Montana Department of LABOR & INDUSTRY

STATE OF MONTANA
DEPARTMENT OF LABOR AND INDUSTRY
SUBSEQUENT INJURY FUND
EMPLOYMENT RELATIONS DIVISION
PO BOX 8011
HELENA MT 59604-8011
(406) 444-6543

DATE RECEIVED

SUBSEQUENT INJURY FUND APPLICATION FOR CERTIFICATION

INSTRUCTIONS

1) PLEASE COMPLETE ALL PARTS OF THIS APPLICATION FORM. IT MUST BE COMPLETED IN ITS ENTIRETY.
2) THE APPLICATION FORM SHOULD BE SUBMITTED TO THE DEPARTMENT OF LABOR & INDUSTRY AT THE ABOVE ADDRESS OR TO YOUR REFERRING AGENT.
3) SIGN AND DATE THE MEDICAL EVIDENCE OF IMPAIRMENT FORM TO BE SUBMITTED BY YOUR PHYSICIAN.

PART A
GENERAL INFORMATION

NAME:

BIRTH DATE:

ADDRESS:

SOCIAL SECURITY:

PHONE:

PART B
IMPAIRMENT

PART OF BODY AFFECTED:

WHAT RESTRICTIONS OR LIMITATIONS DO YOU HAVE BECAUSE OF YOUR IMPAIRMENT?

IN YOUR OWN WORDS, EXPLAIN WHY YOU FEEL THAT YOUR IMPAIRMENT MAY MAKE OR HAS MADE IT DIFFICULT FOR YOU TO FIND EMPLOYMENT:

TREATING PHYSICIAN(S) NAME AND ADDRESS:

PART C
EDUCATION AND TRAINING

DO YOU HAVE A HIGH SCHOOL DIPLOMA OR EQUIVALENT? Yes No

DO YOU HAVE A COLLEGE DEGREE? Yes No

If Yes, What Year Was Degree Received:

Name Degree(s): Major

Minor

CERTIFICATIONS, LICENSES OR TRAINING COMPLETED (VO-TECH, ON-THE-JOB TRAINING, MILITARY, REHABILITATION:

OTHER SKILLS AND ABILITIES:

PART D

EMPLOYMENT STATUS

ARE YOU CURRENTLY EMPLOYED NOW: Yes No

CURRENT EMPLOYER, IF YOU ANSWERED YES:

Name:

Address:

Phone:

TYPE OF POSITION: Permanent Temporary On-The-Job Training

ANSWER THE FOLLOWING:

List the most recent date you returned to work

Did you return to the same employer: Yes No

Did you return to: Same Job New Job Modified Job

SPECIFY ANY MODIFICATIONS AND/OR ACCOMMODATIONS MADE BY YOUR EMPLOYER TO MEET YOUR PHYSICAL RESTRICTIONS:

PART D (CONTINUED)
EMPLOYMENT STATUS

IF YOU ARE NOT CURRENTLY EMPLOYED, ANSWER THE FOLLOWING:

Are You Currently Applying For A Job? Yes No

LIST JOB APPLICATIONS MADE IN THE LAST TWELVE MONTHS (USE ADDITIONAL PAPER IF NEEDED)**:**

Date Applied	Type Of Job	Name Of Employer	City State	Denied Yes No	Reason Denied If Known

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PART E
EMPLOYMENT HISTORY

LIST YOUR LAST **10 YEARS** OF EMPLOYMENT HISTORY. THE APPLICATION WILL NOT BE ACCEPTED WITHOUT THIS INFORMATION IN ITS ENTIRETY. PLEASE PROVIDE JOB TITLES WHERE INDICATED.

DATES FROM	TO	SPECIFIC JOB TITLE	EMPLOYER/BUSINESS NAME	CITY STATE

RIGHTS

The Subsequent Injury Fund is intended as an incentive to employers to hire and retain persons having physical restrictions or impairment that may be a barrier to employment. This program may **NOT** be used as a means of discrimination against you. Various laws have been enacted to prevent discrimination on the basis of a person's disability.

The Workers' Compensation Act provides that an injured worker who has been medically released and is capable of returning to work within two (2) years of injury must be given hiring preference over other applicants for a comparable position that becomes vacant if the position is consistent with the workers' physical condition and vocational abilities; and

The Human Rights Act prohibits discrimination against handicapped individuals if they are otherwise qualified to perform duties of the job with reasonable accommodations by the employer.

The Americans Disabilities Act prohibits employers of 15 or more employees from discriminating against qualified workers or job applicants on the basis of their disability.

If you feel an employer is discriminating against you or using the Subsequent Injury Fund to discriminate against you, call the Human Rights Commission at 1-800-542-0807.

