radiology services (MRI, EMG, NCS, CT, Ultrasound, Bone Scan or Arthrograms) you or your physician must contact us before performing these tests. Additionally, Warren County participates in the AWPRx pharmacy benefits network. Therefore, pharmacy benefits must be obtained from an AWPRx network pharmacy.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

You may hire an attorney or licensed representative, but it isn't required. The Workers' Compensation Board sets their fees, which will be deducted from your lost wages award. You should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may be eligible to receive short term disability benefits while the case is heard. Check with your employer about disability benefits and ask for a DB-450 claim form. If your case is resolved in your favor, the disability benefits would be deducted from your lost wages award.

Help is Available

Sometimes you need help getting back to work. An injury can also cause family or financial problems. The Workers' Compensation Board has vocational counselors and social workers to help. More information is also available on the NYS Workers' Compensation Board website at: wcb.ny.gov

What's Next?

Warren County Self-Insurance will send you information and documentation if your claim is accepted or denied. When the claim is accepted, your treatment will be paid and lost wages benefits begin. If your case is challenged, the Workers' Compensation Board will notify you about resolving the case and may request additional information if necessary.

Important Contact Information

Workers' Compensation Board	877-632-4996
Warren County Self-Insurance	518-761-6528

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_____

Workers' Compensation Medical Visit Encounter Form

<u>To the Injured Worker</u>: Give one copy of this form to your physician/ chiropractor at each visit. (Call Self-Insurance for additional forms or duplicate this one.)

Patient Name:_____

Date of Service:_____ Date of Birth:_____

In your opinion, is the disability arising out of and in the course of employment or occupational disease? Yes No

Date of injury:_____

Is the patient losing time from work? Yes / No First day of lost time:___/___/___

Can the patient return to work? Full duty / Modified duty _____/ _____/_____

Modified duty requirements:_____

Diagnosis:_____

Prescriptions given to treat injury:_____

Treatment Plan:_____

Percentage of impairment (0-100%):_____% Temporary / Permanent

Apportionment? Yes No Pre-existing _____% Current injury_____%

Next visit:___/___/___ Time:_____ with Provider:_____

Providers Signature:_____ Date:____/____/____

Print Providers Name:_____

Facility Name:_____

Please Fax this form immediately to: 518-761-6249
or email to warrencountyinsurance@warrencountyny.gov

The AWPRx pharmacy network is a national network that includes both national chains and local independent pharmacies. For a list of network pharmacies, please visit our website at www.awprx.com or call our customer service team for a list of network pharmacies in your area **888-700-0992**.

A&P
ACME PHARMACY
AHF PHARMACY
BARTELL DRUGS
BEL AIR PHARMACY
BIG Y PHARMACY
BI-MART PHARMACY
BROOKSHIRE BROTHERS
CITY MARKET PHARMACY
COBORNS PHARMACY
CONTINUCARE MEDICAL GROUP
COSTCO WHOLESALE
CVS PHARMACY
DIERBERGS
DISCOUNT DRUG MART
EMBLEMHEALTH SERVICES
ESSENTIA HEALTH
FAGEN PHARMACY
FARM FRESH PHARMACY
FARMACIAS PLAZA
FOOD CITY PHARMACY
FOOD LION PHARMACY
FRUTH PHARMACY
FRYS FOOD AND DRUG
GERBES PHARMACY
GIANT EAGLE PHARMACY
HAGGEN PHARMACY
HARRIS TEETER PHARMACY
HARTIG DRUG CO INC
HARVARD VANGUARD MEDICAL ASSOCIATES PHAR
HARVEYS SUPERMARKET
HEALTHPARTNERS
HEB PHARMACY
HENRY FORD MEDICAL CENTER
HOUSECALLS PHARMACY
HY-VEE PHARMACY
KELSEY PHARMACY
KERR DRUG
KING KULLEN PHARMACY
KING SOOPERS PHARMACY
KINNEY DRUGS
KMART PHARMACY
KROGERS
LONESTAR RX
LOWELL COMMUNITY HEALTH CENTER PHARMACY
MACEYS PHARMACY
MARCS PHARMACY
MARSH DRUGS
MARSHFIELD CLINIC SPECIALTY
MARTINS PHARMACY
MEDFAST PHARMACY
MEIJER PHARMACY
NAVARRO HEALTH SERVICES
OMNICARE
OSCO PHARMACY
PARADIS SHOP N SAVE
PATHMARK PHARMACY
PATIENT FIRST
PICK N SAVE PHARMACY
POSTAL PRESCRIPTION SERVICES
PRICE CHOPPER PHARMACY
PRICE CUTTER PHARMACY
PUBLIX PHARMACY
QFC
QOL MEDS
QUICK CHEK PHARMACY
RALEYS PHARMACY
RALPHS PHARMACY
REASORS PHARMACY
RITE AID PHARMACY
RITZMAN PHARMACY
ROY HARMONS APOTHECARY
RXAMERICA
SAFEWAY PHARMACY
SAFFA INFUSION PHARMACY
SARTORIS SUPER DRUGS
SAVE MART PHARMACY
SAVON PHARMACY
SCHNUCKS PHARMACY
SHOPKO STORE
SHOPPERS PHARMACY
SHOPRITE PHARMACY
SMITHS PHARMACY
ST JOHN SPECIALTY PHARMACY
STOP AND SHOP PHARMACY
SUN MART PHARMACY
SUPER ONE
TARGET STORES
TEXAS ONCOLOGY PHARMACY
TFHC23 PHARMACY
THE PHARMACY CENTER
TIMES PHARMACY
TIMPVIEW PHARMACY
TOPS PHARMACY
UNITED MEDICAL
UNITED PHARMACY
VANGUARD ADVANCED PHARMACY SYSTEMS
VG'S PHARMACY
VILLAGE PHARMACY
VILLAGE SUPERMARKETS
VONS PHARMACY
WALDBAUMS PHARMACY
WALGREENS PHAMACY
WALMART PHARMACY
WEGMANS FOOD MARKETS
WEIS PHARMACY
WELLSPRING FAMILY MEDICINE
WHITE DRUG
WINN DIXIE PHARMACY

