MADISON COUNTY

Summary - Injury/Illness Incident Reporting

(See Injury/Illness Incident Reporting Procedure for details)

Step 1. All injury/illness incidents – no matter how minor- should be reported to the Department Head/Elected Official before the end of the work shift. Notice may include:

A. Oral notice/person to person
B. Voicemail message
C. Written – note or Incident Report

- Notice should include: Name, Date, and Description of Injury

Step 2. Determine need:

A. If the incident requires simple First Aid or no attention: The employees has the option of:
1. Filing a First Report of Injury form to open a Workers' Compensation claim.
2. Filling out an Incident Report – include name, date, and description of injury.

B. If the incident requires medical attention:
1. Seek medical assistance immediately.
2. Fill out a First Report of Injury form. (See Sample First Report of Injury form)
   a. Employee – Worker (1), Accident Description(3), Medical (4), and Signature (5) field.
   b. Dept. Head/Elected Official (DH/EO) – Employer (6) field.
   c. Finance Dept. – Wages field (2), Tax I.D.(7) and Payroll classification (8).

Step 3. A claim is filed - When the Finance Dept. files the claim with MACo Workers' Compensation Division.

Step 4. Medical authorization:

A. Immediate return to work - If the employee is authorized to return to work no other documentation is required.
B. Work restriction or time loss - If work restrictions/loss time is required a Medical Status form must be provided before returning to work.

Step 5. Workers' Compensation claim information -

A. Claim information: The employee will receive claim number and information within approximately 2 days after filing a claim.
B. Responsibility: The employee is responsible for providing claim information to the medical care provider for payment of medical services.

Step 6. Claim assistance - The Dept. Head/Elected Official and Safety Coordinator (843-4026/c-498-0243) will assist the employee through the claim process.

Madison County Employees Return to Work
Authorization Form for Release of Information

A. Identification
This document authorizes the use and/or disclosure of confidential protected health care information about:

Employee Name: _____

Address: _____

Date of Birth: _____

Daytime Phone Number: _____

B. Directions for Release
This authorization applies in accordance with my directions as checked below:

I authorize the release of information from:
___My Physician/Provider (Name): _____
___MACo Workers' Comp Claims Department
___Other (Name or describe): _____ to release and/or use protected health information pertaining to my current and expected medical restrictions and functional abilities and expected recover timelines related to **my work-related injury or occupational disease.**
The information may also include medical opinions and evaluations of potential temporary transitional duty assignments and/or return to work activities.

I authorize the disclosure of information to:

___HR personnel/Designated RTW Coordinator within Madison County
___Temporary Transitional Committee
___Other (Name or describe): _____

I authorize the disclosure and/or use for the following reasons:

1. To evaluate the appropriateness of temporary transitional duty assignments;
2. To evaluate ongoing temporary transitional duty assignments;
3. To evaluate the appropriateness of returning to full unrestricted duties.

C. Right to Revoke
I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire on the date I am declared maximally medically improved (MMI) by my Health Care Provider for my work-related injury or occupational disease. To revoke the Authorization, I understand I must contact the following person in writing:
HR Personnel/Designated RTW Coordinator _____

D. Authorization and Signature
I authorize the release of my confidential health information as described in my directions in Section B. I understand that this authorization is voluntary, that some of the information to be disclosed *may* be protected by law, and the use/disclosure is to be made to conform to my directions.

I, _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions.

_____ _____
Employee Signature Date

_____ _____
Signature of Witness Date

Complete, Sign, and Return this form to your HR personnel/Designated RTW Coordinator

MEDICAL STATUS FORM

This form is intended to: 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical status to the insurer.

Patient/ Employee Info

Patient/Employee Name (Last, First)	
Date of Injury (mm/dd/yyyy)	Claim Administrator Number
Date of Next Visit	

Provider Info

Timestamp for Health Care Provider	
Health Care Provider Name & Address	

Released for Work?

