

MONTGOMERY COUNTY DISABILITY PROCESS

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

1. Contact Montgomery County Employee Retirement Plans at 240-777-8230 or retirement@montgomerycountymd.gov. An Analyst will discuss all of the information regarding the process and benefits associated with your disability benefit. Please note that on average the process takes 3-6 months, but can take longer based on your specific situation, before a decision is reached. Please complete and sign the Disability Application and Authorization for Release of Medical Information Form. Please note that if you are in the RSP/GRIP we will place a hold on your Fidelity account pending your SSDI application decision.
2. Compile all medical documentation for the last 5 years and forward copies to Disability Benefits within 30 days of submitting the application. If additional time is needed, contact Disability Benefits for an extension.

Disability Benefits
Montgomery County Employee Retirement Plans
101 Monroe Street, 6th Floor
Rockville, MD 20850
240-777-0815
DisabilityBenefits@montgomerycountymd.gov

3. Once all medical documentation is received (including your personal records, the County's records and, if applicable, Workers' Compensation records), along with the applicable forms, the combined documents are sent to the Disability Review Panel for evaluation. Please be advised that the panel may schedule an Independent Medical Exam (IME) for you.
4. The panel's recommendation is made within 30 days after the panel's final discussion or 30 days after receipt of an Independent Medical Examination (IME) report.
5. The recommendation is forwarded to the Office of the County Attorney within 2 weeks for review and comments.
6. The decision memo is then sent to the Chief Administrative Officer (CAO) who determines the award.
7. MCERP notifies the applicant as well as the applicant's department of the CAO's decision, along with appeal rights. If the applicant is awarded a disability benefit, a counseling appointment is scheduled with a retirement analyst to discuss the benefits and to discuss the completion of the required forms.
8. Please contact Disability Benefits at any time regarding the status of your application.

Montgomery County
Application for Disability Benefits

Name: _____ SSN: _____

Address: _____ Date of Birth: _____

_____ Email: _____

Phone Number: _____ Alt. Phone Number: _____

Department: _____

Supervisor Name: _____ Phone Number: _____

Current Work Status: Full Duty Light Duty Not at Work Terminated/Retired

Effective Date: _____

Retirement Plan: ERS RSP GRIP (check one)

Union Status: MCGEO FOP IAFF Non-Union (check one)

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

- I hereby submit my 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 if I am still employed, I will be contacted to advise me of the decision and, that my employment will be terminated as of that date.
- I understand I am responsible for obtaining any personal medical records to be submitted to the Disability Manager. The Disability Manager will obtain Workers' Compensation and Montgomery County Occupational Medical Services records for the Disability Review Panel. Please be advised that these records will become property of the Montgomery County Employee Retirement Plans (MCERP) and will not be returned to you.

Signature: _____ Date: _____

Print Name: _____

MCERP completes this section

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

Is this an Administrative Application? _____ If yes, attach all documentation provided by the department.

Hold placed on RSP/GRIP account: _____ If yes, attach confirmation.

Notes: _____

MONTGOMERY COUNTY
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SCOPE

This Release for Medical Information is to support the application for disability benefits submitted on _____. This release pertains to all of the following records: Medical, mental health, 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 any health care providers, Workers' Compensation administrators and Montgomery County Occupational Medical Services. Please send to the Montgomery County Employee Retirement Plans (MCERP) within two weeks of submitting the application.

AUTHORITY

I agree that MCERP may see, or obtain a copy of, all records that pertain to

_____, for the sole purpose of processing an application
(Name of Applicant)

for County disability benefits. All such records will be collected for use in evaluating eligibility for disability benefits under the Montgomery County Code. All records collected will be kept as disability benefit medical records, and will be kept separately from employee medical records by the County.

This information is for the sole use of employees and agents of MCERP 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.

MCERP will not incur any liability or assume responsibility for any expenses incurred in complying with this request for medical records.

REVOCATION

I can revoke this authorization by giving written notice to MCERP. The notice will not apply to information released before the date MCERP 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. Upon request, anyone signing this authorization may have a copy of it.

Signature: _____ Date: _____

Printed Name/Relationship _____ (If signed by other than the applicant)

cc: Applicant