

Compensation for Accidental Injury

January 18, 2000

1. PURPOSE

The purpose of this directive is to provide information and instructions for submission of claims for compensation for accidental injury sustained by duly enrolled emergency management volunteers.

2. APPLICABILITY AND SCOPE

All duly enrolled emergency management volunteers who are not eligible to receive benefits under the Workmen's Compensation Laws shall be entitled, except during a state of war or period of armed conflict within the continental limits of the United States, to receive compensation benefits for accidental injuries or death sustained while actually engaged in emergency management activities and services or in or enroute to and from emergency management tests, drills, exercises or operations authorized by the Pennsylvania Emergency Management Agency.

AUTHORITY

Emergency Management Services Code (35 Pa. C.S. Section 7701 – 7707)

3. OTHER INFORMATION

- a. Enclosure 1 provides general information and instructions.
- b. Enclosure 2, Form PEMA-CC-1, is a copy of the compensation claim form.
- c. Emergency Management Directive No. ____ provides important information regarding the procedures to be followed for the official enrollment of emergency management volunteers.
- d. Emergency Management Directive No. ____ provides important information regarding the completion and filing of Training Authorization Request Forms.

4. RESCISSION

This Directive rescinds Pennsylvania Emergency Management Agency Circular dated March 10, 1981, entitled "Payment of Compensation of Accidental Injury Sustained by Duly Enrolled Emergency Management Volunteers."

David L. Smith
Director

Enclosure 1 - General Information and Instruction
Enclosure 2 - Compensation Claim Form (Form PEMA-CC-1)

Distribution: County and Local Emergency Management Offices
PEMA Area Directors
PEMA Bureau Directors

**PENNSYLVANIA EMERGENCY MANAGEMENT AGENCY
HARRISBURG, PENNSYLVANIA**

GENERAL INFORMATION AND INSTRUCTIONS

**CLAIMS FOR COMPENSATION FOR ACCIDENTAL INJURIES SUSTAINED BY DULY
ENROLLED EMERGENCY MANAGEMENT VOLUNTEERS**

PART I – GENERAL INFORMATION

- A. Section 7706 of the Emergency Management Service Code (35 Pa. C. S. 7101 et seq.) provides for the payment of benefits to emergency management volunteers accidentally injured or killed while performing emergency management services or activities. The amounts of these benefits are as follows:
1. A sum of twenty thousand dollars (\$20,000) for accidental injury directly causing or leading to death.
 2. A sum not exceeding fifteen thousand dollars (\$15,000) or reimbursement for medical and hospital expenses associated with accidental injury.
 3. Weekly payments of two hundred (\$200), not to exceed six months in duration, beginning on the eighth day of disability directly arising from accidental injury rendering the individual totally incapable of his/her normal gainful pursuits.
- B. The principal legal restrictions governing payment of the benefits mentioned in Paragraph A above, are:
1. Payments may only be made to those individuals who, at the time of the injury, are duly enrolled in county or local emergency management organizations; in other words, to individuals whose names have been entered on Official Enrollment Lists and who have been issued official emergency management identification cards, and
 2. Individuals who are not eligible to receive benefits under the Workmen's Compensation Laws. Those individuals shall be entitled, except during a state of war or period of armed conflict within the continental limits of the United States, to benefits for injuries sustained while actually engaged in emergency management activities and services or in or enroute to and from emergency management tests, drills, exercises or operations authorized by the Pennsylvania Emergency Management Agency in accordance with Management Directive No. _____, Training and Test Authorization Requests.
- C. Benefits for accidental injuries suffered by duly enrolled emergency management volunteers are paid by the Pennsylvania Emergency Management Agency on the basis of claims submitted in the manner outlined in Part II, below. Payments are made direct to the claimants, following case investigations by representatives of the Department of Labor and Industry and/or the Pennsylvania Emergency Management Agency.