Please select ONE of the following: (Note: Temporary, alternate and full duty return dates are subject to re-assessment)

☐ Condition Unchanged from Last Report	
☐ Patient/Employee Released to Full Duty	Effective Date
☐ Patient/Employee Released to Modified Duty (SEE WORK ABILITIES)	Effective Date
☐ Time Loss Authorized - objective findings indicate worker should remain off work	Effective Date
➢ Anticipated date patient/employee can perform temporary alternate work	Anticipated Date
➢ Anticipated date patient/employee can return to full duty	Anticipated Date

Work Abilities for Temporary or Permanent Modified Work
(Please Mark Choices In All Categories)

Total Number of Hours/Day Patient/ Employee May Work:

_____ days per week

_____ hours per day

Number of Hours — NR = Not Restricted

Sit	0	1	2	3	4	5	6	7	8	NR
Stand	0	1	2	3	4	5	6	7	8	NR
Walk	0	1	2	3	4	5	6	7	8	NR

Patient/Employee
☐ Should / ☐ Must Alternately
☐ Sit / ☐ Stand / ☐ Walk Every
_____ hours

	Never	Occasionally	Frequently	Continuously	Permanent Upon MMI
	Example of an eight hour work day. NEVER equals 0%, OCCASIONALLY equals 1% to 33% (1-2.6 hours); FREQUENTLY equals 34% to 66% (2.6-5.2 hours), and CONTINUOUSLY equals 67% to 100% (5.3+ hours)				
Hand/Wrist Work ☐L,☐R,☐B	☐	☐	☐	☐	☐
Grasping ☐L,☐R,☐B	☐	☐	☐	☐	☐
Pushing/Pulling ☐L,☐R,☐B	☐	☐	☐	☐	☐
Fine Manipulation ☐L,☐R,☐B	☐	☐	☐	☐	☐
Reaching ☐L,☐R,☐B	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐	☐
Lifting 21-25 lbs.	☐	☐	☐	☐	☐
Lifting 26-50 lbs.	☐	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐	☐

Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? ☐ No ☐ Yes If yes please explain _____

Will the patient/employee be required to use any devices or braces? ☐ No ☐ Yes If yes please explain _____

Additional comments specific to patient/employee's work abilities _____

Can the patient/employee return to work at time of injury occupation? ☐ No ☐ Yes

Signatures

Patient/Employee Signature	Date
Health Care Provider's Signature	Date

Montana Association of Counties
Workers' Compensation Trust
MACo JPA

First Report
of Injury and Occupational Disease
MACo Claims Department
PO Box 7059
Helena MT 59604-7059

Adjusters Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number - -
Home address		City	State	Postal Code -

Phone Number ( ) -	Education ☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	Gender ☐ Male ☐ Unknown ☐ Female	Marital Status ☐ Married ☐ Separated ☐ Not Married ☐ Unknown	Number of Dependents

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	Date / Amount /	Date / Amount /	Date / Amount /	Date / Amount /

Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer	Number of days worked per week:	Wage: ☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ Bi-weekly ☐ Year

In addition to gross earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:	Estimated value if any:	Is sick leave available? ☐ Yes ☐ No	Used? ☐ Yes ☐ No

Worked next scheduled shift ☐ Yes ☐ No	Off work more than 4 work days ☐ Yes ☐ No ☐ Not Sure	Date Last Worked	Date of Return to work	Full wages paid for date of Injury? ☐ yes ☐ No	Salary continued? ☐ Yes ☐ No

Accident Description

Description of Accident (continue on separate sheet if necessary)

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date and Time of Injury /

Date disability began:	Date of Death:	Occupation:	Names of witnesses: 1) 2)

Accident on employer's premises? ☐ Yes ☐ No	Accident address or location: City: State: Postal code: -

Date employer notified:	Accident reported to:	Safety equipment provided? ☐ Yes ☐ No	Safety equipment used? ☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code -	Phone Number ( ) -
Hospital Name	Address	State	Postal Code -	Phone Number ( ) -

Type of initial medical treatment received: ☐ No treatment ☐ Emergency room ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be subject to civil and criminal penalties.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)

Mailing Address	City	State	Postal Code -	Phone Number ( ) -

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured? ☐ Yes ☐ No

Employer is a ☐Sole Proprietorship ☐ Partnership ☐Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ A member of the employer's (sole proprietor or) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? ☐ yes ☐ no
Prepared by:	Official title:	Date:

Payroll Classification Code under which you report employee's wages:	Authorized Employer's Signature:_____ Date:_____

Insurer Only

Claim Administrator's Claim Number:	Date reported to Claim Administrator:	The above information is correct with the following exceptions: ☐ (Attach extra sheets if box at right is checked)

Third Party Administrator's Name: MACo Claims Department	Claim Administrator's Address: PO Box 7059 Helena MT 59604 1(888)442-8552	Insurer FEIN:

