

STATE OF NH APPLICATION FOR SHORT TERM DISABILITY INCOME

IMPORTANT NOTE: All fields of the application must be completed. An incomplete application will not be processed and will be returned to the agency for completion.

PART I – To be completed by the employee’s Appointing Authority or designee.

PLEASE PRINT OR TYPE – ALL FIELDS MUST BE COMPLETED

1. Employee Name (Last Name, First Name)		2. Job Title:	
3. Agency:		4. Department/Division:	
5. Work Phone:		6. Home Phone:	
7. Home Address:			
8. The employee is represented by?		Eligible Groups:	
		<input type="checkbox"/> NEPBA	<input type="checkbox"/> Teamsters
		<input type="checkbox"/> Confidential	<input type="checkbox"/> * Unrepresented
9. Is this employee in a probationary or temporary status, or employed seasonally, irregularly or on call?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Has the employee exhausted all sick leave balances?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(a) If not, what are the employee’s sick leave balances?		(a) _____	
(b) The employee’s sick leave available for this absence was/will be exhausted on (date):		(b) _____	
(c) How much sick leave time has the employee used since the onset of the medical condition?		(c) _____	
11. For this absence, the employee receiving/eligible to receive workers’ compensation benefits or is there a pending workers’ compensation appeal?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

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12. Date illness/injury began: _____	13. Length of employee's regular work day: <input type="checkbox"/> 7.5 hours <input type="checkbox"/> 8 hours
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* *Unrepresented Employee* - is an Executive Branch employee that is not in a bargaining unit, is full-time, and who accrues sick leave.

14. APPOINTING AUTHORITY OR DESIGNEE

Name: _____ Title: _____
(Please print)

_____ Date: _____
(Signature)

15. HUMAN RESOURCES

We anticipate that the employee's short term leave will meet and/or exceed the thirty (30) day waiting period and potentially be eligible for the Short Term Disability Income Plan.

Name: _____ Title: _____
(Please Print)

_____ Date: _____
(Signature)

Telephone

Fax

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PART II - To be completed by the Employee or Designee.

IMPORTANT NOTE: This section is to be completed in its entirety. Failure to provide all information requested may result in delay or denial of the employee's application for short term disability income.

PLEASE PRINT OR TYPE- ALL FIELDS MUST BE COMPLETED

1. Name:	2. Job Title:
3. Agency:	4. Division/Department:
5. Work Phone:	6. Home Phone:
7. Home Address:	
8. Is your injury or illness work-related? <input type="checkbox"/> Yes- Stop here , your application cannot be processed if your injury or illness is work related. <input type="checkbox"/> No- Please describe reason for request below. <i>(Please note: In the event of a work-related medical condition, Short Term Disability Income would not be considered until the workers' compensation process has been completed – please discuss with your human resources representative.)</i>	
9. Describe reason(s) for your request in detail. Please include the date of injury or commencement of illness: (a) Include information relative to your diagnosis, course of treatment, and why you cannot return to work at this time. (b) Identify whether your condition is ongoing or not. <p>The reason for the request must be verified by the physician or medical practitioner treating your medical condition. The physician or medical practitioner must provide all of the information requested on PART II of this form and he/she must sign and date the form. PART II and PART III of this form must be submitted to Managed Medical Review Organization (MMro) within 15 calendar days of submitting PART I. MMro Contact Information (866)-516-6676 ext. 104 (P) and (248)-262-5966 (F).</p>	
10. In applying for short term disability income, I agree to have my physician/medical practitioner provide the information requested in PART II and III of the application.	
Signature: _____	Date: _____

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Employee's Authorization and Acknowledgement

11. HIPAA DISCLOSURE:

I authorize any licensed physician, medical provider, medical facility, or provider of health care or similar entity to release any and all of the following information to third party administrators Managed Medical Review Organization. I understand if there are any expenses for releasing this information it is my responsibility to pay those expenses.

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except the third party administrators.

I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying Managed Medical review Organization.

I understand that revoking this Authorization may impair necessary processing of my application.

I, the undersigned, state that the information I provided in this Application is complete and true to the best of my knowledge and belief. I understand that, by applying for income disability benefits, I authorize my physician(s) to provide Managed Medical Review Organization (MMro), with my medical information.

12. PATIENT NAME:

(Please print)

(Signature)

Date: _____

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PART III - To be completed by the Employee's Physician or Medical Practitioner.

IMPORTANT NOTE: FORMS WHICH ARE INCOMPLETE WILL BE RETURNED TO THE EMPLOYEE PRIOR TO CONSIDERATION.

The employee named in PART II has applied to receive short term disability Income through the Short Term Disability Income Program established by the State of NH. You are requested to complete the information below for this individual patient.

PLEASE PRINT OR TYPE- ALL FIELDS MUST BE COMPLETED

1. Patient's Name/Address:			2. Most recent date of examination:
3. The patient is/was:	<input type="checkbox"/> Under my professional care	From:	To:
	<input type="checkbox"/> Hospitalized (N/A if not applicable.)	From:	To:
4. Primary Disabling Condition:			
5. Secondary Condition Impacting Primary Disabling Condition:			
6. Patient Symptoms:			
7. Laboratory and/or Diagnostic Findings:			

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8. Historical Treatment/Care Plan:		
9. Current Treatment/Care Plan:		
10. Current Medications:		
11. The patient has been incapacitated from performing his/her duties:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	From:	To:
12. Anticipated duration the patient will be unable to work due to the condition:	From:	To:
13. If the patient is not able to return to full duty employment, can the patient return to work at less than full duty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(a) If yes, period of partial incapacity:	From:	To:
14. Will this illness or injury permanently prevent the patient from returning to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Physician's Determination – Please include any test results that enabled you to make your diagnosis(es).

Physician Reported Employee Job Restrictions and/or Limitations *Max = Maximum lifting/carrying/pushing/pulling capacity – (lbs.)					
<i>Please address all below, if applicable:</i>	Max* (LBS.)	Not Applicable to condition(s)	Occasional 0 to 2.6 hours/day	Frequent 2.7 to 5.3 hours/day	Constant 5.4 to 8 hours/day
Low <u>L</u> ift (floor to knuckle)					
Mid <u>L</u> ift (Knuckle to shoulder)					
Full <u>L</u> ift (floor to shoulder)					
Carrying					
Pushing					
Sitting	N/A				
Standing	N/A				
Walking	N/A				
Climbing	N/A				
Balance	N/A				
Stoop	N/A				
Kneeling	N/A				
Crouching	N/A				
Crawling	N/A				
Reaching (immediate)	N/A				
Reaching (overhead)	N/A				
Handling	N/A				
Fingering	N/A				
Feeling	N/A				

10. PHYSICIAN'S OR PRACTITIONER'S SIGNATURE

Name: _____ Title: _____
(Please Print)

_____ Date: _____
(Signature)

Address: _____ Phone: _____

Contact information: Managed Medical Review Organization, Attn: Sheryl Gold, NCM
 44090 W. 12 Mile Road
 Novi, MI 48377
 (866)516-6676 ext. 110 (P) (248)262-5955 (F)