Workers' Compensation Claims for State Active Duty – Texas Air National Guard

08 October 2021
VISION:
America’s premier state military comprised of mission-ready professionals fully engaged with our communities, and relevant through the 21st century.

MISSION:
Provide the Governor and President with ready forces in support of state and federal authorities at home and abroad.

PEOPLE FIRST – Invest in our human capital
• Diverse & Engaged Force Sustained Through Effective Retention & Recruiting
• Trained Ethical Professionals
• Resilient Professionals & Families, Supported By Robust Services
• Clearly Communicated Opportunities For Professional & Personal Development

RELEVANT & READY – Provide right force at the right time
• Force Structure Optimized For Federal & State Missions
• Modern Training Areas & Facilities That Support Our Mission
• Effective Resource Management & Protection
• Enhanced Joint, Interagency, Intergovernmental & Multinational Capabilities

COMMUNICATE & PARTNER – Deliver our message and build lasting relationships
• Effective Communication Assets & Channels
• Partnered & Informed Communities
• Engaged & Educated Government Partners
• Strong Department of Defense Relationships
Why is it important to get it right?

### ALL TMD

<table>
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<tr>
<th>FY</th>
<th>Total</th>
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<th>Denied</th>
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<td>55</td>
<td>21</td>
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<td>FY18</td>
<td>103</td>
<td>75</td>
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<td>FY19</td>
<td>16</td>
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<td>FY20</td>
<td>40</td>
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</tr>
<tr>
<td>FY21</td>
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### TXANG (SAD) - claims only

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<tbody>
<tr>
<td>FY22*</td>
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</table>

*FY21 – Current as of 30 September 2021

**NOTE:** Beginning FY21, data is available per section at the agency level.
What happens when SORM denies a claim?

- Delay or denial of benefits
- Unpaid medical bills
- Potential loss of wages
- Frustration and potential hardship for the injured person
Why are claims being denied?

- Delays in submitting required forms
- Incomplete or missing information (*not showing how the incident/injury is related to mission*)
- Poor documentation (*such as using these words on the forms - I don’t know what happened, It happened sometime on mission, or just “on mission”*)
- Confusion about what’s covered
What is Worker’s Compensation?

- State-regulated insurance benefit program
- Pays medical bills
- May replace a percentage of lost wages from full or part time work outside of duty for state active duty members with a qualifying injury or occupational illness

- Replacement or secondary insurance plan for injuries or illnesses that occur outside of the course and scope of employment
- Not a payout for injury or illnesses
Submit forms **NLT 5 days** of event to Workers Compensation Coordinator

*Don’t forget to follow your chain of command*
Responsibilities
## Who Does What?

<table>
<thead>
<tr>
<th>Injured Person</th>
<th>Supervisor (or person responsible for the injured person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Notify Supervisor <strong>immediately</strong> of all emergencies</td>
<td>• Notify the TMD State Workers' Compensation Coordinator (WCC) <strong>within 24 hours</strong> of incident/injury</td>
</tr>
<tr>
<td>• Notify Supervisor of <strong>ALL</strong> incident/injury</td>
<td>• <strong>IMMEDIATELY</strong> notify TMD WCC of hospitalization or death</td>
</tr>
<tr>
<td>• <strong>Complete and submit ALL required forms within 3 - 5 days of the incident/injury</strong></td>
<td>• Assist the injured person with obtaining forms, if needed</td>
</tr>
<tr>
<td>• Seek medical treatment in the CareWorks network, if needed</td>
<td>• Report work status changes to WCC, especially when going off mission and/or unable to perform full time work</td>
</tr>
<tr>
<td>• Inform the doctor this is a work-related incident/injury</td>
<td>• Notify WCC of any issues or concerns</td>
</tr>
<tr>
<td>• Report <strong>ALL</strong> work status changes immediately</td>
<td>• Assist the injured person with return to work</td>
</tr>
<tr>
<td>• Keep all follow-up appointments</td>
<td></td>
</tr>
</tbody>
</table>
Remember...

Delays in reporting may result in a denied claim or delay of benefits for the injured person.
Forms Guidance
Required Forms

**NOTE:** Forms should be emailed to the Workers’ Compensation Coordinator (WCC) as soon as possible. Additionally, fines may occur if the agency neglects to report an injury or status change timely.

**Employee**
- SORM 29 – Employee’s Report of Injury
- SORM 16 – Authorization for Release of Information
- Network Acknowledgement Form
- *Don’t forget a copy of the orders*

**Supervisor**
- SORM 703 – Investigation Form
- DWC1s – Employer’s Report of Injury

**Witness**
- SORM 74 – Witness Form
Injured Person’s Forms
Dear Employee:

We received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. Attach additional sheets if necessary.

