WORKERS' COMPENSATION CLAIM PROCEDURES

Eligible Activities

DSW volunteers may file a claim for injuries sustained while engaged in approved, documented and supervised:

- activities authorized by and carried on pursuant to the California Emergency Services Act while assisting any unit of the emergency organization during a proclaimed emergency or during a search and rescue mission,
- activities performed to mitigate an imminent threat of extreme peril to life, property, and resources, and
- training necessary to engage in such activities; excludes travel to and from the training site.

Volunteers impressed into disaster service by a public official having the authority to do so, may also file a claim for injuries sustained while performing that service.

Unregistered volunteers and those not impressed into service may not file a claim.

Claim Initiation

A claim for injuries may be initiated under several situations

- Upon notice by claimant of an injury that requires medical treatment beyond first aid or results in lost time (Lab. Code, § 5401(a)); or
- A volunteer notifies supervising agency of his/her injury; or
- An injured volunteer presents a physician's note stating a work-related injury may have occurred

Guide to Worker's Compensation

At the same time a claim is initiated, the supervising agency provides the injured DSW volunteer with the *New Disaster Service Worker's Guide to Worker's Compensation.*

Access *Guide* on the Cal OES webpage: Click *For Governments & Tribal*, scroll down to *Plan & Prepare*, and then click *Disaster Service Worker Volunteer Program.*

Signing the claim form is not an admission of liability.

WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

Required Documents

To file a claim, the following required documents must be submitted as stated in section 2573.3 of Title 19 of the California Code of Regulations:

1. State Fund Form e3301, *Workers' *Compensation Claim Form*
2. State Fund Form e3267, *Employer's** Report of Occupational Injury*

   OR

   Call the 24-Hour Claims Reporting Center at (888) 222-3211 to verbally complete the 3267
3. Written incident report
4. DSW volunteer registration and loyalty oath subscription

If injury due to training, additional required documents to submit:

5. Training pre-authorization
6. Training participation document

The supervisor and injured DSW volunteer have responsibilities associated with the worker's compensation claim submission.

* Worker or employee refers to DSW volunteer.
** Employer refers to ADC or authorized designee.

State Fund Form e3301

The State Fund Form e3301, *Workers' Compensation Claim Form*, must be given to the injured DSW volunteer by the supervising agency within one working day of having knowledge of the injury.

Any sustained injuries should be reported to the supervisor immediately; however, this is not always the case. For example, a volunteer sustains an insect bite and reports it a week later when it requires medical care. The 24 hour period starts the date the volunteer informed the supervisor, which is later than the injury date.

Volunteer Instructions

Form e3301 Instructions for: Injured DSW Volunteer	
Complete	Lines 1-7 *If unable due to injury, relative or legal representative may complete.*
Sign	Line 8 *If unable due to injury, relative or legal representative may sign on behalf of injured volunteer.*
Deliver	Completed Form to supervisor or registering agency within three days (72 hours) of receiving it.

Continued on next page

WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

Supervisor Instructions

Form e3301 Instructions for: Authorized Supervisor	
Distribute	Copy to injured volunteer, which is volunteer's receipt of record that claim was filed.
Complete	Lines 9-10: Registering entity name and address Lines 11-13 Line 14: Pre-filled Line 15: Leave blank Lines 17-18
Sign	Line 16
Distribute	1. Mail completed Form to State Fund. 2. Fax or e-mail copy to Cal OES. 3. Deliver completed copy to injured DSW volunteer. 4. Retain copy for supervisor or registering agency's files.

Statute of limitations for filing a claim is one year from date of injury.

