Connecticut State Community College Student On-Campus Injury Procedure

Effective Date:
Version: 1.0

Application: Employees, Faculty, Students, Contractors and Other Representatives

For More Information Contact: Director of Environmental Health & Safety at

860-612-7089 or Jason.Balletto@ctstate.edu

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CT State Student On-Campus Injury Procedure

Record of Changes

Old Version #	New Version #	Summary of Changes	Date of Change	Posted By:
1	1	Written		

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COMMUNITY COLLEGE

I. Purpose

The purpose of this procedure is to establish a consistent and timely process for responding to student injuries that occur on CT State college-owned or controlled property or during CT State sponsored activities. This procedure ensures appropriate medical response, reporting, documentation, and claim submission for eligible medical expense benefits (Appendix A).

II. Scope & Application

This procedure applies to all enrolled students where injuries occur on CT State Colleges campus properties, academic buildings, during CT State sponsored classes, events programs, and supervised extracurricular activities.

This procedure does not replace emergency response protocols and does not determine faults or liability.

III. Responsibilities

- **Environmental Health & Safety (EHS)**
  - Ensure injuries are documented using approved incident reporting documentation
  - Support hazard identification and corrective actions following injury investigations
  - Maintain injury records in accordance with CT State retention requirements
- **Campus Police/Security**
  - Respond to emergencies and serious injuries
  - Secure scenes as necessary
  - Complete law enforcement or security incident reports when applicable
- **Associate Dean of Campus Operations (ADCO)**
  - Advise students of what documentation is needed, including CT State incident report per CT State Student Handbook (Appendix C)
  - Notifies emergency medical care, if necessary
  - Works in collaboration with Director of EHS for document retention and injury investigations
- **Faculty and/or Staff**
  - Ensure appropriate emergency response
  - Reports injuries promptly
  - Cooperate with EHS and Associate Dean of Campus Operations (ADCO) for documentation and investigation

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IV. Immediate Response to Injury

- Emergency Situations
  - If a student sustains a serious or life-threatening injury:
    - Call ***911*** immediately
    - Contact CT State Campus Police, Campus Security, or designated emergency response unit
  - Do not move the injured student unless necessary to prevent further harm to the student
  - Provide basic first aid only within the responder's training
- Non-Life-Threatening Situations
  - Contact Associate Dean of Campus Operations, CT State Campus Police, and/or Campus Security
  - Encourage the student to seek prompt medical attention
    - If student refuses and you think the injury needs to be evaluated, call ***911*** to have emergency services respond for evaluation
      - Once emergency services arrives on scene and are evaluated, they can sign a transport and treatment refusal provided by emergency services.

V. Injury Reporting Requirements

- Incident Reporting
  - An incident report must be completed as soon as practicable after the injury occurs (Appendix A). These reports will be completed by the following individuals:
    - The staff or faculty members who witnessed the injury and/or the student reported the injury to
    - The student who was injured
    - Campus Police and/or Campus Security who responded to the injury
  - The incident report should include the following:
    - Student Name
    - Date, Time, and location of the incident
    - Description of how the injury occurred
    - Nature of the injury
    - Name of witnesses, if applicable
- Notification
  - The following must be notified, and incident reports must be sent to:
    - CT State Director of Environmental Health & Safety
    - CSCC Police
    - Associate Dean of Campus Operations

VI. Medical Treatment and Insurance Coordination

- Students should first use their primary health insurance for medical treatment
- The CT State Community College Participant Accident Insurance (The Hartford), if applicable, typically provides excess medical expense coverage, meaning it may cover eligible expenses after primary insurance has processed the claim. Should a student not have primary coverage, this policy would become primary coverage for a covered event.
- Students are responsible for obtaining and retaining detailed medical documentation and Explanation of Benefits (EOBs) from their primary insurer.