Name: Zolkeph, John

Social Security: 780-22-4560 Gender: M

Date of Injury: 09/17/2021

Primary Phone Number: 741-852-0983 Secondary Phone Number: 210

City: Shreveport State: TX Zip: 70901

Email Address: jolkephjolkeph@gmail.com

1) What was the exact location of the accident? Include street address if possible:

144 Oilco Ave, Covington, TX 72128 - mechanic shop, bldg 101

2) What was happening at the time? What was going on around you, what were you doing, what were other people doing?

I was preparing to go out on a mission. As we were doing a final check on the vehicle, someone noticed it coming from underneath a truck.

3) Briefly describe what exactly caused the injury:

As I approached the truck, I was unable to see anything. When I bent over to get a better look, I felt a pop in my back.

4) What area of your body was injured? It was:

5) When and to whom did you report your injury? Date: 09/17/2021 Time: 0900

Name: Glenny Allbruck Title: CPT Phone Number: 333-842-0170

6) List all known witnesses (continue on back if necessary):

1. Name: Penny Okeo Phone: 768-123-0046
   2. Name: Phone:
   3. Name: Phone:

7) Who is your Primary Care Physician or family doctor? Name: Dr. Oscar Nome Phone: 954-908-7312

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

9) Has a doctor taken you off work? Yes No
   If yes, when was the first day you were off work?

10) If the doctor took you off of work, have you returned to work? Yes No
    If No, when do you think you will return to work?

11) Date of Last Appointment: Date of Next Appointment: pending

12) Have you had previous workers compensation injuries? Yes No
    If yes, please enter injury date and body part injured.

13) On affirming my signature, I attest that all information on this form is accurate and true.

Signature: ____________________________ Date: 09/17/2021
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: John Zeedalep

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X-ray reports, including copies thereof pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name) John Zeedalep

Photostatic copies of this signed authorization will be considered as valid as the original. This is not a release of claims for damages.

SIGNED: [Signature] DATED: 09/07/2021

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU,
STATE OFFICE OF RISK MANAGEMENT

SORM 16 Form 16
Network Acknowledgment Form
Don’t forget a copy of the orders

This helps SORM clarify that you were on mission at the time of the incident/claim.
Supervisor Forms
# DWC1-s Form Guidance (Supervisor)

## DWC1S – Employer’s Report of Injury

- Boxes 1 – 41 are required
- If any box (1-41) is empty, the form will be returned for completion or additional information will be requested
- This is required information when it’s entered in the system

**NOTE:** Incomplete forms may result in a delay or denial of benefits to the injured employee.

- Boxes 1 – 12: Employee logistics
- Boxes 13 – 14: WC doctor information
- Boxes 15 – 27: Injury/Incident information
- Box 28: Supervisor
- Box 29: Date you knew about the injury
- Boxes 30 – 39: Employment information
- Box 40: Name of person completing form
- Box 41: Employer (TMD)
- Box 42: 2200 W 35th St, Austin TX 78703
- Box 51: Signature of person completing form
# SORM – 703 Form Guidance
(Supervisor)

<table>
<thead>
<tr>
<th>Block A</th>
<th>Block B</th>
<th>Block C</th>
<th>Block D</th>
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<tbody>
<tr>
<td>Forms Description</td>
<td>Forms Description</td>
<td>Forms Description</td>
<td>Forms Description</td>
</tr>
<tr>
<td><strong>Employee and supervisor information</strong></td>
<td>Give specific information about the incident/accident</td>
<td>Bottom line cause of injury</td>
<td>Answer both questions and sign the form</td>
</tr>
<tr>
<td>• What specific area did this occur? Hallway, restroom, etc.?</td>
<td>Inappropriate or inadequate training, violation of safety or work procedure, etc.?</td>
<td>• How are you addressing the cause of this incident? Recommend refresher training, complete job safety analysis, etc.?</td>
<td></td>
</tr>
<tr>
<td>• What activities were happening? Roofing work, construction, loading truck, etc.?</td>
<td></td>
<td>• Are you handling this recommendation personally? Are you routing this recommendation up the chain of command? Has management been made aware of the recommendation? Did you notify the Safety Officer and Risk Manager?</td>
<td></td>
</tr>
<tr>
<td>• How did the incident/injury happen? Tripped and fell, lost balance, unstable ladder, etc.?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Did injury occur? What body parts were involved?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Data</td>
<td>Event Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Incident: 09/12/2022</td>
<td>1. Outside the main door on the north side of building 359. The area has gravel, with some degradation due to environmental issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Event/Incident: accidental injury</td>
<td>2. Mariana was returning to the building after a meeting. Her hands were full with her copies and personal items.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Name: Mariana Herbst</td>
<td>3. Someone called out her name. She turned her head at the time she took her next step. She was wearing birkenstocks and stumbled causing her to fall on her knees. The left leg and knee landed on the papers she dropped while her right leg and knee hit the ground.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working Title: Program Specialist</td>
<td>4. She immediately experienced multiple cuts and bruises to her right knee and lower leg area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office: CFO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone: 512-722-9999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor Contact: Robert Downey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone: 512-722-5055</td>
<td></td>
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</table>

