WYOMING WORKERS' COMPENSATION DIVISION
APPLICATION FOR PERMANENT TOTAL DISABILITY BENEFITS

Name (Print):		**Claim Number:**
Address:		**Date of Injury:**
City, State, Zip		**Date of Birth:**
Phone Number:		**Social Security Number:**

ELIGIBILITY STATEMENT

Have you applied for or are you receiving social security benefits? ☐ Yes ☐ No

If you are receiving social security benefits, what is the determination based on? _____

Please provide your Medicare Benefit Number (HICN): _____

Have you received an award for Permanent Partial Physical Impairment for this injury? ☐ Yes ☐ No

_____ _____ _____

If "Yes", on what date? Body part? Percentage of Disability Awarded?

Have you been released to work by your physician of record? ☐ Yes ☐ No

What restrictions, if any has your physician given you for returning to employment (Example: lifting restrictions, kneeling, standing, sitting, reaching, repetitive tasks, etc.)? (If you have reports from your physician indicating your physical restrictions, please attach a copy to this form.)

_____

_____

Do you have a H.S. Diploma or GED Certificate: ☐ Yes ☐ No School Location: _____

If "No", what is the highest grade completed? _____

College, Trade/Vocational School or Training Program and Location	Dates		Major	Degree Earned
	From	To		

Are you currently registered with Job Service? ☐ Yes ☐ No

Where is the office located? _____

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What is the phone Number for that office? _____

Are you seeking work through any other employment agencies? ☐ Yes ☐ No

If "Yes", please list the name, address, and phone number of each:

Are you a member of a labor union? ☐ Yes ☐ No

Provide name and number of union: _____

If "Yes", does the union provide job placement services? ☐ Yes ☐ No

Explain what other methods you are currently using to find work:

WORK HISTORY

List **ALL** jobs in reverse order starting with your present or last job. List your entire work history including volunteer, part-time, temporary, self-employment and military jobs and periods of unemployment. This section must be accurate and complete. If you need more space, attach additional pages in the same format.

Job Title	Type of Business (example, Restaurant)	Dates Worked (month & year)		Hours per Day	Days per Week	Rate of Pay (Per hour, day, week, month or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	

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MEDICAL INFORMATION

What are the illness, injuries or conditions that limit your ability to work?

How do your illness, injuries or conditions limit your ability to work?

List any other injuries or illness you have suffered that contribute to your inability to return to work:

Have you been seen by a doctor/hospital/clinic for **any other** illness, injuries or conditions that limit your ability to work? ☐ Yes ☐ No

Have you been seen by a doctor/hospital/clinic for emotional or mental problems that limit your ability to work? ☐ Yes ☐ No

List **ALL** health care providers you have seen since the date of your work injury: If you need more space, use remarks section.

Provider | Address

First Visit | Last Seen | Next Appointment | Phone

Reason for Visit(s)

Provider | Address

First Visit | Last Seen | Next Appointment | Phone

Reason for Visit(s)

Provider | Address

First Visit | Last Seen | Next Appointment | Phone

Reason for Visit(s)

Provider | Address

First Visit | Last Seen | Next Appointment | Phone

Reason for Visit(s)

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Does anyone else have medical records or information about your illness, injuries or conditions? ☐ Yes ☐ No

If "Yes", complete information below:

Name:	Address:	Phone:

List **all** medications you are currently taking:

Name of Medication	Name of Prescribing Doctor	Reason for Medicine	Side Effects you Have

FUNCTIONAL INFORMATION

Describe what you do all day:

Do you provide primary care of anyone else such as a wife/husband, children, grandchildren, parents, friend or others? ☐ Yes ☐ No

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If "Yes", for whom do you care, and what do you do for them? _____

_____

_____

Do you take care of pets or animals? ☐ Yes ☐ No

If "Yes", what do you do for them? _____

_____

_____

What can you not do because of your injury? _____

_____

_____

What can you not do because of other health conditions? _____

_____

_____

Do the illness, injuries or conditions affect your sleep? ☐ Yes ☐ No

If "Yes", how? _____

_____

Personal Care: Explain how your illness, injuries or conditions affect your ability to:

Dress _____

Bathe _____

Care for hair _____

Shave _____

Feed self _____

Use the toilet _____

Other _____

Check here ☐ if no problem with personal care.

Do you need any special reminders to take care of personal needs and grooming? ☐ Yes ☐ No

If "Yes", what type of help or reminders are needed? _____

_____

_____

Do you need help or reminders to take medicine? ☐ Yes ☐ No

If "Yes", what kind of help do you need? _____

_____

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House and yard work:

List household chores, both indoors and outdoors, that you are able to do (for example, cleaning, laundry, household repairs, ironing, mowing, etc.):

How often do you do each of these things?