VII. Participant Accident Claim Process

- Claim Eligibility
    - Any full-time or part-time registered student may be eligible to submit a claim for medical expense benefits if:
        - The injury occurred during a covered activity
        - The activity was officially supervised or sponsored by CT State Community College
        - The injury is accidental in nature
    - Coverage eligibility is governed solely by the terms of the insurance policy
- Required Claim Form
    - The Hartford Participant Accident Statement of Claim for Medical Expense Benefits (Appendix B)
        - This form includes the following:
            - Part I – Policyholder's Statement
                - Completed and Signed by an authorized CT State Representative
            - Part II – Claimant's Statement
                - Completed and signed by the injured student or parent/guardian if the student is a minor

- Required Supporting Documentation
    - Itemized medical bills (UB-04 for hospital charges and/or CMS-1500 forms for physician charges preferred)
    - Explanation of Benefits (EOBs) from primary insurance carrier
    - Incident reports and/or CT State Community College Police Reports
    - Any related medical records related to the injury
        - Incomplete submission may delay claim processing
- Submission Instructions
    - Completed claim forms and supporting documentation must be submitted according to the instructions provided within the claim form, which include submission by mail or fax to the claim administrator (pg. 4).
        - Submit claim by mail to:

            P.O. Box 189
            Bridgton, ME 04009
            Phone: 1-888-998-2240
            Fax: 1-207-647-4569
    - ***Students are encouraged to retain copies of all submitted documents for their records***

VIII. CT State Community College Responsibilities

- CT State will:
    - Verify student participation in covered activity and enrollment
    - Complete and sign the Policyholder's Statement portion of the claim
    - Provide reasonable assistance with the claim submission process
    - Cooperate with the insurance carrier's claim review, if requested
- ***CT State does not guarantee payment of medical expenses and does not serve as the insurer***

IX. Student Responsibilities

- Students are responsible for the following:
    - Seeking timely medical treatment
    - Completing their portion of the claim form accurately
    - Submitting itemized bills and insurance documentation
    - Complying with all timelines and requirements set by the insurance carrier
- ***Failure to comply may result in denial of benefits***

X. Record Retention and Confidentiality

- All injury and claim records will be maintained in accordance with:
  - FERPA
  - HIPPA (as applicable)
  - CT State Community College record retention procedures
- ***All medical information will be handled confidentially and shared only with authorized personnel***

XI. Disclaimer

- CT State Community College participation in this process does not constitute a guarantee of insurance coverage or payment of medical expenses. Coverage determinations are made solely by the insurance carrier pursuant to policy terms and conditions.

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Incident Report Form

Directions: Complete this form and forward it to the Office of the Associate Dean of Campus OPS;
CT *State Director of Environmental Health and Safety*

Today's Date: _____ Time Incident Reported: _____

Name of person(s) that the Incident was reported to: _____

Your name: _____
Address: _____
City/State: _____
Phone Number: _____
Your signature: _____
Date of Incident: _____
Time of Incident: _____
Location of Incident: _____

Were you transported by ambulance? ☐ Yes ☐ No

☐ Student
☐ Employee
☐ Student Worker
☐ Vendor

Was this incident an injury or other?

☐ Injury ☐ Other

If other, explain:

_____
_____
_____

Describe incident in detail:

_____
_____
_____
_____
_____
_____

WITNESSES:

_____
_____
_____

Please attach any other important information.
Route to: Director of Environmental Health & Safety Associate Dean of Campus Operations

Participant Accident
Statement of Claim for
Medical Expense Benefits

THE HARTFORD

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Medical Expense benefits under a Participant Accident policy.

Step 1: Submit a completed Notice of Claim to our office by fax or mail

Part I – Policyholder's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.
- ☐ Provide any necessary attachments (see Section D).

Part II – Claimant's Statement

- ☐ Form is to be completed in its entirety and signed by the Claimant or their parent/guardian.
- ☐ Read and sign the Important Notice on page 4.

Step 2: Submit itemized medical bill(s) and supporting documentation (see below)

Helpful Information for submitting claims and expediting payment

- If the Participant Accident Policy provides coverage on an Excess basis, you must file your bills through your primary insurance carrier prior to filing for benefits under this Policy. The Explanation of Benefits (EOB) that corresponds with the medical bill(s) that have been processed by the other carrier must be submitted with your claim. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.
- A fully-completed Notice of Claim is required for each accident/injury a Claimant incurs. Submitting incomplete information will delay the processing of your claim.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date(s) of service, diagnosis, procedure code(s), amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough detail to process the charges. Accordingly, we recommend providers submit standardized billing statements, specifically, UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges.
- Claim payment is sent directly to the medical providers unless proof that a Claimant has paid the bill in whole or in part (e.g., a copy of check or balance statement) is received.