**B. Incident Description**

Obtain written or recorded statements from injured employee. What happened? What caused the accident? What were the contributing factors? Reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. This document becomes a legal accounting of the facts surrounding the incident/injury. When documenting the form, include answers to the following questions:

1. Where did the accident happen? Provide a full description of the surroundings of the location.
2. What was happening at the time of the incident? What were the events leading up to the incident?
3. What caused the physical injury? What were the mechanics involved? Or, if a physical injury was avoided, what could have happened to cause an injury?
4. Describe any injury incurred by the employee, what body parts and what kind of injury/loss. If there are no injuries, no entry.
### C. Incident Findings
After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the incident/injury?

Uneven ground

### B. Corrective Action
What is recommended to prevent this type of incident/accident from occurring again?

Level the ground or provide a safer path to enter the building

Actions taken to ensure recommendations are considered:

Review recommendation with management to determine the safest option.

**Signature of Accident Investigator:**

**Date:** 09/11/12  
**Time:** 09:30

**Internal Distribution:**
- Original: Agency Risk Manager or Risk Management Contact
- Copies: Agency Safety Officer, Employer's Supervisor, Director/Manager of Department or Section

Maintain one copy in any retrievable format in the site file for a minimum of 3 years, or in the case of an occupational illness or injury, for 30 years.

**Note:** If a workers' compensation claim is filed, send:
- 1 copy to the State Office of Risk Management (SORM) Claims Department at 512-472-0237.

9/26/12
Texas Military Department
Workers’ Compensation Contacts

Workers’ Compensation Coordinator (WCC)
Helena La Fleur
O (512) 782-5306
F (512) 374-0299
Helena.lafleur@military.texas.gov

OR

benefits@military.texas.gov

Backup Contact
Angela Hawley
benefits@military.Texas.gov
O (512) 782 - 3385
F (512) 374 - 0299
References — *Where do we get the rules?*

- Texas Workers Compensation Act
- State Office of Risk Management (SORM)
- Texas Administrative Code
- Occupational Health and Safety Act
- Risk Management Guidelines (SORM)
- Life Safety Code
- Texas Labor Code
- Texas Department of Insurance - Division of Workers' Compensation
Per the Texas Workers' Compensation Act, here are a few important reminders.

**Sec. 409.006. RECORD OF INJURIES; ADMINISTRATIVE VIOLATION.** (a) An employer shall maintain a record of each employee injury as reported by an employee or otherwise made known to the employer.

**Sec. 501.024. EXCLUSIONS FROM COVERAGE** – (1) a person performing personal services for the state as an independent contractor or volunteer; (2) a person who at the time of injury was performing services for the federal government and who is covered by some form of federal workers' compensation insurance; (3) a prisoner or inmate of a prison or correctional institution, other than a work program participant participating in a Texas Correctional Industries contract described by Section 497.006, Government Code; (4) a client or patient of a state agency;

**CHAPTER 451. DISCRIMINATION PROHIBITED** Sec. 451.001. DISCRIMINATION AGAINST EMPLOYEES PROHIBITED. A person may not discharge or in any other manner discriminate against an employee because the employee has: (1) filed a workers' compensation claim in good faith;

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A few confusing definitions clarified in the Texas Workers' Compensation Act

"Injury" means damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.

"Compensable injury" means an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle.

"Compensation" means payment of a benefit.

"Course and scope of employment" means an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer. The term includes an activity conducted on the premises of the employer or at other locations. The term does not include: (A) transportation to and from the place of employment unless: (i) the transportation is furnished as a part of the contract of employment or is paid for by the employer; (ii) the means of the transportation are under the control of the employer; or (iii) the employee is directed in the employee's employment to proceed from one place to another place; or (B) travel by the employee in the furtherance of the affairs or business of the employer if the travel is also in furtherance of personal or private affairs of the employee unless: (i) the travel to the place of occurrence of the injury would have been made even had there been no personal or private affairs of the employee to be furthered by the travel; and (ii) the travel would not have been made had there been no affairs or business of the employer to be furthered by the travel.

"Occupational disease" means a disease arising out of and in the course of employment that causes damage or harm to the physical structure of the body, including a repetitive trauma injury. The term includes a disease or infection that naturally results from the work-related disease. The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is an incident to a compensable injury or occupational disease.
Health Benefits for State Active Duty

After you’ve been on mission for 60 days, health benefits are available

NOTE: This is regular health insurance
How Do I Sign Up?

- Send a completed Benefits Enrollment Form to the benefits coordinator.
- She will enroll you in the ERS system.
- Contact Angela Hawley
  Angela.Hawley@military.Texas.gov
  O (512) 782 - 3385
  F (512) 374 - 0299
Questions?