

ERS DISABILITY PROCESS

The purpose of this informational handout is to provide you with a basic and general overview of the disability process.

1. Schedule a disability counseling appointment with a Benefits Specialist in the Office of Human Resources (OHR). The specialist will go over all of the information regarding the process and benefits associated with a disability retirement. Please note that the process takes approximately 6 months before a decision is reached based on the volume of applications for review. Complete and sign your Disability Retirement Application.
2. Compile all medical documentation for the last 5 years and forward to OMS. Please note that when OMS receives the application from OHR they will send out a letter to you requesting medical information and give you 10 days to reply. If OMS does not hear from you, they will send out a 2nd letter giving you another ten days and if no reply to that letter, OMS will send out a 3rd & final letter giving you 10 days to reply with the information requested. If additional time is needed, contact OMS for an extension of time.

Montgomery County Government
Occupational Medical Services
Attn: Sally Miller (Confidential)
255 Rockville Pike, Suite 125
Rockville, MD 20850
240-777-5118

3. If you need to inquire regarding the status of your claim, contact OMS. The Benefits Team has no information on status.
4. Once all the medical documentation is received, along with all the appropriate completed forms, OMS will prepare records for the Disability Review Panel.
5. The panel will meet within 60 days of the application date. The panel may schedule an Independent Medical Exam (IME).
6. The panel's recommendation is made within 30 days of meeting or 30 days after receipt of IME report.
7. The recommendation is then forwarded to OMS.
8. OMS forwards recommendation to County Attorney within 2 weeks for review and comments.
9. OMS forwards comments, if any, to the OHR Director.
10. OHR director forwards decision memo to CAO requesting final decision.
11. OHR notifies employee of CAO's decision, along with appeal rights. OHR will notify the employee's department of the final decision. If employee is awarded a disability retirement, then a retirement counseling appointment is scheduled to go over the benefits.
 - Please note that if you want to apply for LTD1 through The Standard, you **must** apply before you retire or terminate employment.

**Montgomery County
Application for Disability Benefits**

Name: _____ SSN: _____

Address: _____ DOB: _____

_____ Sex: _____

Phone Number: _____ (home/cell) _____ (work)

Department: _____

Supervisor Name: _____ Phone Number: _____

Current Work Status: Full Duty / Light duty / Not at Work

Other: _____ Effective Date: _____

Retirement Plan: ERS / RSP/GRIP (circle one)

Union Status: MCGEO / FOP / IAFF / Non-Union (circle one)

Do you want the union to receive a copy of this application: Yes / No (circle one)

- I hereby make application for disability benefits and certify that the information I have provided is true and correct to the best of my knowledge.
- I understand that the disability benefit, if approved, will be effective on the earlier of the date that the CAO renders a decision or the date my sick leave and compensatory leave in excess of 80 hours is exhausted. I understand that this means that I may receive a telephone call advising me that I am retired and that my employment will be terminated as of that date.
- I understand I am responsible for obtaining any medical records from my personal physician to be submitted to Occupational Medical Services (OMS) and that OMS will obtain any Workers' Compensation and OMS medical records for the Disability Medical Review Panel. Please be advised that these records will become property of the County and will not be returned to you.

Signature: _____ Date: _____

OHR completes this section:

Hire Date: _____ Job Class: _____ (name) _____ (number)

Notes: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SCOPE

This Release for Medical Information is to support the application for disability benefits submitted on _____. Unless limits* are shown below, this release pertains to all of the following records: medical, mental and dental care, drug or alcohol use, prescribed drugs, employment and insurance coverage records.

This authorization is for the release of medical records from health care providers, hospitals, pharmacists, employers, and all other agencies or organizations. This includes insurers, Blue Cross-Blue Shield and prepaid health plans, Workers' Compensation administrators and Montgomery County Occupational Medical Section. Please send to the Occupational Medical Section, Office of Human Resources, by _____
(Date)

* LIMITS: _____

AUTHORITY

I agree that the Montgomery County Government's Occupational Medical Section may see, or get a copy of, all records that pertain to _____, for the sole
(Name of Employee)

purpose of processing an application for County disability benefits. All such records will be collected for use in evaluating eligibility for disability benefits under the County's retirement laws. All records collected will be kept as retirement medical records, and will be kept separately from employee medical records.

This information is for the sole use of employees and agents of The Montgomery County Government who are engaged in the processing and evaluation of the application for disability benefits. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing.

The Montgomery County Government will not incur any liability or assume responsibility for any expense incurred in complying with this request for medical records.

REVOCATION

I can revoke this authorization by giving written notice to the Occupational Medical Section of the Office of Human Resources. The notice will not apply to information released before the date the Occupational Medical Section has the notice. If not revoked, this form will be valid while the claim is pending but not for more than one year from the date it is signed.

I agree that a photocopy of this form will be as valid as the original. Anyone signing this authorization may have a copy of it, upon request.

Signed _____ Date _____

Relationship _____ (If signed by other than the employee)

cc: Employee
Occupational Medical