Access the e3301 on Cal OES webpage: click *For Governments & Tribal*, scroll down to *Plan & Prepare*, and then click *Disaster Service Worker Volunteer Program.*

WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

Example: COMPLETED E3301 FORM REV.1.12

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Volunteer's Name Today's Date. *Fecha de Hoy.* 01/06/1956
2. Home Address. *Dirección Residencial.* Volunteer's Address
3. City. *Ciudad.* ______ State. *Estado.* ______ Zip. *Código Postal.* ______
4. Date of Injury. *Fecha de la lesión (accidente).* 01/04/1956 Time of Injury. *Hora en que ocurrió.* 9:15 a.m. ______ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* Training classroom located at 123 Street City, State Zip
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Tripped over mannequin during training and injured left ankle.
7. Social Security Number. *Número de Seguro Social del Empleado.* xxx-xx-xxxx
8. Signature of employee. *Firma del empleado.* Volunteer's Signature

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* Name of accredited disaster council (ADC) or authorized government designee
10. Address. *Dirección.* Address of ADC or authorized government designee
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 01/04/1956
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 01/04/1956
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 01/06/1956
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* State Compensation Insurance Fund
15. Insurance Policy Number. *El número de la póliza de Seguro.* NA
16. Signature of employer representative. *Firma del representante del empleador.* Signed by person authorized by ADC or designee
17. Title. *Título.* Title 18. Telephone. *Teléfono.* (555) 555-5555

WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

State Fund Form e3267

The State Fund Form e3267, *Employer's Report of Occupational Injury*, must be submitted by the authorized supervisor **within five days** of injury knowledge. It is imperative to meet this time frame as State Fund will send a letter to the injured volunteer **within 14 days of the injury**. Late reporting may result in penalties being paid out of the DSW fund.

This Form is completed in one of two ways:

1) typing or writing on the Form e3267, OR
2) calling the State Fund Claims Reporting Center and providing information over the telephone.

Injured DSW volunteer does not complete this Form!

Instructions

Form e3267 Instructions	
Line(s)	**Authorized Supervisor types or prints:**
1	Registering agency name
1a	Pre-filled
2-3	Registering agency address
4 & 6	Pre-filled
5	Leave blank
7-10	Self-explanatory
11-16	*If unknown, leave blank*
17-26	Self-explanatory
27-29	*If unknown, leave blank*
30-34	DSW volunteer information
35 & 41	Regular job; ***NOT*** DSW classification
36-39	*If unknown, leave blank*
40	Registering agency information
42-43	Self-explanatory

OR

Claims Reporting Center (CRC) Instructions	
Action	**Authorized Supervisor:**
Calls	(888) 222-3211, *(State Fund operated 24/7)*
Answers	Form 3267 questions via phone to CRC representative
Action	**State Fund CRC Representative:**
Completes	Form 3267, which establishes claim

Access the e3267 on Cal OES webpage: click *For Governments & Tribal*, scroll down to *Plan & Prepare*, and then click *Disaster Service Worker Volunteer Program*.

WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

Example: COMPLETED E3267 FORM REV.11-13 (front side)

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	STATE COMPENSATION INSURANCE FUND 24-Hour Claims Reporting Center Telephone (888) 222-3211 Fax (800) 371-5905 ALSO SEND ONE COPY TO: CALIFORNIA GOVERNOR'S OFFICE OF EMERGENCY SERVICES - ATTENTION PREPAREDNESS BRANCH 3650 SCHRIEVER AVENUE, MATHER, CA 95655 BOTH SIDES OF THIS FORM MUST BE COMPLETED (Claims Management Service is a division of State Compensation Insurance Fund)	OSHA Case No. DR ☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

COUNCIL

1. LOCAL ACCREDITED DISASTER COUNCIL OR AUTHORIZED REGISTERING GOVERNMENT AGENCY: Name of ADC, its government designee, Cal OES, or authorized state agency
1a. Policy Number: DIS REL
2. MAILING ADDRESS (Number and Street, City, Zip):
2a. Phone Number: (555) 555-5555
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip): Address of authorized registering government agency
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: Cal OES
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.: Leave blank
6. TYPE OF EMPLOYER: ☐ PRIVATE ☐ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL DIST. ☒ OTHER GOVERNMENT - SPECIFY: DISASTER COUNCIL