Please detach this page and forward the completed Statement of Claim and supporting documentation to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim by mail to: The Hartford
One Hartford Plaza, T-14
Hartford, CT 06155
Telephone: 1-800-678-6702
Fax: 1-866-954-3993

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.

Please verify if the insured qualifies for any other group benefits through The Hartford and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

Participant Accident
Statement of Claim for Medical Expense Benefits

Mail forms to: The Hartford
One Hartford Plaza, T-14
Hartford, CT 06155
Fax: 1-866-954-3993
Telephone: 1-800-678-6702

PART I - POLICYHOLDER'S STATEMENT – To be completed by the Official Representative of the Policyholder/Plan

A. Information About the Policyholder

Policy Number:	Policyholder Name:	
Policyholder Email Address:	Policyholder Telephone Number: ( )	Policyholder Fax Number: ( )
Policyholder Address (Street, City, State, & Zip Code):		
Participating Organization (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):	

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )

C. Information About the Claim

Medical Expense benefits claimed due to:

☐ Contagious and Infectious Disease ☐ Accidental Injury ☐ Heart or Circulatory Malfunction ☐ Sickness

For claims due to injury, complete the following:

Date of Accident:	Time of Accident (hh:mm): ☐ AM ☐ PM	Place of Accident:
Nature of injury(ies):		
Fully describe the circumstances of the Accident (Use a separate sheet of paper, if necessary):		

For claims due to illness, complete the following:

Nature of illness:	Date illness first commenced:
Fully describe the circumstances of the sickness (Use a separate sheet of paper, if necessary):	

D. Required Attachments and Signature

Please attach copies of the following documents as applicable:

- Medical information from the Claimant's file relating to this injury/illness, if available.
- Incident/police reports relating to the Incident.

I hereby certify the Insured is a member of the group insured under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The Hartford and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

Participant Accident
Statement of Claim for Medical Expense Benefits

Mail forms to: The Hartford
One Hartford Plaza, T-14
Hartford, CT 06155
Fax: 1-866-954-3993
Telephone: 1-800-678-6702

THE HARTFORD

PART II – CLAIMANT'S STATEMENT – To be completed by the Adult Claimant or parent/guardian if Claimant is a minor

A. Information about the Claimant

Name: (Last, First, Middle Initial)	Date of Birth:	Social Security Number:
Address: (Street, City, State, & Zip Code)		Gender: ☐ Male ☐ Female

Name of Parent/Guardian and relationship to Claimant (if applicable):

Phone Numbers:
Daytime: (____) _____ Evening: (____) _____ Personal Cell Phone: (____) _____
E-mail Address: _____
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐Yes ☐No
and/or request this by E-mail? ☐Yes ☐No

_____ _____
Signature Date

Please indicate any other sources of medical insurance under which the Claimant is covered:

Medicare	☐	Mother's Employer's policy*	☐
Medicaid	☐	Father's Employer's policy*	☐
Employer's policy*	☐	Guardian's Employer's policy*	☐
Spouse's Employer's policy*	☐	Any other medical policy*	☐

*If Yes and the Participant Accident Policy provides coverage on an Excess basis, please include the other carrier(s) Explanation of Benefits (EOB) for each medical bill submitted. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.

B. Information about the Claimant's condition

1. For injury, answer the following questions:

When, where, and how did the injury occur?

Name and address of law enforcement agency involved and Case Number (if applicable):

2. For illness, answer the following questions:

What were the first symptoms?

When did the symptoms begin?	Has the claimant had this illness before? ☐ Yes ☐ No If Yes, when?

3. For injury or illness, answer the following questions:

Date of initial treatment:	Nature of treatment received to date:

Is further treatment anticipated? ☐ Yes ☐ No If Yes, nature and duration of expected treatment:

C. Certification

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have read and signed the Important Notice on page 4 of this form. I also authorize any physician/hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

_____ _____
Signature of Adult Claimant or Parent/Guardian Date

Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

STUDENT HANDBOOK

Academic Year 2024-2025

ctstate.edu

CT STATE COMMUNITY COLLEGE

Injury While on Campus

If you are injured on a CT State campus, please notify the Associate Dean of Campus Operations at that campus location. They will advise you of any required paperwork that may need to be completed to document the incident. Please visit the campus staff directory links in the **CT State Community College Directory** section of this Handbook, the **campus website**, or the campus information desk to obtain the Associate Dean's office location information.

