Georgia State Board of Workers' Compensation

REHABILITATION & MANAGED CARE PROCEDURE MANUAL

This Procedure Manual is to be used as a reference tool in conjunction with and as an adjunct to Title 34, Chapter 9 of the Official Code of Georgia Annotated and the Rules and Regulations of the State Board of Workers' Compensation. The Procedure Manual is updated annually to reflect any changes in the workers' compensation law or rules. Copies of the Procedure Manual may be obtained on line at the Board's web site at www.sbwc.georgia.gov.

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PROCEDURE MANUAL

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REHABILITATION & MANAGED CARE

Introduction

This Chapter is to be used in conjunction with and as an adjunct to O.C.G.A. §34-9-200.1 and §34-9-208 and accompanying Board Rules 200.1 and 208. These laws and rules are subject to change on July 1 of every year. It is every rehabilitation supplier's, case manager's, and certified Managed Care Organization's responsibility to maintain knowledge of changing laws and rules regarding rehabilitation and certified MCOs. To order copies of the *Georgia Workers' Compensation Laws, Rules, and Regulations Annotated*, call Lexis Law Publishing at 1-800-542-0957 or contact them on the web at www.lexis.com. This Procedure Manual is also revised yearly. The most recent version is available at the Board's web site, www.sbwc.georgia.gov.

A. Rehabilitation and Case Management

Rehabilitation suppliers assess, plan, implement, coordinate, monitor and evaluate options and services to meet an injured employee's health care needs. They deliver and coordinate services under an individualized plan; provide counseling; vocational exploration; psychological and vocational assessment; evaluation of social, medical, vocational and psychiatric information; job analysis, modification, development and placement; in addition to other services through communication with the injured employee and others and available resources to promote quality cost-effective outcomes that lead to return to work. Rehabilitation suppliers shall provide these services independently in a manner consistent with their education and experience and refer to other professionals as appropriate. Rehabilitation suppliers shall serve as an advocate for the injured employee within the confines of the Workers' Compensation Act. Individuals performing any of these functions must be registered with the Managed Care and Rehabilitation Division of the State Board of Workers' Compensation as a rehabilitation supplier.

The goal of these services is to restore the injured employee to suitable employment. If this is not possible, then the injured employee should be restored to the highest possible level of physical functioning and to a level of independence similar to that possessed by the employee prior to his or her injury.

Only Board registered rehabilitation suppliers shall perform the activities outlined herein. However, direct employees of insurers, third party administrators and employers may perform a portion of these activities in the administration of their workers' compensation claims. Other rehabilitation suppliers not registered with the Board, or any person performing any of the activities described in Rule 200.1(a)(1)(i), (ii) who are not direct employees of insurers, third party administrators or employers, or any person who violates the provisions of Board Rule 200.1 shall be subject to civil penalties in accordance with O.C.G.A. §34-9-18. Complaints must be received in writing to the Division Director of Managed Care and Rehabilitation at the Board. An investigation of the complaint will be conducted to determine if a hearing should be scheduled.

O.C.G.A. §34-9-200.1 requires the employer/insurer to provide rehabilitation services that are reasonable and necessary to catastrophically injured employees. For cases with dates of injury on or after July 1, 1992, catastrophic injury is defined in O.C.G.A. §34-9-200.1(g) as follows:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, hand, foot, or leg involving the effective loss of use of that appendage;

3. Severe brain or closed head injury as evidenced by:
   Severe sensory or motor disturbances
   Severe communication disturbances
   Severe complex integrated disturbances of cerebral function
   Severe disturbances of consciousness
   Severe episodic neurological disorders;
   Other conditions at least as severe in nature as any condition provided in subparagraphs (a) through (e) preceding this paragraph

4. Second or third degree burns over 25 per cent of the body as a whole, or third degree burns to 5 per cent or more of the face or hands

5. Total or industrial blindness

6. (A) Any other injury of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy for which such employee is otherwise qualified; provided, however, if the injury has not already been accepted as a catastrophic injury the employer and the authorized treating physician has released the employee to return to work with restrictions, there shall be a rebuttable presumption during a period not to exceed 130 weeks from the date of the injury, that the injury is not a catastrophic injury. During such period, in determining whether an injury is catastrophic, the Board shall give consideration to all relevant factors including, but not limited to, the number of hours for which an employee has been released. A decision granting or denying disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act shall be admissible in evidence and the Board shall give the evidence the consideration and deference due under the circumstances regarding the issue of whether the injury is a catastrophic injury.