PART II – INSTRUCTIONS FOR SUBMISSION OF CLAIMS

- A. All claims for compensation made under the provisions of Section 7706 of the Emergency Management Services Code, must be submitted on Form PEMA-CC-1, entitled “Compensation Claim – Accidental Injury Sustained by Duly Enrolled Emergency Management Volunteer.”
- B. Claim forms must be submitted in triplicate. The original form is submitted to the Pennsylvania Emergency Management Agency; the second is for retention by the claimant for reference and file; and the third is for preliminary draft, or “working” purposes. Copies of the form may be obtained through the appropriate PEMA Regional Office.
- C. If physically able to do so, an emergency management volunteer who is injured while engaged in an emergency management activity or service must personally complete Form PEMA-CC-1 and formally swear to the facts set forth therein. If the injured emergency management volunteer should die, or is otherwise unable to personally file a claim for compensation, the coordinator of that emergency management organization, in which the injured individual was duly enrolled, shall be responsible for the completion and formal filing of Form PEMA-CC-1.
- D. Detailed instructions for completion of Form PEMA-CC-1 are as follows:
1. Individuals preparing compensation claims should seek information from local emergency management officials, doctors, hospitals and other individuals and organizations having knowledge of the case.
 2. All information contained on the original claim form must be either typewritten, or legibly printed with pen and ink.
 3. Paragraph 1 of Form PEMA-CC-1: Enter in the first blank, the full name of the emergency management organization. The requested enrollment number is that number that appears on the claimant’s official emergency management identification card and on the official enrollment list of the county in which the claimant was enrolled.
 4. Paragraph 4 of Form PEMA-CC-1: In the first blank, briefly describe the accident location. In describing the manner of the accident, be specific as to exactly what the claimant was doing at the time of injury and exactly how the injury was sustained. For example, “During county-wide emergency management test, the claimant was directing traffic at Market Square. An approaching motorist lost control of his vehicle on an icy street and the vehicle struck the claimant, who was unable to reach a point of safety because of presence of the other vehicles.” Similarly, “During authorized rescue training class, the claimant was climbing a ladder. A rung of the ladder broke and the claimant fell to the ground.”
 5. Paragraph 5 of Form PEMA-CC-1: Briefly describe the specific nature and location of the injury, i.e., “Slight brain concussion, compound fracture of upper right arm and serious bruising and abrasion of left shoulder”. (If treatment of the injury

required the services of a doctor, the doctor would be the best source for this particular information.)

6. Paragraph 8 of Form PEMA-CC-1: Under Hospital Expenses, fill in the blank in part (c) only if claimant has been discharged from the hospital and a final bill has been received. Under “Medical Expenses”, fill in parts (d) and (3) only if the claimant is NO LONGER under the care of a doctor. Similarly, fill in parts (f) and (g) only if the claimant is STILL under the care of a doctor or doctors.
 7. Paragraph 10 of Form PEMA-CC-1: In the blank, fully describe the claimant’s full time employment. Also state the name and address of the employer.
 8. In the “Verification” portion of Form PEMA-CC-1 (page 7): Part (A) or (B) must be signed with pen and ink by either the claimant or by the emergency management coordinator, acting on behalf of the claimant.
- E. The original copy of the Compensation Claim form (Form PEMA-CC-1) must be sworn to before a notary public or other person legally authorized to administer oaths, who shall affix his/her signature and seal to the claim form.
- F. Following completion of notarization, the original copy, together with one copy of all pertinent bills and other required attachments, must be mailed directly to: Pennsylvania Emergency Management Agency, Attention: Chief Counsel, 2605 Interstate Drive, Harrisburg, Pennsylvania 17110-9364
- G. Claimants will be notified of action taken on their respective claims following completion of required case investigations by representatives of the Department of Labor and Industry and/or the Pennsylvania Emergency Management Agency.

