Central California Legal Services

Justice. Equity. Power.

Workers' Compensation & COVID-19 What You Need to Know

For more assistance please call our Legal Advice & Referral Line at:
1-800-675-8001

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Workers' Compensation Basics

- One event (injury) OR repeated exposure, *Some* psychological injuries.
- Benefits include: Medical Care, Disability, Supplemental Job Displacement, and Death Benefits.
- You must report the injury to your employer within 30 days.
- Benefit amounts vary.
- Employers must have measures in place to prevent injuries; training, inspections, and procedures for unsafe corrections.
- Get emergency treatment if needed, call 911!

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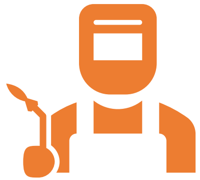
What if my employer is uninsured?

- California law requires employers to have Workers' Compensation Insurance
- Employees are still entitled to Workers' Compensation medical or other benefits
- Uninsured Employers Benefits Trust Fund
- Resources are available for assistance

  1. Local Workshops
  2. Information & Assistance office
  3. www.dwc.ca.gov

WHAT IF THE EVENT WAS MY FAULT?



Workers' Compensation is a "No-Fault" System

Aimed to balance employer and employee rights

Employer must provide benefits regardless of fault; **employee *generally* surrenders the right to sue employer.**

Workers' Compensation Claim Timeline

Injury or illness occurs at work

Immediately notify your supervisor and if emergency, call 911.

Employer gives you a claim form (DWC-1). Complete & return to supervisor.

If your employer does not give you a claim form, fill out DWC-1 or contact the Department of Industrial Relations

Your employer will complete the claim form and give a copy to you and the insurance company.

You should have access to medical care within 1 day of reporting your injury/illness. If not, contact the Department of Industrial Relations

Within 14 days, the insurance company will send you a notice regarding the status of your claim.

If your employer does not have insurance, contact an attorney for assistance.

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Legal Status

- Workers' Compensation available for everyone… **Yes, everyone!**
- Citizen, Legal Permanent Resident, Undocumented access.
- Must be an injury related to work

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- Executive Order issued by Gov. Gavin Newsom
- Changed Workers' Compensation landscape to include COVID-19
- Must have contracted COVID-19 from a work-related event
- Outlines elements to meet a COVID-19 Workers' Compensation claim
- This order sunsets 60 days from its issuance – July 5, 2020

"It is Hereby Ordered That…"

- A Workers' Compensation claim is valid for COVID-19 if…
  - Diagnosed or positively tested within 14 days of working at employment
  - On or after **March 19, 2020**
  - Place of employment is not employee's home or residence
  - The diagnosis was found by a licensed physician/surgeon and is confirmed within 30 days.

So What Else About the Order?

Full Workers' Compensation benefits still apply.

If the employee has paid sick leave specific to COVID-19, the benefits must be used **before** Workers' Compensation temporary disability benefits can begin.

No waiting period for Worker's Compensation temporary disability benefits.

How Do I Apply? What Do I Need?

Report the injury to your employer within **30 days**

Your employer may refer you to a medical professional

If you are not referred, seek medical care!

If the injury is an emergency call 911 or check-in at an ER.

Find and submit a DWC-1 form to your employer

Contact our Legal Advice and Referral Line at **1-800-675-8001** to know your rights!

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DWC-1

PRINT CLEAR

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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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.* ______ Today's Date. *Fecha de Hoy.* ______
2. Home Address. *Dirección Residencial.* ______
3. City. *Ciudad.* ______ State. *Estado.* ______ Zip. *Código Postal.* ______
4. Date of Injury. *Fecha de la lesión (accidente).* ______ Time of Injury. *Hora en que ocurrió.* ______ a.m. ______ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* ______
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* ______
7. Social Security Number. *Número de Seguro Social del Empleado.* ______
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. ______ *Correo electrónico del empleado.* ______.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* ______

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

10. Name of employer. *Nombre del empleador.* ______
11. Address. *Dirección.* ______
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ______
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ______
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* ______
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* ______
16. Insurance Policy Number. *El número de la póliza de Seguro.* ______
17. Signature of employer representative. *Firma del representante del empleador.* ______
18. Title. *Título.* ______ 19. Telephone. *Teléfono.* ______

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

Thank You For Joining Us!

If you still have questions, or need assistance legal matters, please call us. We are here to help!

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www.centralcallegal.org

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