   (B) Once an employee who is designated as having a catastrophic injury under this subsection has reached the age of eligibility for retirement benefits as defined in 42 U.S.C. Section 416(l), as amended March 2, 2004, there shall arise a rebuttable presumption that the injury is no longer a catastrophic injury; provided, however, that this presumption shall not arise upon reaching early retirement age as defined in 42 U.S.C. Section 416(1), as amended March 2, 2004. When using this presumption, a determination that the injury is no longer catastrophic can only be made by the board after it has conducted an evidentiary hearing.

   Please see the Appendix, ***Information Required to Process Requests for Catastrophic Designation,*** at the end of this Chapter for the procedure to follow when filing a request for

catastrophic determination of a claim. All requests for catastrophic determination shall be submitted to the Division of Managed Care and Rehabilitation.

B. Appointment of a Board Registered Catastrophic Rehabilitation Supplier

1. In any catastrophic injury case, the employer/insurer shall designate a Board registered catastrophic rehabilitation supplier within 48 hours of accepting the injury as compensable, or notification of a final determination of compensability, by filing a Form WC-R1 (Request for Rehabilitation) with the Board. This may occur simultaneously with the filing of the Employer's First Report of Injury (Form WC-1) or within 20 days of notification that rehabilitation is required. If the employer/insurer does not file the Form WC-R1, or catastrophic designation is being requested by the employee or the employee's attorney, the employee shall file a Form WC-R1CATEE to request catastrophic designation and the appointment of a catastrophic supplier. The requesting party shall send copies of the Form WC-R1CATEE to all parties and the supplier and complete the certificate of service on the Form WC-R1CATEE. The requesting party shall also attach all documentation required for the review process to determine catastrophic designation. Please see the Appendix at the end of this Chapter, ***Information Needed to Process Requests for Catastrophic Designation,*** for a list of information needed by the Board to process requests for catastrophic designation. The employer/insurer are given 20 days to file an objection by filing a Form 102d, Objection to Rehab, or any party may file a WC-14 Hearing Request within 20 days. If the employer/insurer does not appoint a designated catastrophic supplier timely, and the Board determines rehabilitation is necessary, the Board may appoint a catastrophic supplier and notify all parties and the involved supplier. Subsequent to either an employer's designating an employee's injury as catastrophic or a board determination as to the catastrophic or noncatastrophic nature of an employee's injury, either party may request a new determination, based on reasonable grounds, as to the catastrophic or noncatastrophic nature of the employee's injury.

2. For cases with dates of injury prior to July 1, 1992, unless excused by the Board, any case party shall file a Form WC-R1 with the Board at any time for the designation of a rehabilitation supplier. For all dates of injury, the Board recognizes the following as case parties: employee, employer, insurer, servicing agent or third party administrator if there is one on the case, counsel for employee, counsel for employer/insurer, Subsequent Injury Trust Fund if there is a reimbursement agreement or order, and counsel for the Subsequent Injury Trust Fund if counsel has been assigned. ***Rehabilitation suppliers and case managers are not considered to be case parties.*** The Forms WC-R1 and WC-R1CATEE are used to request initial appointment. The Form WC-R1 is also used to reopen rehabilitation. The request shall include pertinent medical information available concerning the injured employee, as well as a statement supporting the need for rehabilitation services. The requesting party shall complete and send copies of the Form WC-R1 or WC-R1CATEE to all parties and the supplier and complete the certificate of service on the Form WC-R1 or WC-R1CATEE. If the Board deems a rehabilitation supplier is needed and no party has requested appointment, the Board may appoint a supplier and will notify all parties and the involved supplier.

3. For claims with dates of injury prior to July 1, 1992, the injured employee may be eligible for rehabilitation services if, in the judgment of the Board, those services are likely to return the employee to suitable employment consistent with the employee's prior occupational level and/or will restore the employee to optimal physical functioning.

4. Reporting to the Board on rehabilitation cases is required only if the injury or case is designated as catastrophic or if the injury occurred prior to July 1, 1992. Reporting to the Board on voluntary rehabilitation/case management cases is allowed, but not required.

5. For suppliers who meet additional education and experience criteria, the Board may assign a catastrophic designation. Only rehabilitation suppliers who are registered with the Board as catastrophic rehabilitation suppliers shall be assigned as rehabilitation suppliers to the cases of injured employees whose injuries have been designated as catastrophic. If a supplier who does not hold the catastrophic designation is assigned to work with an injured employee, and then discovers that the employee's injuries are catastrophic in nature, it is the supplier's responsibility to notify the Board and all case parties of the situation and to close their file...

6. In the event rehabilitation services are being voluntarily provided by agreement of the parties, and the case is subsequently determined to be catastrophic secondary to the provisions of O.C.G.A §34-9-200.1(g) (6), the employer/insurer shall file a Form WC-R1 to designate a catastrophic supplier.