Temporary Prescription Form

Client Name: **Warren County**

1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for a temporary **10 day supply**, and please fill out the information below:

Claimant Name: _____ **SSN:** _____
Claimant DOB: _____ **Claimant's Home Phone #:** _____
Claimant Employer: Warren County **Date of Injury:** _____
Claimant Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer Representative: _____ **Date:**_____

2. Instructions for the **INJURED WORKER**:

- **You, the injured worker will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**

3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **AWPRX**
- **BIN** **610237**
- **PCN** **AWPRX**
- **Group ID** **AWPRx63**
- **ID number** **Use Social Security from the top of the form**
- Prescription(s) will fill for a **10 Day Supply**. If there is a remaining balance on the script after the **10 Day Supply i**s filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **888-700-0922**.

AWPRx office hours are Monday through Friday, 8:00AM EST to 8:00PM EST. We also have representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888)-700-0922

SUPERVISORS REPORT OF INCIDENT INVESTIGATION

This form is to be used to determine the root cause of an incident and how a similar incident can be prevented in the future. Supervisors should complete this form for every incident involving employee injury or near miss. Please print.

Employee Injured:_____Date of incident:_____ **Time:**_____

What was the task or job just before the incident occurred, include who was on site or involved? (i.e. Employees John & Tom were replacing a culvert at 123 Route 5 Whooville)

What was the incident? (While Tom was lifting the culvert with the loader the chain broke and culvert fell on John)

When did you know about the incident?

What body parts did the employee injure and to what extent? (Be specific, i.e. bruised right leg below knee)

Was there any damage to property or equipment? (Note: auto & property damage may require additional forms.)

What was the ROOT cause(s) of the incident? (ask "why" until root cause(s) is determined)

Was the incident preventable?
What actions will / should be taken to eliminate future repeats of the incident? (i.e. training, use PPE, other equipment)

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Signature:_____Date:_____

NEW YORK STATE Workers' Compensation Board

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ **Date of Injury** _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Warren County Self Insurance **Insurer ID** W874754

Name Warren County Self Insurance

Info/Attn _____

Address 1340 State Route 9

City Lake George **State** NY

Postal Code 12845 **Country** _____

Claim Admin ID _____

EMPLOYEE INFORMATION

First Name _____ **Middle Name/Initial** _____

Last Name _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Phone Number _____ **Date of Hire** _____

Date of Birth _____

Gender ☐ Male ☐ Female ☐ X ☐ Unknown

Employee SSN _____

Occupation Description _____

Employee Email Address _____

CLAIM INFORMATION

Time of Injury _____ **Date Employer Had Knowledge of the Injury** _____

Employment Status _____ **Date Employer Had Knowledge of Date of Disability** _____

Estimated Weekly Wage _____ **Number of Days Worked Per Week** _____

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐ Yes ☐ No **Employer Paid Salary in Lieu of Compensation** ☐ Yes ☐ No

Initial Treatment ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment
☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown **Date of Death** _____ **Number of Dependents** _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** ☐ Actual ☐ Released

Initial Date Disability Began _____ **Physical Restrictions** ☐ Yes ☐ No

Initial Return to Work Date _____ **Return To Work Same Employer** ☐ Yes ☐ No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name _____

Street _____ **State** _____

City _____ **Postal Code** _____

County _____ **Country** _____

Location Narrative _____

Witnesses **Business Phone Number**

_____ _____

_____ _____

_____ _____

EMPLOYER INFORMATION

Name _____ **Employer FEIN** _____

UI Number _____ **Manual Classification Code** _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

Insured Type ☐ Insured ☐ Self-Insured ☐ Uninsured **Insured Location ID** _____

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ **Date** _____

Print Name _____

Title _____ **Phone Number** _____