

# Work Injury Report

Return to: Minnesota Department of Human Services  
 Benefit Recovery Section  
 PO Box 64994  
 St. Paul, MN 55164-0994

**You may lose your benefits (MA, MFIP, GA, MSA, RCA, GAMC) if you do not return this form.**

If you have any questions about this form call:  
 (651) 431-3237 or toll free (800) 657-3963  
 For TTY/TDD service call (800) 627-3529.



Work Injury Date:



## IMPORTANT: PLEASE READ CAREFULLY

The person whose name is on this form reported a work injury to their employer on the date listed above. Department of Human Services (DHS) must ask about the injury to see if we paid bills or cash benefits that may have been related to the injury. This information is needed to determine if an insurance company must reimburse DHS for related expenses.

We request this information to tell if there are others who may pay for your medical care or cash benefits. The information may be shared with county welfare agencies, DHS or its agents, insurance companies, employers, or other people who may pay some of your bills. We will not give this information to anyone else without your consent. You are not legally required to give us this information but if you don't you may not be able to get benefits.

**1. Type of injury:**

(NAME A PART OF THE BODY, SUCH AS "BROKEN ARM/BACK INJURY")

**2. Are you still receiving medical care for this injury?**  Yes  No

**3. Have you filed a claim for workers' compensation?**  Yes  No  
 If yes, is it active?  Yes  No

**4. Is the insurance company for your employer paying for your related medical care?**  Yes  No

**5. Have you hired an attorney to pursue a claim for you?**  Yes  No  
 If yes, complete the following:

NAME OF ATTORNEY	TELEPHONE NUMBER
STREET ADDRESS	CITY, STATE AND ZIP CODE

This information is available in other forms to people with disabilities by contacting us at (651) 431-3237 (voice) or toll free at (800) 657-3963. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

6. A. If you cannot remember this injury or you do not understand how to answer this form, check here . Also sign the form below.

If necessary you will be contacted for more information. ***This form must be returned.***

B. I hereby declare that the information I have stated on this form is accurate and complete.

SIGNATURE**	TELEPHONE NUMBER	DATE
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\*\* If you are completing this form on behalf of the recipient, indicate your relationship to the recipient and the reason they cannot complete the form.

RELATIONSHIP	REASON YOU ARE SIGNING FOR RECIPIENT
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Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຂຽວ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນັກງານຊ່ວຍວຽກ ຂອງທ່ານ ຫຼື ໂທຫາ ຕາມເລກໂທ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.