C. Rehabilitation Supplier Duties in Catastrophic Cases: Plans; Non-Catastrophic Medical Care Coordination of Pre-July 1, 1992 Cases; Non-Catastrophic Medical Care Coordination for Dates of Injury On or After July 1, l992 (Voluntary Cases)

1. Rehabilitation Supplier Duties

The Board registered rehabilitation supplier shall have sole responsibility for each individual case. The rehabilitation supplier shall complete, with the injured employee, the initial rehabilitation evaluation within 30 days of appointment to the case. The catastrophic rehabilitation supplier shall also complete, in person with the employee, an appropriate plan of services on Form WC-R2A within 90 days of appointment to the case. The case may be closed after the initial rehabilitation assessment, when appropriate.

Initial evaluation means a personal interview between the employee and approved catastrophic rehabilitation supplier. The rehabilitation supplier reviews the medical and other records to determine if the employee is in need of rehabilitation services and the feasibility of providing rehabilitation services. The written evaluation report shall provide the supplier's conclusion as to why the employee would or would not benefit from rehabilitation services, and provide an indication of what further services are needed.

A Board-registered rehabilitation supplier may obtain specific services from another qualified individual, facility, or agency for direct services outside the scope of expertise of the supplier upon Board approval of a plan that specifies such services.

The registered rehabilitation supplier shall complete, sign and file all rehabilitation reports with the Board as required by the rules, and send copies of those reports, as well as any available medical reports, simultaneously to all case parties, as soon as the supplier creates or receives such reports. All correspondence and reports should include the supplier's registration number and Board claim number. The employee's attorney may accept service of the employee's copy.

The written initial rehabilitation report shall include at least the following information, whether the report is written by a counselor or a nurse, and shall always be submitted along with the first Form WC-R2 (transmittal report) or Form WC-R2A (proposed rehabilitation plan) submitted to the Board, within 90 days of the supplier's appointment to the case:

a. Summary of current medical status, secondary conditions affecting recovery, treatment, prognosis and estimate of time frames, if possible;
b. Employer contact (specify name and title) regarding return to work possibilities, including same job, modified job, different job, graduated return to work, or termination;
c. Social history;
d. Educational background;
e. Employment history;
f. Average weekly wage at the time of injury;
g. Transportation availability;
h. Summary of positive and negative indicators for return to work; and
i. Statement of supplier's conclusion regarding the employee's need for rehabilitation services and the likelihood of whether the employee will benefit from further rehabilitation services.

2. Plan Submission; Objections; Approval

In all catastrophic injury cases, for as long as rehabilitation services are necessary, the registered rehabilitation supplier shall submit a proposed Individualized Rehabilitation Plan (Form WC-R2A) to the Board, copied to all parties. The initial proposed plan is due within 90 calendar days of the supplier’s appointment. The proposed plan shall include goals, justification for goals, objectives to achieve goals, dates for completion of objectives, delineation of responsibilities of the parties involved, and estimated rehabilitation costs of the supplier’s services to complete the plan. The objectives shall be stated in measurable terms and shall be related to the established goal. The proposed plan will include documentation of the participation of the employee in person in the development of the rehabilitation plan including comments, if any, regarding opposition to the plan, and will be signed by the employee or his/her attorney. If the employee or his/her attorney fails to, or refuses to, sign the plan within 20 days of submission, despite the rehabilitation supplier’s attempts to obtain same, the rehabilitation supplier shall file the plan with the Board with it marked “unsigned” across the top of the form. In addition, the rehabilitation supplier shall write the date the plan was submitted to the employee and his/her attorney on the employee’s signature line.

See Board Rule 200.1(b) (3) and (c) for procedures regarding approvals and objections.

Unless excused by the Board, for catastrophic injury cases, after the initial plan is approved, the supplier shall submit progress reports, with updated medical reports and supporting documentation, every 90 days under cover of a Form WC-R2. ***Catastrophic-injury cases are to be covered by a current plan at all times; a new proposed plan is due to the Board 30 days prior to the expiration of the preceding plan.*** Medical care coordination and independent living plans, (which are not allowed in non-catastrophic injury cases with dates of injury prior to July 1, 1992) as well as extended evaluation, return to work, training, and/or self employment plans may be written for catastrophically-injured employees. The first proposed rehabilitation plan is due to the Board within 90 days of the rehabilitation supplier's appointment.

See Board Rule 200.1(a) (5) for types and descriptions of plans.

Extended evaluation plans (written for no more than one year) are for the purpose of ascertaining if vocational rehabilitation is feasible, and if so, to identify specific job goals. Often labor market surveys, vocational evaluations, and functional capacity evaluations are services proposed in this type of plan.