How long does it take you to do each of these things?

Do you need help or reminders to do these things? ☐ Yes ☐ No

If "Yes", what reminders are needed?

If you do not do house or yard work, explain why not:

Outside Activities:

How often do you leave your house (for shopping, medical appointments, recreation)?

If you do not go out at all, explain why not:

When going out, how do you travel? Check all that apply.

☐ Walk ☐ Drive a car ☐ Ride in a car ☐ Ride a bicycle

☐ Use public transportation ☐ Other (explain)

When going out, can you go out alone? ☐ Yes ☐ No

If "No", explain why you cannot go alone:

Can you drive? ☐ Yes ☐ No

If "Yes", provide driver's license number and State issued:

Does your Driver's License have any restrictions imposed on it? ☐ Yes ☐ No

If "Yes", list restrictions:

If you do not drive, explain why not:

Hobbies and Interests:

What are your hobbies and interests (for example, reading, watching TV, sewing, playing sports, etc.)?

How often and how well do you do these things?

Describe any changes in these activities since the illness, injuries or conditions began:

Social Activities:

Do you spend time with others (in person, on the phone, on the computer, etc.)? ☐ Yes ☐ No

If "Yes", describe the kinds of things you do with others:

How often do you do these things?

List the places you go on a regular basis (for example, church, community center, sports events, social groups, etc.):

How often do you participate in social activities, and how much do you take part?

Information about abilities:

Are you? ☐ Right Handed ☐ Left Handed

How far can you walk before needing to stop and rest?

If you have to rest, how long before you can resume walking?

Do you use any of the following Assistive Devices? Check all that apply

☐ Crutches	☐ Cane	☐ Hearing aid(s)
☐ Walker	☐ Brace/Splint	☐ Glasses/Contact lenses
☐ Wheelchair	☐ Artificial limb	☐ Artificial voice box

☐ Other (explain)

Which of the above were prescribed by a doctor?

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When were these devices prescribed? _____

_____

_____

When do you need to use these devices? _____

_____

_____

Which, if any, of the following items are affected by your illness, injuries or conditions:

Explain how your illness, injuries or conditions affect each of the items you checked: For example, if you checked lifting, how many pounds can you lift?

- ☐ Lifting _____
- ☐ Squatting _____
- ☐ Bending _____
- ☐ Standing _____
- ☐ Reaching _____
- ☐ Walking _____
- ☐ Sitting _____
- ☐ Kneeling _____
- ☐ Talking _____
- ☐ Hearing _____
- ☐ Stair climbing _____
- ☐ Seeing _____
- ☐ Memory _____
- ☐ Completing tasks _____
- ☐ Concentration _____
- ☐ Understanding _____
- ☐ Following instructions _____
- ☐ Using hands _____
- ☐ Getting along with others _____

Has your personal vehicle been modified to accommodate your illness, injuries or other conditions? ☐ Yes ☐ No

If, not, does it need to be? Please explain: _____

_____

Has your home been modified to accommodate your illness, injuries or other conditions? ☐ Yes ☐ No

If, not does it need to be? Please explain: _____

I am responsible for child support payments? Yes☐ No☐ If yes, to whom are payments made?

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I hereby make application for dependent children benefits as provided by the Wyoming Workers' Compensation Act for the following children. The following documentation needs to be included with the application:

- Birth Certificate for each child
- Adoption Order, if applicable

NAME	AGE	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY NUMBER

The foregoing facts are true as set forth. Any children for whom I have made application were unmarried and receiving substantially all of their financial support or court ordered support from the employee at the time of the compensable injury.

_____ _____ is the legal guardian of the employee's children

I hereby make application for Permanent Total Disability benefits as provided by the Wyoming Worker's Compensation Act.

Employee Release and Certification: I authorize the Division of Workers' Compensation to disclose and/or obtain information about my case to or from other state agencies, insurers, group health plans, third party administrators, health maintenance organizations or similar entities. The information that may be released or obtained includes: my name, my social security number, the medical services I received and the dates of those services, the amounts charged by health care providers for my medical services, and the amount of benefits paid. This information may be needed to ensure that benefit payments are not duplicated.

The information given by me herein is true and correct. I further acknowledge that misrepresentation or fraud can lead to a civil action or criminal prosecution. By filing this report, I grant the Division of Workers' Compensation full access to any records maintained by any of my health care providers. Photocopies of this authorization shall be given the same effect as the original.

I agree this release shall remain in full effect until revoked by me in writing.

Applicant/Claimant Printed Name	Applicant/Claimant Signature	Date

Please complete and return to:
Division of Workers' Compensation
5221 Yellowstone Road
Cheyenne, WY 82009

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Remarks

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