NEW YORK STATE | Workers' Compensation Board

# Extreme Hardship Redetermination Request

Section 35(3) of the Workers' Compensation Law

## Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: _____ WCB Case #: _____ My PPD Cap Benefits Will Expire On (MM/DD/YYYY): _____

## Employee Information

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: USA

Daytime phone #: _____ Email Address: _____

**When to file Form C-35** - Use this form if you are an injured worker requesting a redetermination due to an extreme hardship as described in Section 35(3) of the Workers' Compensation Law **and** you have been classified with a permanent partial disability with a loss of wage earning capacity of greater than 75%, **and** your capped benefits will expire within one year (365 days or less from today's date).

## Non-Wage Household Income - List all non-wage income received monthly.

| | Injured Worker | Spouse | Other Adult residing with injured worker |
|---|---|---|---|
| Workers' Compensation Benefits | | | |
| Social Security Disability Benefits | | | |
| Social Security Retirement Benefits | | | |
| Child Support Income | | | |
| Spousal Maintenance | | | |
| Other Income (specify): _____ | | | |
| Other Income (specify): _____ | | | |
| Other Income (specify): _____ | | | |
| **TOTAL Non-Wage Household Income** | | | |

## Monthly Necessary Living Expenses - List monthly amounts. For expenses paid other than monthly, see instructions.

| **Household Expenses** | Monthly Expenses | **Other Expenses** (specify) | Monthly Expenses |
|---|---|---|---|
| Rent or Mortgage | | | |
| Electric, Oil/Gas, Water/Trash | | | |
| Telephone/Cell/Cable/Internet | | | |
| | | **TOTAL Household Expenses** | |

**Other factors that contribute to an extreme hardship** - Use this space or attach additional sheets to provide details about any other factors that contribute to an extreme hardship.

**Injured Worker Signature:** _____ **Date:** _____

**Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.**



**This form and any attachments must be mailed, faxed or emailed to the Workers' Compensation Board**

## To the Injured Worker - General Information On Using This Form

You may file this form (C-35) and any attachments with the Workers' Compensation Board via fax, email or by regular mail. See below for address information. Please retain a copy of your completed form and supporting documentation. After the Board reviews your completed form, we may contact you for additional information. If this form does not provide sufficient space for you to include all relevant information, attach additional information in a separate document. Please label all documents clearly with your name, WCB Case number and date of injury or illness.

1. This form is only for use by injured workers who have been classified as having a permanent partial disability with a loss of wage earning capacity of greater than 75%.

2. This form can be filed with the Workers' Compensation Board within the year prior to the scheduled exhaustion of compensation payments. Forms filed before one year prior to the exhaustion of benefits will be returned and will not be processed.

3. Use this form to list income from all sources, including from others living in the same household as the injured worker. Attach additional sheets as necessary. Use this form to list household expenses and any other factors that contribute to an extreme hardship.

   Enter monthly amounts for expenses. For any expenses not paid monthly, convert as follows:

| **If a bill is paid …** | **Calculate the monthly amount by …** |
|---|---|
| Quarterly | Dividing by 3 |
| Weekly | Multiplying by 4.3 |
| Biweekly (every two weeks) | Multiplying by 2.17 |
| Semimonthly (twice each month) | Multiplying by 2 |

4. Submit documentation for all expenses and household income listed on the C-35. Incomplete applications may be delayed pending receipt of complete information.

Complete the identifying information at the top of Form C-35 and send the form, WITH ALL APPLICABLE INFORMATION ATTACHED, to:

**Workers' Compensation Board**
**PO Box 5205**
**Binghamton, NY 13902-5205**

**Address for Email Filing: wcbclaimsfiling@wcb.ny.gov • Statewide Fax Line: (877) 533-0337**

**Disclosure of Information**: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our webpage,www.wcb.ny.gov. It can be found under the heading Common Forms Online. Mail the completed authorization form to the address listed above.

**Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).** The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.