

# **SHORT-TERM DISABILITY**

## **IMPORTANT REMINDER**

- **Hall County provides Short – Term Disability Insurance for all employees once your benefits are in effect. As an employee of Hall County you must file for short-term disability when you are out of work for more than fourteen (14) days**
- **You will be charged leave for the first fourteen (14) calendar days, except in the case of Workers' Compensation.**
- **You will receive a check for 60% of your base pay, plus up to 40% from your accrued sick and/or vacation leave to supplement your benefit up to 100% of your weekly earnings for the first six weeks of your disability. If you are out of work due to an on the job injury, the benefit will coordinate with Workers' Compensation pay.**
- **All money received from short-term disability will be taxable.**
- **You will receive your short-term disability check on the regular pay date in the usual practice of pay (i.e. direct deposit or pick-up in your department).**

**WHEN YOU APPLY FOR SHORT-TERM DISABILITY, YOU MUST COMPLETE THE EMPLOYEE SECTION OF THE SHORT-TERM DISABILITY FORM AND HAVE YOUR DOCTOR COMPLETE THE PHYSICIAN'S STATEMENT SECTION. ONCE THE EMPLOYEE AND PHYSICIAN SECTIONS ARE COMPLETED, MAIL OR RETURN THE FORMS TO:**

**Joni M. Holloway  
Human Resources Department  
P.O. Drawer 1435  
Gainesville, Ga. 30503  
(770) 531-6712  
(770) 531-7137 Fax**



**HALL COUNTY SHORT – TERM DISABILITY CLAIM**  
**HALL COUNTY GOVERNMENT**  
**POST OFFICE DRAWER 1435**  
**GAINESVILLE, GA. 30503**

(770) 531-6710 MAIN  
(770)531-7137 FAX

PLEASE HAVE ALL SECTIONS COMPLETED

**A. ATTENDING PHYSICIAN’S STATEMENT (Please Print)**

1. Name of Patient:		Date of Birth:	Social Security Number:	
2. Diagnosis – Please include the primary diagnosis and list any secondary conditions.				
Date of Last Examination:	Diagnosis (including any Complications) Include ICD9 and /or DSM IV Multi Evaluation Nomenclature and Code No.			
Objective findings (including current e-rays, EKG’s, psychiatric testing, laboratory data and any clinical findings)				
Symptoms:				
Is this condition due to <input type="checkbox"/> an Accident <input type="checkbox"/> a Sickness?			Date symptoms first appeared or accident occurred:	
Is the accident or sickness related to the patient’s employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Date Restrictions and Limitations began:	Has patient ever been treated for the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state when and describe			
3. Information About the Patient’s Ability to Work – this information is critical to understanding your patient’s condition.				
Has patient been released to work in his/her occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No in any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below				
Fully describe restrictions and limitations. RESTRICTIONS: (What the patient should not do)				
LIMITATIONS: (What the patient cannot do)				
When should the patient be able to return to work?		Full Time:	Part Time:	
Height/Weight	Blood Pressure Last Visit:	If Pregnancy, Expected Delivery Date:	If Delivered, Actual Delivery Date:	Delivery Type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section
Date of first visit for this illness or injury:	Date of next visit:	Date of Last Visit:	Frequency of visits:	
Is patient : <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed Confined <input type="checkbox"/> House Confined <input type="checkbox"/> Hospital Confined		Has Patient been admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from: _____ To: _____		
If Hospital Confined, give name and address of hospital:				
Have you completed claim form regarding this patient for other insurance carriers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state date and name of Insurance company:				
4. Names and Addresses of Other Treating Physicians:				
Referring physician or other treating physicians (names, address, phone number)				
<b>REQUIRED ATTACHMENTS AND SIGNATURES:</b> Please make sure that office notes, test results and discharge summaries are attached, This will help reduce additional requests. <b>FRAUD NOTICE:</b> Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form. The above statements are true and complete to the best of my knowledge and belief.				
Print or Type Name:		Degree:	Medical Specialty:	
Street Address:			Phone Number ( )	
City:	State:	Zip Code:	Fax: ( )	
Signature of Physician:			Date:	



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Telephone: (770) 531-6710

Fax Number: (770) 531-7137

**FOR EMPLOYEE TO COMPLETE – INITIAL APPLICATION (Please print)  
 GENERAL INFORMATION**

Employee Name:	Job Title:	
Home Address:	List of Duties of your occupation at time of your disability:	Number of Weekly hours spent at duty
	Duty	
Home Phone Number: (      )		
Date of Birth:		
Soc. Security Number:		
Male <input type="checkbox"/> Female <input type="checkbox"/>		
You have been medically unable to work because of this condition since what date:		
Describe the injury occurred (what, how, where, when) or the nature and details of the sickness and when it began:		

**INFORMATION ABOUT PHYSICIANS AND HOSPITALS**

**First medical attention for the current disability was given by**

Doctor's Name:	Doctor's Name:
Address:	Address:
Doctor's Office Number:	Doctor's Office Number:
Hospital Name:	Hospital Name:
Address:	Address:
Dates of Disability from work. Per physician's note: From: _____ To: _____	Dates of Disability from work. Per physician's note: From: _____ To: _____
Have any other doctor's been seen for this disability? (If yes please explain the reason):	

**Check other income benefits you are receiving or are eligible to receive as a result of your disability:**

Social Security                  Yes <input type="checkbox"/> No <input type="checkbox"/>	No-Fault Insurance                  Yes <input type="checkbox"/> No <input type="checkbox"/>
Workers Comp.                  Yes <input type="checkbox"/> No <input type="checkbox"/>	Unemployment                  Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby request and authorize you to furnish to the Hall County Government or its representative all information concerning any illness, injury, medical history, prescription, or treatment, including copies of all hospital and medical records related to my care. A photostatic copy of this authorization shall be considered as effective and valid as the original. By applying for these benefits, I expressly agree to all items within the Short-term Disability Policy.

Signed By: \_\_\_\_\_ Date: \_\_\_\_\_