Texas Department Of Insurance
Division of Workers' Compensation
Policy Implementation & Outreach, MS-29
7551 Metro Center Dr. Ste.100
Austin, TX 78744-1609
(512) 804-5000 (512) 804-4121 fax www.tdi.state.tx.us

DWC Claim#

Carrier Claim#

<- Send completed form to TDI-DWC at this address.

RETURN-TO-WORK PILOT PROGRAM FOR SMALL EMPLOYERS – DWC Form-008

Check one: ☐ **PREAUTHORIZATION PROPOSAL PLAN** ☐ **APPLICATION FOR REIMBURSEMENT**

I. EMPLOYER ELIGIBILITY

1. Number of company's employees during the preceding calendar year: Lowest Number Employed ______ Highest Number Employed ______

2. On the date of employee's injury this company had workers' compensation insurance coverage from the following insurance carrier

II. EMPLOYER INFORMATION

3. Company Name		**4. Federal Tax ID or Social Security Number**
5. Mailing Address (Street or PO Box, City State Zip)		
6. Employer Contact Name		**7. Title**
8. Contact's Phone #	**9. Fax**	**10. Email Address**

III. INJURED EMPLOYEE INFORMATION

11. Injured Employee's Name (First, MI, Last, Suffix)		**12. Social Security Number** (last four digits)
13. Address (Street or PO Box, City State Zip)		
14. Phone Number	**15. Employee's Date of Injury**	**16. Date of Return to Work**

IV. RETURN-TO-WORK MODIFIED OR ALTERNATE DUTIES

17. Describe the employee's post-injury job.

V. RETURN-TO-WORK WORKPLACE MODIFICATION INFORMATION

18. Describe in detail the workplace modifications/purchases (physical modifications, equipment, devices, furniture, tools, etc.), this company will/has provide(d) in order to return this employee to work. Include sketches, diagrams, or other information that describe the modification. Attach additional documents to this form, if necessary

VI. ITEMIZED LIST OF PROPOSED/ ACTUAL WORKPLACE MODIFICATIONS

19. In the space below or in an attachment, itemize each of the proposed/actual costs of any of the following that your company will/has provide(d) to facilitate the injured employee's return to work.

(1) **Physical Modifications** to the workplace or employee's workstation.
(2) **Equipment, Devices, Furniture, or Tools** to enable the employee to perform modified or alternate duties.
(3) **Other Costs** necessary to reasonably facilitate the employee's capabilities and doctor-identified restrictions.

Itemized List of Proposed/Actual Modifications or Other Costs	Estimated/Actual Cost
20. TOTAL ESTIMATED/ACTUAL COST OF MODIFICATIONS	
21. REIMBURSEMENT REQUESTED	

The maximum amount that a single employer may be reimbursed is $ 2,500 annually.

VII. EMPLOYER CERTIFICATION

NOTE: An employer who willfully applies for or receives reimbursement from the Texas Department of Insurance, Division of Workers' Compensation under the Return-to-Work Pilot Program for Small Employers knowing that the employer is not an eligible employer commits a violation of the Texas Workers' Compensation Act.

I hereby certify the following:

A. Preauthorization Proposal Plan

(1) The workplace modifications described in this proposal will be placed in service to facilitate the injured employee's return to work.
(2) This company will be able to sustain or continue the employment of the injured employee as a result of the above referenced proposed workplace modifications, modified duty, and/or alternate duty assignments.
(3) All information provided in this proposal is correct.

B. Reimbursement Request

(1) The workplace modifications described in this request were placed in service to facilitate the injured employee's return to work.
(2) This company will be able to sustain or continue the employment of the injured employee as a result of the above referenced workplace modifications, modified duty, and/or alternate duty assignments.
(3) All information provided in this proposal is correct.

I hereby authorize the Texas Department of Insurance, Division of Workers' Compensation to verify all information contained in this proposal / application.

22. Signature of Authorized Company Representative ____ **23. Date** ______

24. Printed Name of Authorized Company Representative ______

25. Title of Company Representative

VIII. DWC APPROVAL / DISAPPROVAL (For DWC use only)

☐ Approved	Signature	
☐ Disapproved	Printed Name	Date

Completing the Preauthorization Proposal Plan / Application for Reimbursement (DWC Form-008)

WHO MAY USE THIS FORM?

Small employers in Texas may be eligible for reimbursement under the Return-to-Work Pilot Program for Small Employers for the cost(s) of providing workplace modification(s) to facilitate an injured employee's return to modified or alternative work following an injury. Complete details regarding the Return-to-Work Pilot Program for Small Employers may be found at the following website: http://www.tdi.state.tx.us/wc/rtw/index.html.

