Post-Traumatic Stress Disorder Grant Application

Submit completed application and required attachments to: wc.ombudsman@tn.gov
Incomplete applications will be returned. For assistance call: 800-332-2667

Grant Award Conditions: By submitting this application, Employer agrees to, upon request, provide the TN Department of Labor and/or the TN Bureau of Workers' Compensation the following information as a condition of receiving the grant: (please check all)

☐the number of claims brought under Section 1 of the James "Dustin" Samples Act,
☐the portion of those claims that resulted in a settlement or award of benefits, and
☐the effect of these claims on costs to Employer.

Employer, City, or County Name: _____

Fire Department: _____

Address: _____

City: _____ Zip: _____

Workers' compensation provider: _____

Did Employer choose to accept the Workers' Compensation Law? ☐ No ☐ Yes

If no, submit a HIPAA release completed by the injured firefighter.

Eligibility Requirements: Check all applicable boxes below.

☐Employer provides mental health awareness training approved by the TN State Fire Marshal.

Name of Course: _____.

Date course was submitted to commission for approval: _____.

Did the firefighter attend PTSD training? ☐ No ☐ Yes, Date of most recent training _____.

☐Employer has accepted the diagnosis of PTSD as compensable for an eligible firefighter.

☐Treatment has been provided by a qualified mental health expert **and** the injury was diagnosed **or** verified by a psychiatrist or psychologist.

Name(s) of Mental Health Provider(s): _____

☐Workers' compensation benefits have been paid as a direct result of an injury occurring on or after January 1, 2024, and on or before December 31, 2028.

Date of Injury: _____

PTSD Injury Details:

Injured Firefighter Name: _____ Date of Birth _____

Is the firefighter a regular or full-time paid employee? (Part-time are not eligible.) ☐ No ☐ Yes

What amount of money are you requesting for the grant award? $_____

Documentation: A committee will review all grant applications. To assist with their review, include with this application:

☐relevant mental health records, including diagnosis, treatment, causation, impairment, and how the eligibility criteria are met,
☐the firefighter's application for benefits, which may be a First Report of Injury,
☐final court documents, and
☐enter the number of firefighter PTSD claims employer has had for the following years below:

_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028

Certification:

Select one

By signing below, I certify, to my knowledge, as the ☐ *employer, OR* ☐ *wc benefit provider, that all information included above is accurate and true and that the subject injury meets all statutory and regulatory requirements.*

Sign: _____ Date: _____

Print: _____

Email: _____ Phone: _____

Application Number: _____

Review by Tennessee Department of Labor and Workforce Development

☐ Payment recommended by Firefighter PTSD Review Committee

☐ Payment authorized by Tennessee Bureau of Workers' Compensation Administrator

Signed _____
Troy Haley, TN BWC Administrator