



CLAIM # _____

Carrier's Claim No. _____

APPLICATION FOR SUPPLEMENTAL INCOME BENEFITS

To Employee: You must file an *Application for Supplemental Income Benefits* for a determination to be made on whether you are entitled to receive supplemental income benefits. You may file the form by first class mail, personal delivery or facsimile. Only for the first quarter, return this form to the Division's local office handling your claim. For all subsequent quarters, return the form to the insurance carrier 14 days before the beginning of the quarter for which you are applying for benefits. For the qualifying period (see dates in Step Two, Block 4 below), you must provide documentation that you earned less than 80% of your average weekly wage as a direct result of your impairment from the compensable injury. You must attach copies of supporting payroll documentation (paycheck stubs, employer statement(s) or other valid documentation) of your wages for the qualifying period. If you are not working, you must in good faith look for a job that matches your ability to work in **every week** of the qualifying period.

STEP ONE: EMPLOYEE INFORMATION

1. Employee's Name (Last, First, M.I.)		2. Mailing Address (Street or P.O. Box)		
3. Telephone Number ()	4. Social Security Number	City	State	ZIP Code
5. Date of Injury	6. Impairment Rating	7. Date of Maximum Medical Improvement		
8. Employer's Business Name on Date of Injury		9. Current Treating Doctor's Name and Telephone Number ()		
10. Insurance Carrier's Name		11. Adjuster's Name and Telephone Number ()		

STEP TWO: REQUIRED GENERAL INFORMATION

This form must be filed no later than the filing deadline shown in Block 2 below. Late filing will delay any possible payments and may result in a reduced payment. If the form is received by the insurance carrier earlier than 20 days before a subsequent quarter begins, it will be returned to you to resubmit no later than 7 days before and no earlier than 20 days before the beginning of the quarter (Block 3 below). Read all questions and instructions carefully.

1. Quarter Number:	2. Filing Deadline:
3. Dates of Quarter: Beginning: Ending:	4. Dates of Qualifying Period: Beginning: Ending:
5. Did you earn any wages or have any job offers during the qualifying period shown in Block 4? Yes _____ No _____ If yes, you must complete Step Three (page 2) and attach documentation.	
6. If you are not currently working, are you able to work in any type of job in any capacity? Yes _____ No _____ If yes, you must look for work that matches your ability to work every week of the qualifying period (dates in Block 4) and document your job search in Step Four (pages 2 and 3). If no, see Block 8 below.	
7. Are you enrolled in, and satisfactorily participating in, a full-time vocational rehabilitation program sponsored by the Department of Assistive and Rehabilitative Services or a private provider that is included in the Registry of Private Provider of Vocational Rehabilitation Services? Yes _____ No _____ If yes, this may be considered a good faith effort to find a job that matches your ability to work. Please attach documentation to show your participation and progress in the program. For example, this may be a letter from your TRC counselor or instructors and a copy of your college registration or grades (if applicable).	
8. Has your doctor documented that you cannot do any type of work in any capacity? Yes _____ No _____ If yes, you must attach a current medical report from your doctor that specifically explains how the injury prevents you from doing any type of work. There can be no other records showing that you are able to return to work.	

The information I have provided on this *Application for Supplemental Income Benefits* is true. I understand that if I intentionally provide false information to obtain benefits, I can be charged with an administrative or criminal penalty.

Employee's Signature	Date
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NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.



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Employee's Name _____
 Social Security No. _____ Date of Injury _____

STEP THREE: WAGES DURING QUALIFYING PERIOD (see STEP TWO, BLOCK 4 for dates)

The qualifying period is a 13-week period in which your wages are reviewed to determine whether you are entitled to receive supplemental income benefits. If you are able to work in **any** capacity and are employed, you must report your earned wages by attaching a copy of paycheck stubs, employer statement(s) or other documentation for this qualifying period. If you have **any** offers of employment which you do not accept, you must include information about the offered wages as part of this application. If you are self-employed, show your gross weekly wages as the total amount of income received from self-employment. You also should attach additional information on the normal and fixed expenses of the business. If no wages were earned during a specific week, write "none."

IMPORTANT: If you earned less than 80% of your average weekly wage, were your reduced earnings a direct result of the impairment from the compensable injury? Yes ___ No ___

Week Ending	Gross Wages Earned	Week Ending	Gross Wages Earned
1.	\$	8.	\$
2.	\$	9.	\$
3.	\$	10.	\$
4.	\$	11.	\$
5.	\$	12.	\$
6.	\$	13.	\$
7.	\$		

STEP FOUR: JOB SEARCH EFFORTS DURING QUALIFYING PERIOD (Continued on Page 3)

If you have not returned to work and you are able to work in **any** capacity, you must look for a job to match your ability to work during **every week** of the qualifying period (see dates in Step Two, Block 4 on page 1). You must carefully and completely document your job search efforts. You must keep the kind of information shown below. **If necessary, attach additional pages with this same information to keep track of all your job search efforts.** It is recommended that you keep a copy of all job applications or resumes you turn in to companies during each qualifying period to support your search efforts. If you do not keep complete records, you may not be given credit for the searches. Job search documentation is not the only information that will be considered to determine your entitlement to Supplemental Income Benefits. Consideration also will be given to the number of jobs applied for during the qualifying period, the type of jobs you looked for, your education and work experience, amount of time you spent looking for jobs, any job search plan you developed, registration with the Texas Workforce Commission, any potential barriers to successful job searches and other relevant factors. In each quarter that you apply for these benefits, you must show that you searched for jobs in good faith throughout the qualifying period if you were able to work but remained unemployed.