Insurer's Name:	Third Party Administrator's FEIN:

Policy Number:	Policy Effective Date:	Policy Expiration Date:

- Sample -

Montana Association of Counties
Workers' Compensation Trust
MACo JPA

FIRST REPORT
of Injury and Occupational Disease

MACO CLAIMS DEPARTMENT
P.O. Box 7059 Helena, MT 59604

Adjusters Date Stamp

(1.) Employee — Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number
				Must Be Included

Home Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Not ☐ Unknown	

(2.) Finance — Wages

Date Hired	Gross Earnings for Four Pay Periods Preceding the Injury	Date/Amount	Date/Amount	Date/Amount	Date/Amount
		/	/	/	/

Employment Status	Number of Days Worked per Week	Wage
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer		☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ Bi-weekly ☐ Year

In addition to Gross Earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other: Estimated value if any

Worked next scheduled shift	Off work more than 5 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury?	Salary Continued?
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

(3.) Employee — Accident Description

Job Title	Description of Accident
Dept.	* As much detail as possible

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date and Time of Injury
						/

Date Disability Began	Date of Death	Names of Witnesses:	1)	2)	3)

Accident on Employer's Premises?	Accident Address or Location	City	State	Postal Code
☐ Yes ☐ No				

Date Employer Notified	Accident Reported to	Safety Equipment Provided?	Safety Equipment Used?
		☐ Yes ☐ No	☐ Yes ☐ No

(4.) Employee — Medical N/A if no medical atention

Attending Physician's Name	Address	State	Postal Code	Phone Number
Hospital Name	**Address**	**State**	**Postal Code**	**Phone Number**

Type of initial medical treatment received ☐ No Treatment ☐ Emergency Room ☐ Treatment on-site by employer or medical staff ☐ Clinic/Dr. Office ☐ Hospital

(5.) Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. I understand that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information relevant to this claim to the workers' compensation insurer and the insurer's agents (medical records pursuant to HIPAA, Public Law 104-191, 42 U.S.C. 1301 et seq. and Section 50-16-527(4)&(5). I also understand that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned."

Signature of Injured Worker or Beneficiary: X Date X

(6.) Dept. Head/Elected Official — Employer — Finance (7)

Employer Name	Doing Business As	Federal Employer Identification Number (Tax I.D.)

Mailing Address:	City	State	Postal Code	Phone Number

Location of Operation, if different from mailing address	Nature of Business or SIC/NAICS Code	Self-Insured?
		☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company

Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space.

Was worker injured while in your employ? ☐ Yes ☐ No

Prepared by	Official Title	Date:

Payroll Classification Code under which you report employee's wages

Authorized Employer's Signature X Date X

Finance (8)

Insurer

Claim Administrator's Claim Number	Date reported to Claim Administrator	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Third Party Claim Administrator's Name	Claim Administrator's Address	Insurer FEIN
MACO CLAIMS DEPARTMENT	PO BOX 7059 HELENA, MT 59604 1-888-442-8552	

Insurer Name	Third Party Administrator FEIN

Policy Number	Policy Effective Date	Policy Expiration Date

MADISON COUNTY

INCIDENT REPORT
*PROPERTY DAMAGE WITH/WITHOUT INJURY
*NEAR MISS * SAFETY VIOLATION

Name: Date: Time:

Exact location:

Describe the incident/violation:
_____
_____
_____

Describe the weather conditions at the time of the incident /violation if applicable: _____
_____

Describe the events leading up to the incident/violation: Describe the equipment involved and damage caused if any:
_____
_____
_____
_____
_____
_____

Estimated cost of damages• If applicable, draw a diagram or sketch and attach:

Full name, address and phone number of all witnesses involved:

Name	Address	Phone#

• Attach witness statements:

Determine corrective actions:
_____
_____
_____
_____

Employees Signature: _____ Date:_____

Supervisor's Signature :_____ Date: _____

*Return Incident Report/Property Damage Without Injury report to the Commission Office for processing
*With Injury requires filing of Workers' Compensation "First Report of Injury" with MACo Workers' Comp.
*Near Miss and Safety Violations should be reported to Dept. Head/Elected Official and Safety Coordinator for Investigation.
*Reporting Safety Violations to the Dept. Head/Elected Official and Safety Coordinator may remain anonymous.