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): mm/dd/yy
8. TIME INJURY/ILLNESS OCCURRED: ____ A.M. ____ P.M.
9. TIME EMPLOYEE BEGAN WORK: ____ A.M. ____ P.M.
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
12. DATE LAST WORKED (mm/dd/yy): if known
13. DATE RETURNED TO WORK (mm/dd/yy): if known
14. IF STILL OFF WORK, CHECK THIS BOX ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy): mm/dd/yy
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): mm/dd/yy
19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Bruised, swollen left ankle; possible fracture or severe sprain.
19a. BODY PART AFFECTED:
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address): Street, City, State
20a. ZIP: XXXXX
20b. COUNTY: County
21. ON EMPLOYER'S PREMISES? ☑ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☑ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop: County conference training facility.
23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: (Name of injured volunteer) training with CPR mannequin.
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck: (Name of injured volunteer) stumbled over mannequin as moved to next training station.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS; e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: (Name of injured volunteer) foot caught mannequin's arm causing fall and twisting left ankle.
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip): Physician's name and address
27a. Phone Number: (555) 555-5555
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip): If yes, enter hospital/medical facility name and address.
28a. Phone Number:
29. Employee treated in Emergency Room? ☐ YES ☐ NO

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.

DISASTER WORKER

30. EMPLOYEE NAME: Name of injured volunteer
31. SOCIAL SECURITY NUMBER: XXX-XX-XXXX
32. DATE OF BIRTH (mm/dd/yy): mm/dd/yy
33. HOME ADDRESS (Number, Street, City, Zip): Address of injured volunteer
33a. PHONE NUMBER: (555) 555-5555
34. SEX: ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular Job Title, NO initials, abbreviations or numbers). DO NOT ENTER DSW classification: EX: Engineer NOT: SAR, CERT, other class
36. DATE OF HIRE (mm/dd/yy):
37. EMPLOYEE USUALLY WORKS: ____ hours per day ____ days per week ____ total weekly hours
37a. EMPLOYMENT STATUS: ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal ☐ disabled ☐ retired ☐ laid-off ☐ unemployed ☐ on strike ☐ other
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY: $ ____ per ____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO
40. NAME AND ADDRESS OF PRESENT EMPLOYER: EX: Engineering Company — Street, City, State Zip

Completed By (type or print): Authorized person by ADC or designee
Signature & Title: Signature of authorized person with his/her title or position

(back side)

41. OCCUPATION/Regular Job Title. DO NOT ENTER DSW classification.
EX: Engineer, Retired, Nurse, etc. DO NOT ENTER DSW Classification!

42. WAS WORKER REGISTERED WITH A LOCAL ACCREDITED DISASTER COUNCIL or AUTHORIZED REGISTERING GOVERNMENT AGENCY? IF SO, WHICH
Name of ADC, its government designee, Cal OES, or authorized state agency

43. DID INJURY ARISE OUT OF ACTIVITIES AS A DISASTER SERVICE WORKER? yes or no

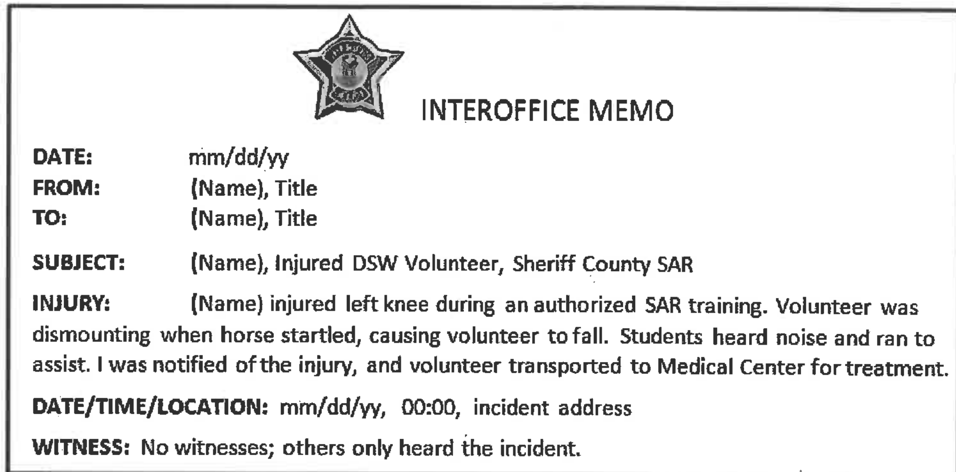
WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

Written Incident Report

A written incident report is required as part of the claim submission. It is a brief narrative of how the injury occurred, where it happened, and may include witness statements.

