Ohio | Bureau of Workers' Compensation

Application for Handicap Reimbursement

Under the Ohio Revised Code Section 4123.343, BWC uses this application to determine the percentage of compensation to properly charge to, or to refund from, the Statutory Surplus Fund due to an aggravation of one or more of the pre-existing conditions below:

01 Epilepsy
02 Diabetes
03 Cardiac disease
04 Arthritis
05 Amputated foot, leg, arm or hand
06 Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75 percent bilaterally
07 Residual disability from poliomyelitis
08 Cerebral palsy
09 Multiple sclerosis
10 Parkinson's disease
11 Cerebral vascular accident
12 Tuberculosis
13 Silicosis
14 Psycho-neurotic disability following treatment in a recognized medical or mental institution
15 Hemophilia
16 Chronic osteomyelitis
17 Ankylosis of joints
18 Hyper Insulinism
19 Muscular dystrophies
20 Arterio-sclerosis
21 Thrombo-phlebitis
22 Varicose veins
23 Cardiovascular and pulmonary diseases of a firefighter employed by municipal corporation or township as a regular member of a lawfully constituted fire department
24 Coal miners pneumoconiosis
25 Disability with respect to which an individual has completed a rehabilitation program for a previous injury or claim (ORC 4121.61-69)
26 Service connected injury (see ORC 4123.63)

Attachments

1. Medical evidence (in the form of doctor's reports, diagnostic tests such as an MRI, X-RAY, or CTScan, laboratory records) that the employee suffered from one or more of the conditions listed above.
2. Evidence that the condition constituted a handicap within the meaning of the law, including but not limited to evidence that **prior** to the injury, disease or death, the handicap condition caused the employee to be hospitalized or to obtain extensive medical treatment.
3. Evidence that the injury, disease, death, or the handicap condition caused the employee to be absent from work for at least eight or more consecutive days or resulted in a scheduled loss under R.C. 4123.57(B).
4. Evidence in the form of affidavits or medical reports to support the contention that the injury, disease or death would not have occurred but for the pre-existing handicap condition of the employee or that the resulting disability or death was caused, in part, through aggravation of the handicapped condition.
5. Under BWC rules, if the application is not accompanied by all relevant medical evidence and substantial proof, the Administrator may dismiss the application.

Filing instructions

- You may hand deliver this application to:
  BWC, Customer Service, 30 W. Spring St., Columbus, OH, Second Floor.
- You may mail this application to: **BWC, Attn: Handicap Reimbursement Unit, 30 W. Spring St., 26th Floor, Columbus, OH 43215-2256.** If you provide a copy of the application and a self-addressed stamped envelope, BWC will mail a date-stamped copy to the employer representative. Note: You may send an e-mail with any questions concerning the Handicap Reimbursement Program by using: HandreimbQuest@bwc.state.oh.us

To be completed by employer or employer representative

Injured worker name	Social Security number	Claim number
Nature of handicap	**Date of injury**	**Date of death**

History of injury	Allowed condition(s) in this claim

State how the pre-existing handicap increased the cost of this claim (Staple attach all forms) ***Note: The administrator will not consider applications lacking a sufficient description concerning the handicapped condition's impact on the occupational injury, disease or death. The administrator will make a determination based on the information contained in this application.***

Type of compensation	☐ Temporary Total	☐ Wages in lieu of TT *(attach proof)*	☐ R.C. 4123.57 (B) *(scheduled loss)*	☐ Permanent Total	☐ Death
Do you request an informal conference	☐ In person	☐ By phone	Contact name		

Fill out information below completely

Employer name		Risk number	Manual number
Address			**Telephone number** ( )
City	**State**	**Nine-digit ZIP code**	**E-mail address**
Employer representative name		**Docketing (contact name)**	
Address			**Telephone number** ( )
City	**State**	**Nine-digit ZIP code**	**E-mail address**