Off-Campus Injuries

In the event of an injury occurring at a college-sponsored, off-campus event, please notify the CT State faculty or staff member in charge. That person will decide the best course of action and will report the injury to a member of Public Safety or the Associate Dean of Campus Operations upon return to your CT State campus.

Opioid Overdose Prevention and Awareness

CT State is committed to preventing overdose-related deaths through the proper training, administration, and usage of naloxone hydrochloride, commonly known as NARCAN® Nasal Spray, or other similarly acting and equally safe overdose-reversing drug approved by the FDA. The Connecticut Good Samaritan Law allows anyone, if acting with reasonable care, to administer an opioid antagonist to a person one believes in good faith is experiencing an opioid-related drug overdose without criminal or civil liability.

Intranasal naloxone kits are stored and accessible to students, faculty, and staff at several locations on each CT State campus, including the following:

Asnuntuck Campus	• Building 1, North Corridor B (adjacent to Admissions Suite 104) • Building 2, Lobby 400 (adjacent to entrance vestibule)
Capital Campus	• Public Safety HQ (Suites #101/102 in the lobby) • Public Safety Substation (Room #714 - on the 7th floor, next to the cafeteria)
Gateway Campus	New Haven Campus: • North Building Cabinets 1. Lower-level elevator lobby 2. 1st floor elevator lobby 3. 2nd floor elevator lobby 4. 3rd floor elevator lobby 5. 4th floor elevator lobby • South Building Cabinets 1. 1st floor elevator lobby 2. 2nd floor Library entrance, S-201 3. 3rd floor elevator lobby 4. 4th floor elevator lobby North Haven Campus (88 Bassett Road): • Lobby area near restroom entrances
Housatonic Campus	• Public Safety Office, Beacon Hall, Room 110 • Public Safety Office, Lafayette Hall, Room A127

Manchester Campus	• Campus Police dispatch office, Student Services Center, L174
Middlesex Campus	• With AED (Automated External Defibrillator) Machine, Founders Hall, Room 147 • With AED Machine, Wheaton Hall, Main Hallway, First Floor, Near Restrooms • With AED Machine, Snow Hall, Main Hallway, First Floor, Near Restrooms • With AED Machine, Chapman Hall, Upper-level Hallway • With AED Machine, Chapman Hall, Main Lobby
Naugatuck Valley Campus	• Main Public Safety Office, Room C122 • Student Center, Room S520 • Public Safety Satellite Office, Room C101.
Northwestern Campus	• Founders Hall and Annex: 1. Founders Hall – 1st Floor Hallway outside Office #105 2. Founders Hall Annex – 2nd Floor Hallway next to Restrooms/#211 • Arts and Science Building – 2nd floor Student Lounge next to #204 • Joyner – 1st floor Student Lounge #132 • Greenwoods Hall – 2nd Floor Hallway outside of Registration #219 • Learning Resource Center – 2nd floor landing next to #208
Norwalk Campus	• East Campus Information Desk • West Campus Main Lobby Security Post
Quinebaug Valley Campus	Opioid Rescue Kit locations: • 1st Floor Corridor next to Atrium, W113 • 1st Floor East Corridor by E186 • 1st Floor West Vestibule Manufacturing Wing, N113 • 2nd Floor Library entrance, C224 , E233 • Campus Security, Atrium of West Wing, W113 • Willimantic Site, Main Lobby
Three Rivers Campus	• Security, Main Lobby entrance desk
Tunxis Campus	• Welcome Center, 100 Building, Main Entrance • Circulation Desk, 1st Floor, Library Circulation Desk

The Clery Act

The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act or Clery Act (20 U.S.C §1092(f)) is a federal law that requires colleges and universities to disclose information about crime on and around their campuses and to provide the institution's policies concerning campus security. CT State campus Security and Uniform Campus Crime Reports (SUCCR) can be accessed: Consumer Information - CT State. Upon request, a copy of the report for your home campus can be obtained from that campus's Associate Dean of Campus Operationss.