MONTH DAY YEAR	EMPLOYER NAME AND ADDRESS	HOW CONTACTED	PERSON CONTACTED AND PHONE NUMBER	JOB APPLIED FOR	RESULTS	APPLI- CATION OR RESUME FILED
1.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO



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Social Security No. _____ Date of Injury _____

STEP FOUR: JOB SEARCH EFFORTS DURING QUALIFYING PERIOD (Continued from Page 2)

If necessary, attach additional pages with this same information to complete the record keeping responsibility you have for your job search efforts. Remember to keep copies of any applications or resumes which document your efforts to find a job. If you do not keep complete accurate records, you may not be given credit for the searches. (Make certain that you sign this *Application for Supplemental Income Benefits* on page 1.)

MONTH DAY YEAR	EMPLOYER NAME AND ADDRESS	HOW CONTACTED	PERSON CONTACTED AND PHONE NUMBER	JOB APPLIED FOR	RESULTS	APPLI- CATION OR RESUME FILED
7.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
9.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
10.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
11.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
12.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
13.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
14.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
15.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
16.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
17.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
18.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
19.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO
20.		<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE <input type="checkbox"/> MAIL or FAX			<input type="checkbox"/> NOT HIRING <input type="checkbox"/> PENDING <input type="checkbox"/> OFFER	<input type="checkbox"/> YES <input type="checkbox"/> NO



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Employee's Name _____
 Social Security No. _____ Date of Injury _____

STEP FIVE: NOTICE OF ENTITLEMENT OR NON-ENTITLEMENT

NOTICE OF ENTITLEMENT OR NON-ENTITLEMENT
 Quarter No. _____ Beginning Date _____ Ending Date _____
 To Be Completed By Division For First Quarter And By Insurance Carrier For Subsequent Quarters

Employee Entitled to Supplemental Income Benefits Monthly Payments for 3 Months \$ _____

Employee Not Entitled to Supplemental Income Reason for Non-entitlement: _____

Signature of Reviewing Authority _____ Date _____

Printed Name of Reviewing Authority _____

Title _____ Telephone Number () _____

INFORMATION FOR DISPUTING ENTITLEMENT OR AMOUNT OF SUPPLEMENTAL INCOME BENEFITS:

To Employee

- To dispute non-entitlement to supplemental income benefits or the monthly amount to be paid in any quarter, you must have facts, such as your detailed job search record or a current medical report supporting your disability, or a legal basis.
- To dispute the determination by the Division or the insurance carrier, you must request a benefit review conference by contacting the local office handling your claim or call (800) 252-7031.

To Insurance Carrier

- To dispute the first quarter, request a benefit review conference within 10 days after receiving notice from the Division.
- To dispute entitlement to a subsequent quarter when payment has been made in the previous quarter, request a benefit review conference within 10 days after receiving the employee's *Application for Supplemental Income Benefits*.
- To dispute entitlement to a subsequent quarter without prior payment in the previous quarter, send the notice of non-entitlement to the employee within 10 days of the date the form was filed with the insurance carrier. Include the reason(s) for finding non-entitlement and give instructions to the employee about how to dispute the insurance carrier's determination.

CALCULATION OF SUPPLEMENTAL INCOME BENEFITS

To Be Completed By Division Or Insurance Carrier To Show Wages Used To Calculate Monthly Payments

1.	\$ _____ (Average Weekly Wage)	X	80%	=	\$ _____ (Transfer to Line 4A)
2.	\$ _____ (Earned Wages)	+	\$ _____ (Offered Wages)	=	\$ _____ (Transfer to Line 3A)
3.	\$ _____ (3A - Total Wages)	÷	13	=	\$ _____ (Transfer to Line 4B)
4.	\$ _____ (4A)	-	\$ _____ (4B)	=	\$ _____ (Transfer to Line 5A)
5.	\$ _____ (5A)	X	80%	=	\$ _____ (Transfer to Line 6A)
6.	\$ _____ (6A)	X	4.34821	=	\$ _____ (Monthly Payment)
If Contribution: (% _____)					
7.	\$ _____ (Monthly Payment)	X	_____ % (% of Reduction)	=	\$ _____ (Transfer to Line 8B)
8.	\$ _____ (Monthly Payment)	-	\$ _____ (8B - Contribution Reduction)	=	\$ _____ (Reduced Monthly Payment)