COMPENSATION CLAIM

**ACCIDENTAL INJURY SUSTAINED BY DULY ENROLLED
EMERGENCY MANAGEMENT VOLUNTEER**

(See Enclosure 1, "General Information and Instructions")

Under the provisions of Section 7706 of the Emergency Management Services Code, I, the undersigned, do hereby formally make claim, to the Pennsylvania Emergency Management Agency, for legally permissible compensation for accidental injury suffered in the performance of official duties as a duly enrolled emergency management volunteer. In submission of this claim, I do solemnly swear:

1. That, prior to the time of the accident and injury described in Paragraphs 4 and 5, below, the claimant was duly enrolled as a member of the (full name of emergency management organization _____, in (name of county) _____ county, Pennsylvania, Enrollment Number (as listed on official emergency management identification card) _____, assigned for duty with the (name of service) _____ Service.
2. That the name of the duly appointed coordinator of the organization named in Paragraph 1 is (name) _____, whose address is (street or R. D. name and number) _____, (name of city or town) _____, Pennsylvania, and whose telephone number is (area code and number) _____.
3. That the claimant is not eligible, insofar as the accident and injury described in Paragraphs 4 and 5 below is concerned, to receive benefits under the State Workmen's Compensation Laws. Also, claimant declares that a claim for compensation under the State Workmen's Compensation Laws has not been, and will not be, made by the claimant or his or her heirs or estate.
4. That the accident resulting in claimant's injury or injuries described in paragraph 5 occurred at or near (geographical location) _____, in (name of city, borough, town or township) _____, Pennsylvania, at or about (approximate hour, A.M. or P.M.) _____ on

(month/day/year) _____, and in the following manner, namely:
(describe briefly)

Check this block if additional space is required to complete accident description beginning above. Continue description on separate sheet, sign sheet at bottom and attach the continuation sheet hereto.

5. That the accident described in Paragraph 4 directly resulted in the following bodily injury or injuries to the claimant: (indicate nature and location)

6. That at the time of the accident and injury described in Paragraphs 4 and 5, above, the claimant was officially engaged in emergency management activities and services (check appropriate block) training, tests, drills, exercises, or operations, which were authorized by the Pennsylvania Emergency Management Agency and were carried out under the immediate direction of (name of individual) _____, whose emergency management title is (full title) _____.

7. That the accident described in Paragraph 4, above, (check appropriate block) was, was not, observed by one, or more known witnesses, whose name(s) and address(es), are:

- (a) Name (in full) _____
Street or R.D. name or number _____
City or town _____, Pennsylvania
(zip) _____

(b) Name (in full) _____
Street or R.D. name or number _____
City or town _____, Pennsylvania
(zip) _____

8. That as a result of injury or injuries described in paragraph 5 above, the claimant has paid or is directly responsible for payment of the following hospital and/or medical expenses:

Hospital Expenses: Check this block if treatment required hospitalization. Also check all appropriate blocks and fill in all pertinent blanks immediately below.

(a) The Claimant entered the (name of hospital _____, located at (street and Number) _____, Pennsylvania _____ on (month/day/year) _____.

(b) The Claimant was (Check appropriate block and fill in pertinent date):

Was discharged from the hospital named above on (month/day/year) _____.

Is still a patient in the hospital named above and expects to be discharged on or about (month/day/year) _____.

(c) The total bill covering the period of hospitalization indicated above was (if discharged, enter amount of bill) \$ _____, and a copy of the itemized bill is hereto attached.

(SPECIAL NOTE: If still hospitalized, the claimant subsequently will be required to furnish either the Pennsylvania Emergency Management Agency, and/or the case investigator, a copy of the final, itemized bill for hospitalization.)

Medical Expenses: Check this block if treatment required the services of a doctor or doctors. Also check all appropriate blocks and fill in all pertinent blanks immediately below.

(d) The claimant was under the care of (doctor's name) _____, whose office address is (street and number) _____

(name of city or town) _____,
Pennsylvania (zip) _____ from the time of first treatment, or
examination on (month/day/year) _____, until the time of last
treatment, or examination, on (month/day/year) _____. The
total amount of the bill for the professional services rendered by this
doctor was (amount) \$ _____, and a copy of the itemized
bill is hereto attached.