This information is completed by the supervising authority and may be submitted via interoffice memo, e-mail, ICS 214 Activity Log or similar document.

Examples



INTEROFFICE MEMO

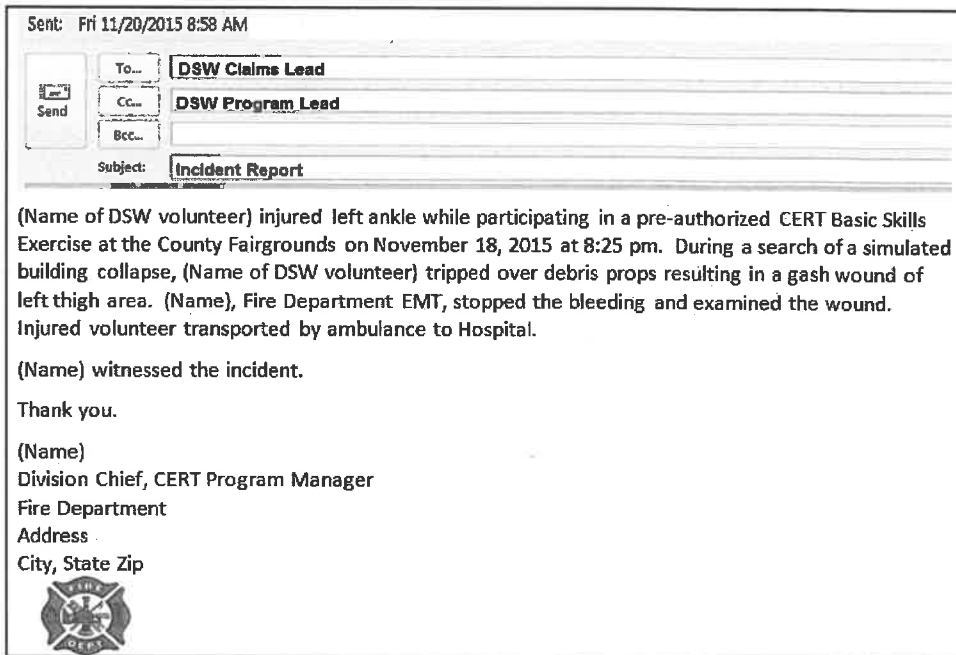
DATE: mm/dd/yy
FROM: (Name), Title
TO: (Name), Title

SUBJECT: (Name), Injured DSW Volunteer, Sheriff County SAR

INJURY: (Name) injured left knee during an authorized SAR training. Volunteer was dismounting when horse startled, causing volunteer to fall. Students heard noise and ran to assist. I was notified of the injury, and volunteer transported to Medical Center for treatment.

DATE/TIME/LOCATION: mm/dd/yy, 00:00, incident address

WITNESS: No witnesses; others only heard the incident.



Sent: Fri 11/20/2015 8:58 AM

To... **DSW Claims Lead**
Cc... **DSW Program Lead**
Bcc...
Subject: **Incident Report**

(Name of DSW volunteer) injured left ankle while participating in a pre-authorized CERT Basic Skills Exercise at the County Fairgrounds on November 18, 2015 at 8:25 pm. During a search of a simulated building collapse, (Name of DSW volunteer) tripped over debris props resulting in a gash wound of left thigh area. (Name), Fire Department EMT, stopped the bleeding and examined the wound. Injured volunteer transported by ambulance to Hospital.

(Name) witnessed the incident.

Thank you.

(Name)
Division Chief, CERT Program Manager
Fire Department
Address
City, State Zip

WORKERS' COMPENSATION CLAIM PROCEDURES, Continued

Registration and Oath Subscription

A copy of the original DSW volunteer registration and oath subscription are essential components of the claim submission. Claim's processing will be delayed until receipt of this information.

Training Documents

If injury is due to a training activity, copies of the following *additional* documents are required:

- ✓ written pre-authorization, confirming training approved in advance, and
- ✓ verification of training to substantiate volunteer's participation

Claim Assembly and Distribution Table

The Claim Assembly and Distribution table below is a reference tool to assist in claim submissions.

