TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Complete if known:

DWC Claim #

Carrier Claim #

Send completed form to the address above or fax to 512-804-4682

Return-to-Work Reimbursement Program for Employers

Application for (check one): ☐ **PREAUTHORIZATION** ☐ **REIMBURSEMENT** ☐ **ADVANCE**

I. INJURED EMPLOYEE INFORMATION

1. Injured Employee's Name (First, Middle, Last)		2. Social Security Number (last four digits) xxx-xx-
3. Address (Street or PO Box, City State Zip)		
4. Phone Number	5. Employee's Date of Injury	6. Actual/Expected Date of Return to Work

II. EMPLOYER INFORMATION

7. Company Name		8. Federal Tax ID or Social Security Number
9. Mailing Address (Street or PO Box, City State Zip)		
10. Employer Contact Name		11. Title
12. Contact's Phone #	13. Fax	14. E-mail Address

III. EMPLOYER ELIGIBILITY

15. Number of employees during the preceding calendar year: Lowest Number of Employees	Highest Number of Employees
16. Workers' compensation insurance coverage: Current Carrier	Carrier on the date of injury, if different

IV. RETURN-TO-WORK MODIFIED OR ALTERNATE DUTIES

17. Describe the employee's post-injury job or attach job description. Explain how the proposed modifications will facilitate the employee's return to work. In addition, a copy of the Work Status Report (DWC073) must be attached.

V. ITEMIZED LIST OF ESTIMATED/ACTUAL COST OF PROPOSED WORKPLACE MODIFICATIONS

18. In the space below or in an attachment, itemize each of the estimated/actual costs of any of the following that your company will/has provide(d) to facilitate the injured employee's return to work. If necessary to describe the modification, attach sketches, diagrams, or other information.

(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 accommodate the employee's capabilities and doctor-identified restrictions.

Itemized List of Proposed/Actual Modifications	Estimated/Actual Cost
19. TOTAL ESTIMATED/ACTUAL COST OF MODIFICATIONS	
20. AMOUNT REQUESTED	

- Documentation of all expenses, including receipts, must be provided to the Division with this application.
- Disbursements are contingent upon the availability of funds and approval by the Texas Comptroller of Public Accounts.
- The maximum disbursement a single employer may receive is $ 5,000 annually.

VI. EMPLOYER CERTIFICATION

I hereby certify the following:

(1) The injured employee returned to work or will return to work in a modified or alternate duty capacity as a result of the workplace modifications.
(2) The company was able or will be able to sustain the employment of the injured employee as a result of the workplace modifications.
(3) None of the workplace modifications referenced in Part V. above have been made as of the date of this application. The modifications will be completed within six months or the advance will be repaid. (applies to application for advances only)
(4) All information provided in this application is correct.

I hereby authorize the Texas Department of Insurance, Division of Workers' Compensation to verify all information contained in this application, including on-site verification inspections.

21. Signature of Authorized Company Representative _____ **22. Date** _____

VII. APPROVAL / DISAPPROVAL (For DWC Use Only)

☐ **Approved**	**Signature**	
☐ **Disapproved**	**Printed Name**	**Date**

WHO IS ELIGIBLE FOR THIS PROGRAM?
Employers in Texas may be eligible for reimbursement or an advance under the Return-to-Work Reimbursement Program for the cost of providing workplace modifications to facilitate an injured employee's return to modified or alternative work following an injury. Complete details regarding the Return-to-Work Reimbursement Program may be found at the following website: http://www.tdi.texas.gov/wc/rtw/index.html

An employer in Texas is eligible to apply for reimbursement or an advance under the Return-to-Work Reimbursement Program if:

(a) the employer employs at least two but not more than 50 employees on each business day of the preceding calendar year;
(b) the employer's workers' compensation insurance is currently in effect and was in effect on the date of the injury; and
(c) the employer is not an agency of the State of Texas or a political subdivision of the state.

It is a violation of the Workers' Compensation Act for an employer to willfully apply for or receive reimbursement or an advance under the Return-to-Work Reimbursement Program knowing that the employer is not eligible. It is also a violation for an employer to use a reimbursement or an advance for purposes other than those stated in the employer's application.

IS ANY OF THE REQUESTED INFORMATION OPTIONAL?
No, provide all of the requested information. An incomplete proposal/application will delay processing and may be rejected or returned for additional information.

QUESTIONS? Please contact Return-to-Work Services at 512-804-4809 or e-mail: rtw.services@tdi.texas.gov

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you.
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html