RESPONSIBILITIES AND CONSENT

I understand and agree I am applying for certification as a person having a qualifying physical restriction or impairment. I believe I have a medically certifiable permanent impairment, which may present a substantial obstacle to obtaining or continuing employment. **SIGNING THIS APPLICATION FORM FOR CERTIFICATION IS MY AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION, MEDICAL RECORDS, WORKERS' COMPENSATION AND REHABILITATION RECORDS TO THE SUBSEQUENT INJURY FUND, EMPLOYMENT RELATIONS DIVISION.**

_____

SIGNATURE OF APPLICANT **DATE**

Name and Address of Referring Agent

(Referring Agent Must Have "Authorization for Release of Subsequent Injury Fund Certification Fund Status" signed to be notified by the Department)

Telephone:

Email Address:

To ensure that workers' compensation systems will not be disrupted, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Public Law 104-191 42 USC 1301, et. seq., **permits the disclosure of protected health care information pursuant to the provisions of state laws regarding workers' compensation**. 45 CFR 165.512 (l) states:

"Standard: Disclosures for workers' compensation: A covered entity may disclose protected health information **as authorized by and to the extent necessary to comply with the laws relating to workers' compensation** of other similar programs, established by law, that provide benefits for work-related injuries or or illness without regard to fault."

AUTHORIZATION FOR THE RELEASE OF SUBSEQUENT INJURY FUND CERTIFICATION STATUS

The Subsequent Injury Fund is intended as an incentive to employers to hire and retain persons having physical restrictions or impairments that may be a barrier to employment. Certification is entirely voluntary and may NOT be used as a means of discrimination against you. In order to receive the benefits of the Fund employers and insurers must be advised the worker has been certified under the Fund. Please complete the following authorization if you would like to notify any of the parties below.

I hereby authorize the Subsequent Injury Fund to release my certification status to the following: (please check one or more)

_____ Employer

_____ Insurer or third-party administrator

_____ Vocational Rehabilitation provider

_____ Other:_____

NOTE: This authorization will allow the Fund to disclose whether or not you have been certified under the Fund. The Fund will not disclose any medical information to the parties listed above.

I may withdraw this consent by giving written notification of withdrawal to the Subsequent Injury Fund. The date for withdrawal will be the date written notification is received by the Fund, and any action taken by the Fund based upon this consent prior to receipt of my written withdrawal is expressly authorized.

DATED:_____

SIGNATURE:_____

TYPE OR PRINT NAME:_____

NOTE: This release is good for 1 year from the date it is originally signed.

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SUBSEQUENT INJURY FUND MEDICAL EVIDENCE OF IMPAIRMENT FORM

PART I
(*To be completed by applicant)*

NAME OF APPLICANT: SSN #:

ADDRESS: PHONE:

BIRTH DATE:

PART OF BODY

SIGNING THIS MEDICAL EVIDENCE OF IMPAIRMENT FORM IS MY AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION TO THE SUBSEQUENT INJURY FUND, EMPLOYMENT RELATIONS DIVISION.

SIGNATURE OF APPLICANT **DATE**

PART II
INSTRUCTIONS
(*To be completed by a medical doctor or chiropractor)*

The above named individual has applied for certification by the Subsequent Injury Fund as a person having physical restrictions or impairment that may be a barrier to employment. To help us determine if the applicant meets the criterion, please complete this questionnaire and return it to the Subsequent Injury Fund. Also, attach any medical records that substantiate the impairing medical condition of the applicant. If you have any questions, please contact the Employment Relations Division, Subsequent Injury Fund at (406) 444-6543.

Section 39-71-901, MCA defines a person with a disability as a person who has a medically certifiable permanent impairment that is a substantial obstacle to obtaining employment or to obtaining reemployment if the employee should become unemployed, considering such factors as the person's age, education, training, experience, and employment rejection. Permanent restrictions placed on workers' return to employment or reemployment is compared to the above factors to determine whether there is a substantial obstacle as a result of the permanent impairment.

To meet the medical requirement for certification, the applicant must substantiate that he/she has "a medically certifiable permanent impairment." The American Medical Association (***Guides to Evaluation of Permanent Impairment***) defines impairment "as the loss of, loss of use of, or derangement of any body part, system or function. A permanent impairment is an impairment that has become static or well stabilized with or without medical treatment, or that is not likely to remit despite medical treatment of the impairing condition."

QUESTIONNAIRE

ARE YOU OR HAVE YOU BEEN THE APPLICANT'S TREATING PHYSICIAN? Yes No

DATE OF MOST RECENT EXAMINATION OF APPLICANT:

NATURE OR DIAGNOSIS OF INJURY OR CONDITION AND MEDICAL DIAGNOSIS CODE:

HAS MAXIMUM HEALING BEEN REACHED? Yes No

If No, When Do You Anticipate It Will Be Reached?

IS THERE PERMANENT IMPAIRMENT AS DEFINED ON PREVIOUS PAGE: (PLEASE NOTE: A Rating Need Not Be Assigned To Meet Our Criteria.) Yes No

If No Impairment, Please Explain:

ARE THERE PERMANENT RESTRICTIONS OR LIMITATIONS? Yes No

Please Describe In Detail:

IS CONDITION STABLE? Yes No

If No, Explain:

WHAT MEDICAL TREATMENT, IF ANY, IS RECOMMENDED TO TREAT THIS CONDITION?

OTHER COMMENTS OR CONCERNS:

PHYSICIAN NAME: (PLEASE PRINT)

ADDRESS:

PHONE:

SIGNATURE OF PHYSICIAN **DATE**