Application for Resolution of a Claim – 101-COV
September 2021 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Application Seeking TTD Benefit and Expedited Hearing
FORM 101 - COV
Claim No. _____

_____	vs.	_____
Plaintiff		Defendant/Employer (Business Name)
_____		_____
Social Security Number/ Green Card		Defendant/ Employer Mailing Address
_____		_____
Birth Date Gender		City/State/Postal Code
_____		_____
Plaintiff Mailing Address		Insurance Carrier
_____		_____
City/State/Postal Code		Insurance Carrier Mailing Address
☐ Outside United States		_____
		City/State/Postal Code
_____		
Country		
_____		
Plaintiff's Phone Number		
_____		
Email Address		

Additional Parties

_____	_____
Additional Party	Additional Party
_____	_____
Mailing Address	Mailing Address
_____	_____
City/State/Postal Code	City/State/Postal Code
Reason for Joinder:	Reason for Joinder:
_____	_____
_____	_____

1. What is your occupation? (Check one; your occupation must be listed to proceed.)

- ☐ Employee of healthcare entity
- ☐ Law enforcement personnel
- ☐ Emergency medical services personnel
- ☐ Fire department personnel
- ☐ Corrections officer
- ☐ Military personnel
- ☐ Activated National Guard personnel
- ☐ Domestic violence shelter worker
- ☐ Child advocacy workers
- ☐ Rape crisis center staff
- ☐ Department of Community Based Services worker
- ☐ Grocery worker
- ☐ Postal service worker
- ☐ Child care workers permitted by the Cabinet for Health and Family Services to provide child care in a limited duration center during the state of emergency

2. Where you removed from your work by a physician due to COVID-19 exposure? ☐ Yes ☐ No
3. Location of exposure (City/State/Postal Code): _____

   State why you believe you were exposed to COVID-19 at work:

4. On what date did the physician remove you from work? _____

   PLEASE ATTACH THE PHYSCIAN'S NOTE REMOVING YOU FROM WORK

5. What is your average weekly wage? (before taxes are deducted) _____

   PLEASE ATTACH THE MOST RECENT W2 OR YOUR MOST RECENT PAYSTUB

6. Will an interpreter be needed for the formal hearing? (Yes / No) ☐ Yes ☐ No

   If yes, in which language? _____

7. Do you work anywhere else? ☐ Yes ☐ No

   Name and address of concurrent employer

   Concurrent Employer Name _____

   Concurrent Employer City _____

   Concurrent Employer State _____ Postal Code _____

KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will took effect. This regulation limits the situations in which medical providers may release patient information unless the information is necessary for the purpose of treatment, payment, or health care operations. In most instances, disclosure for the purpose of workers' compensation are exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires regarding disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the **requesting party** with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 1-800 554-8601.

MEDICAL WAIVER AND CONSENT

I, _____, by signing and submitting this document to the Kentucky Department of Workers' Claims ("Department") have filed a claim for temporary total disability benefits pursuant to Executive Order 2020-277 and 21 SS HJR 1/GA. By my signature below, I understand I am waiving any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers' compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my claim for temporary total disability benefits pursuant to Executive Order 2020-277 and 21 SS HJR 1/GA **and** authorizing the Department to share copies of this form to the parties listed in this sentence solely for that purpose.

This information or written material reasonably related to my claim is being disclosed solely for the purpose of facilitating my claim for temporary total disability benefits pursuant to Executive Order 2020-277.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of my claim for temporary total disability benefits.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Attestation:

I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

By entering my name below, I confirm the accuracy of this form to the best of my knowledge. I further acknowledge and agree to the medical waiver provided above.

Claimant Signature

This form prepared and submitted by

Relationship to exposed worker

Submitter Phone Number

Submitter Email Address