Ohio | Bureau of Workers' Compensation

Instructions for Completing the Request for Temporary Total Compensation

This *Request for Temporary Total Compensation* (C-84) is the application you complete to request temporary total disability benefits.

You must complete the entire form and sign it. It is your responsibility to secure supporting medical documentation from your treating provider for the requested period of disability using the MEDCO-14 form or equivalent documentation. You must complete this form every time you make a request for an initial period of temporary total compensation or an extension of an existing period of temporary total compensation.

Instructions

Section	**1**	**Injured worker demographics:** BWC will use the address provided to mail all correspondence to you. A home and/or cell phone number is helpful if we need to contact you. Providing your email address allows you to communicate with your claims specialist electronically, if you choose to do so.
Section	**2**	**Disability information:** Please mark if this current period of disability is a new period of disability or an extension. If this is an application for a new period of disability, please list the last day you worked. For both new periods and requests for extensions of disability, list all providers currently treating you for this claim.
Section	**3**	**Employment information:** BWC will use this information to help facilitate your return to work and ensure proper payment.
Section	**4**	**Vocational rehabilitation information:** BWC will use this information to help facilitate your return to work.
Section	**5**	**Benefits/earnings received or requested during the period of disability:** Indicate if you have received any of the listed benefits. If you answer yes to any of the benefits on the list, provide the requested information.
Section	**6**	**Injured worker signature:** Please sign and date this form when requesting temporary total disability compensation. If you cannot sign, please mark the form and have a witness sign the form next to your mark. Signing the form means you have answered the questions truthfully and completely. It also means you are aware that you are not knowingly making a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or knowingly accepting compensation to which you are not entitled. Providing false information or concealing information to obtain compensation may subject you to felony criminal prosecution, and may be punished by a fine, imprisonment, or both.

Where do I file the C-84?

For injured workers whose employer is self-insured: If your employer is self-insured, send the form to your employer. If you are not sure if your employer is a self-insuring employer, contact your employer.

For all other injured workers: You may also complete this form online at ohiobwc.com. If you have completed a hard copy of this form, fax it to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.

Where do I find more information or assistance?

For injured workers whose employer is self-insured: Call your employer, or contact BWC's self-insured department at 1-800-OHIOBWC, and listen to the options to reach a BWC customer service representative.

For all other injured workers: Please call 1-800-OHIOBWC, or contact your BWC customer service office.

You can obtain BWC forms at ohiobwc.com, by calling 1-800-OHIOBWC and listening to the options to reach a BWC customer service representative, or at your BWC customer service office.

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Request for Temporary Total Compensation

Injured worker demographics

1

Name	Claim number		Date of injury
Address	City	State	Nine-digit ZIP code
Email address (optional)	Home phone number — —	Cell phone number — —	

Disability information

2

- Is this application requesting a new period of temporary total compensation or an extension? ☐ New ☐ Extension
- If this is a new period, what was the last date worked due to the current period of work-related disability? ____/____/____
- List all providers **currently** treating you for this work-related disability claim. _____

Employment information

3

What was your occupation at the time of the injury/disease? _____

- Do you have a job to return to? ☐ Yes ☐ No ☐ I don't know
  - o If yes, who is your employer? _____
  - o If yes, does your employer offer modified (light-duty) work? ☐ Yes ☐ No ☐ I don't know
  - o If yes, do you feel capable of performing any of your job duties at this time? ☐ Yes ☐ No
    If yes, what duties? _____

Working includes full or part-time, self-employment, income-producing hobbies, commission work, or unpaid activities that are not minimal and directly earn income for someone else.

- Are you currently working in any capacity (as defined above)? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
- Have you previously worked in any capacity (as defined above) during this requested period of disability? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
  - o If no, when was the last date you worked anywhere? ____/____/____ Reason for leaving _____
- What do you feel is preventing you from returning to work at this time? Please describe physical, employment and personal barriers.

Vocational rehabilitation information

4

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job-seeking skills or necessary retraining.

- If appropriate, would you consider participating in vocational rehabilitation? ☐ Yes ☐ No If no, why not? _____

Benefits/earnings received or requested during the period of disability

5

Type of benefit	Receiving	Beginning date of benefit
Unemployment **If yes, from which state are you receiving benefits?** _____	☐ Yes ☐ No	
Social Security retirement	☐ Yes ☐ No	
Public assistance **If yes, include case number:** _____	☐ Yes ☐ No	
Sick leave **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Wage/salary continuation **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Disability **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Earnings **(to include full or part time, self employment, income-producing hobbies or commission work)** **If yes, name of employer and job duties.** _____	☐ Yes ☐ No	

Injured worker signature

6

I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature	Date