(e) The claimant was also (if treated by more than one doctor) under the care
of (doctor's name) _____, whose office address is (street
and number) _____,
(name of city or town) _____,
Pennsylvania (zip) _____ from the time of first treatment, or
examination on (month/day/year) _____, until the time of last
treatment, or examination, on (month/day/year) _____. The
total amount of the bill for the professional services rendered by this
doctor was (amount) \$ _____, and a copy of the itemized
bill is hereto attached.

(f) The claimant is (if still under doctor's care) under the care of (doctor's
name) _____, whose office address is (street and number)
_____,
(name of city or town) _____,
Pennsylvania (zip) _____ from the time of first treatment, or
examination on (month/day/year) _____, until the time of last
treatment, or examination, on (month/day/year) _____. It is
now believed that the claimant necessarily will have to remain under
his/her care for approximately (number) ____ additional weeks.

(g) The claimant is also (if still under more than one doctor's care) under the
care of (doctor's name) _____, whose office address is
(street and number)

_____,
(name of city or town) _____,
Pennsylvania (zip) _____ from the time of first treatment, or
examination on (month/day/year) _____, until the time of last
treatment, or examination, on (month/day/year) _____. It is
now believed that the claimant necessarily will have to remain under
his/her care for approximately (number) ____ additional weeks.

(SPECIAL NOTE: If still under the care of a doctor or doctors, the claimant subsequently will be required to furnish the Pennsylvania Emergency Management Agency, and/or the case investigator, a copy of the final, itemized bill or bills covering such professional services.)

Other Medical Expenses: Check this block if treatment involved medical expenses other than those summarized immediately above and itemize immediately below.

(h) Item No. 1 Paid for (item or service) _____
Paid to (agency or individual) _____
Total cost (amount) \$ _____

Item No. 2 Paid for (item or service) _____
Paid to (agency or individual) _____
Total cost (amount) \$ _____

Item No. 3 Paid for (item or service) _____
Paid to (agency or individual) _____
Total cost (amount) \$ _____

Itemized bills covering all obligations listed above are hereto attached.

Check this block if additional space is required to list other similar expenses, continue listing on separate sheet, sign sheet at bottom and attach hereto both the continuation sheet and itemized bills covering all items listed on the sheet.

9. That, directly and solely as a result of the injury described in Paragraph 5 above, the claimant (check appropriate block) was, was not, rendered totally

incapable of performing his/her, normal employment, which is (state full and exact nature of employment or other pursuit)

The period of the claimant's total disability (if so incapacitated) began on (month/day/year) _____ and ended on (month/day/year) _____, when the claimant resumed employment on a full or part-time basis.

Check this block if still totally incapacitated and leave the last blank empty.

Claim submitted by, or for and on behalf of: (full name of individual who suffered the injury described in paragraph 5 above) _____, herein referred to as the claimant, whose address (as listed on the injured individual's official emergency management identification card) is (street or R. D. name and number) _____, (city or town) _____, Pennsylvania (zip) _____.

Claimant's Signature and Notarization

Claim filed by: (complete only (a) or (b) immediately below, as appropriate)

- (a) If physically able to personally file claim, the above named claimant must check this block and sign as follows:

(Claimant's signature)

(Date)

- (b) If the above named claimant is deceased, or otherwise physically unable to personally file this claim, the emergency management coordinator named in Paragraph 2 above, acting for and on behalf of the claimant, must check this block and sign as follows:

(Coordinator's signature)

(Date)

NOTARIZATION:

Sworn and subscribed before me this

_____ day of _____

in the year _____.

Signature _____

(SEAL)

RECORD: PENNSYLVANIA EMERGENCY MANAGEMENT AGENCY

Claim No. _____ Name _____

Address _____

Complete and final

Possible supplement

Allowances: Death \$ _____ Hosipital \$ _____ Medical \$ _____

Other Medical \$ _____ Disability (____ wks.) \$ _____ Total \$ _____

Disallowance's:

Action: _____

Signed: _____

Director, Pennsylvania Emergency
Management Agency

Date