INSTRUCTIONS for SUPERVISING AGENCY

CLAIM ASSEMBLY AND DISTRIBUTION

DOCUMENT	STATE FUND	CAL OES	INJURED DSW VOLUNTEER	COMMENTS
State Fund Form e3267	Fax Copy & Mail Original	Fax or Scan Copy	*DO NOT PROVIDE COPY!*	State Fund Fax: 707-646-0173 Cal OES Fax: 916-845-8736
State Fund Form e3301	Fax Copy & Mail Original	Fax or Scan Copy	Provide copy of: ① *Temporary Receipt* - *volunteer's proof of filing* ② Completed & signed Form - after bottom section completed	
DSW Registration & Oath	Fax Copy	Fax or Scan Copy	DO NOT PROVIDE COPY!	
Incident Report	Fax Copy	Fax or Scan Copy	DO NOT PROVIDE COPY!	
*Training Pre-Authorization**	Fax Copy	Fax or Scan Copy	DO NOT PROVIDE COPY!	**Required for training injuries*
*Training Verification**	Fax Copy	Fax or Scan Copy	DO NOT PROVIDE COPY!	**Required for training injuries*

NOTE: Supervising Agency (and Registering Agency) retain copy of entire claim submission. 11/2015

Contact Information

State Compensation Insurance Fund
DSW Claims Adjuster
PO Box 65005
Fresno, CA 93650

Cal OES Preparedness Branch
DSW Volunteer Program
3650 Schriever Avenue
Mather, CA 95655

WORKERS' COMPENSATION COVERAGE INFORMATION

Medical Treatment

When an injury occurs, the DSW volunteer should be referred to a medical provider for evaluation and treatment. If the injury requires emergency care, the supervising agency can select the most appropriate medical provider.

If the DSW volunteer has designated a medical provider or facility prior to the injury, treatment with that provider must be allowed. If no designation was made, the supervising agency has the authority to select a medical provider or facility.

The supervising agency *may* exercise control over medical treatment on a State Fund accepted injury for the first 30 days. If treatment goes beyond 30 days, the DSW volunteer has the right to select his or her own doctor and may use State Fund's Medical Preferred Network (MPN) by Harbor Health at www/statefundca.com and click on Find a doctor.

Pre-existing Condition

The DSWVP is "No Fault" coverage. The existence of, and the percentage of disability from any pre-existing condition is factored into the percentage of compensation coverage under the DSWVP.

Claim Decision

State Fund is obligated to make a final decision to accept or deny a claim within 90 days after the date of the claim form or it is deemed accepted by operation of law subject to certain exceptions. The claimant, *aka injured DSW volunteer*, and Cal OES receive notification upon determination.

The decision process may involve medical evaluations and investigative interviews to assess the claim.

Acceptance: If within 90 days, State Fund decides the claim has merit, Cal OES and the claimant are notified. Retroactive benefits will be paid to the claimant.

State Fund monitors all medical treatment resulting from the injury and reports the status to Cal OES.

Denial: State Fund denies a claim based on the information provided by Cal OES, the supervising agency, and its own examinations and questions.

WORKERS' COMPENSATION COVERAGE INFORMATION, Continued

Disputes

If the supervising agency has cause to dispute a claim:

- Notify State Fund immediately by phone or fax.
- Report the dispute in writing.
- Provide names of supervisors, witnesses, and other relevant information.

Disputing a claim does not remove the supervising agency's obligation to provide the injured DSW volunteer with the State Fund Form 3301, *Worker's Compensation Claim Form.*

If the supervising agency does not dispute a claim within 90 days after notification of an injury, the claim is presumed compensable.

Mandatory Medicare Reporting

The Centers for Medicare and Medicaid Services (CMS) is a federal agency responsible for administration of the Medicare Secondary Payer Program which requires all workers' compensation payers to report payments issued on behalf of Medicare beneficiaries.

The DSW Program pays worker's compensation and is primary payer to Medicare; therefore, Cal OES must report DSW claimant data to CMS to be in compliance with the federal government.

Cal OES works with a Medicare Reporting vendor and State Fund to ensure federal requirements are met. Non-compliance may result in fees and penalties.