An employer in Texas is eligible to apply for reimbursement under the Return-to-Work Pilot Program for Small Employers if:

(a) the employer employs at least two but not more than 50 employees on each business day of the preceding calendar year; and
(b) the employer has workers' compensation insurance coverage in Texas.

Agencies of the State of Texas and political subdivisions of the state are not eligible employers

ARE ANY OF THE FIELDS OPTIONAL?

No, provide all requested information. This will avoid any delays in processing the proposal / application. An incomplete proposal / application may result in the proposal / application being returned for additional information or being rejected as incomplete. Print legibly or type all information. Check whether the form is for a "Preauthorization Proposal Plan" or an "Application for Reimbursement."

WHERE DO I SEND THE COMPLETED FORM?

File this proposal / application, including the form DWC form-073 Work Status Report and any related photographs, drawings, diagrams, and any other supporting information by any of these methods:

Mail: Texas Department of Insurance
Division of Workers' Compensation
Policy Implementation & Outreach, MS-29
7551 Metro Center Dr., Suite 100
Austin, Texas 78744-1609

Delivery: A list of TDI-DWC locations is available at www.tdi.state.tx.us/wc/dwccontacts.html#offices

Fax: 512-804-4682

E-Mail: rtw.services@tdi.state.tx.us

QUESTIONS? Please contact Policy Implementation and Outreach at 512-804-5000 or E-Mail: rtw.services@tdi.state.tx.us

HELP WITH SPECIFIC SECTIONS AND FIELDS:

Field	Instructions
Claim Numbers	If known, provide the DWC claim number assigned to the injured employee's claim by the Texas Department of Insurance, Division of Workers' Compensation and the claim number assigned to the injured employee's claim by the insurance carrier providing workers' compensation coverage in effect at the time of the employee's injury.
I. Employer Eligibility	The employer must provide general eligibility information to participate in the Return-to-Work Pilot Program for Small Employers.
1. Number of Employees	Indicate in the spaces provided the lowest and highest number of employees that are employed by your company on each business day during the preceding calendar year (January 1 through December 31).
2. Workers' Compensation Insurance Coverage	Indicate the name of the insurance company that provided workers' compensation insurance coverage at the time your employee was injured.
II. Employer Information	Provide the company's name, complete mailing address, and federal employer identification number (FEIN). The social security number of the principal owner of the company may be provided in lieu of a FEIN. Provide the name, title, and contact information of the employer's designated contact for purposes of participation in the Return-to-Work Pilot Program for Small Employers.
III. Injured Employee Information	Provide the full name, social security number (last four digits only), complete mailing address, and telephone number of the employee who was injured and for whom reimbursement is requested.
17. Description of Proposed / Performed Post-Injury Return-to-Work Job Duty	Describe the injured employee's modified job duties or alternate job duties that are proposed to be assigned or have been assigned upon the employee's return to work following the injury. An additional page may be provided if necessary. Alternatively, a job description may be attached to this form.
18. Workplace Modification Information	Describe in detail the workplace modifications/purchases (physical modifications, equipment, devices, furniture, tools, etc.), your company will/has provide(d) in order to return the employee to work. A workplace modification includes any physical modification to the work environment or any special equipment, device, furniture, or tool that will be necessary to facilitate any doctor-identified restrictions. Include with your proposal / application any sketches, diagrams, or other information that describes the modification. Additional documentation/pages may be attached to this form, as necessary.
19. Itemized List of Workplace Modifications and Costs	Provide a complete itemized list that includes the associated costs of any proposed or provided physical modification, equipment, furniture, tool, device, or other cost that is necessary to reasonably facilitate the injured employee's return to work. Additional documentation/pages may be attached to this form, as necessary.
20. Total Costs of Workplace Modifications	Provide a total of all proposed costs or expenditures made by your company that are (were) necessary to return the injured employee back to work.
21. Amount of Request for Reimbursement	Specify the amount your company is requesting to be reimbursed for completed or proposed workplace modifications or other costs. Note: The maximum amount an eligible employer may be reimbursed is $ 2,500 annually.
22. Employer Signature and Certification	The employer must sign and date the proposal / application form. The signature by an authorized company representative is a certification that the workplace modifications and other costs described in the proposal / application will be or have been provided and placed in service. The signature also authorizes the Texas Department of Insurance, Division of Workers' Compensation to verify all information provided on the proposal / application.