All return to work situations, whether to the employer of injury or to a new employer, are to be covered by a return-to-work plan submitted by the assigned rehabilitation supplier. Such plans should clearly document the expectations and requirements of both the employee and the employer. The plan should be accompanied by a current release to return to work from the authorized treating physician(s) and an approved job description or analysis of the job to which the employee is returning. Return-to-work plans are written in the following order (the "return-to-work hierarchy"):

1) return to work with the same employer;
2) return to different job with same employer;
3) return to work with new employer;
4) short-term training;
5) long-term training;
6) self-employment.

In some catastrophic injury cases, parties may agree that training is the most efficient way to return an employee to work, and the employee may be able to begin training while recovering from his or her injury. In most cases, however, the feasibility of direct placement must be considered first, and then ruled out, before a training plan can be written. Likewise, short-term training must be considered before a plan for long-term training. The rehabilitation supplier shall document the reason a specific type of plan is proposed, and why another type of plan, earlier in the hierarchy, is not feasible. The return-to-work plan shall be in place for no longer than a one-year period.

All job search plans (written for no more than one year) should be accompanied by documentation of labor market surveys or other information which documents a reasonable

possibility of suitable employment in the job objectives listed on the plan. The plan must be submitted along with a current release to return to work from the authorized treating physician(s). Employment goals should be reasonably consistent with the employee's prior vocational status, including average weekly wage, as well as within the employee's current physical abilities. All treating physicians must concur that the employee is released to return to work.

Training plans (written for no more than one year) should be submitted only when direct placement (placement with the employer of injury or with another employer) is not possible or feasible, unless all parties agree to training. If this is the case, it should be clearly documented on the proposed training plan. All training plans shall be submitted with complete documentation of the proposed training program, including its length and total cost, and should include a provision that the employee must maintain at least passing grades for the plan to continue. Training plans are in place for no more than one year.

Self-employment plans (written for no more than one year) are submitted only when direct placement and training plans are documented as not possible or feasible. The self-employment plan must further document that the proposed type of self-employment is likely to be successful. An extended evaluation may assist in determining success in self-employment.

Medical Care Coordination plans (written for no more than one year) are to be submitted only in cases of catastrophic injury. These plans must address the employee's comprehensive medical needs.

Independent Living plans (written for no more than one year) are to be submitted only in cases of catastrophic injury. These plans must address the employee's comprehensive rehabilitation needs, including suitable housing and transportation. If a plan incorporates any of these issues, it should be designated Independent Living, even if other aspects of services are incorporated as well.

The rehabilitation supplier shall always submit whatever type of rehabilitation plan the supplier believes, in his or her independent professional judgment, is most appropriate at the time, irrespective of any case party's opinion on the matter. Any party may object by filing a Form 102d, Objection to Rehab once the plan is submitted to the Board, and the Board will issue a decision on the matter and/or hold a conference to discuss it.

3. Non-catastrophic Medical Care Coordination – Pre July 1, 1992

For cases with dates of injury prior to July 1, 1992, when a rehabilitation plan is not appropriate because the employee is not yet medically stable enough to proceed to vocational planning or services, the registered rehabilitation supplier shall submit a report of proposed medical care coordination services for non-catastrophic cases by filing Form WC-R2 with the Board copied to all parties with a certificate of service within 90 days of appointment to the case. The report shall include the initial evaluation report, recent

medical reports, and an outline of services that the rehabilitation supplier will provide to resolve existing and potential problems that interfere with the physical recovery.

In such cases, the registered rehabilitation supplier shall submit progress reports with Form WC-R2 if the status changes, at the request of the Board, or at least every 26 weeks, as long as the rehabilitation supplier is providing only medical care coordination services. The rehabilitation supplier shall prepare and submit a proposed plan of vocational rehabilitation services when the physician has recommended vocational rehabilitation activities; the injured worker is medically stable and ready to begin the return to work process; the physician has provided physical guidelines and/or a release to return to work; and there appears to be a reasonable chance vocational services will enable the injured worker to return to suitable employment.

4. Non-Catastrophic Medical Care Coordination – Voluntary Cases

For employees injured on or after July 1, 1992, whose injuries are not catastrophic in nature, rehabilitation services may be provided on a voluntary basis if all parties agree, for so long as such agreement continues. The rehabilitation supplier must obtain written permission from the employee or his/her attorney prior to the provision of any services. All suppliers providing rehabilitation services in such cases are required to register with the Managed Care & Rehabilitation Division of the Board. Refer to Board Rule 200.1(h), regarding documentation of agreement for voluntary rehabilitation and case management, withdrawal of agreement, and supplier responsibilities and services allowed after withdrawal of agreement.

Rehabilitation suppliers shall avoid initiating or continuing consulting or counseling relationships with an injured employee when the injured employee can no longer reasonably be expected to benefit from further services or is unwilling to accept further services. The rehabilitation supplier should complete an initial evaluation of the injured employee as soon as possible after the voluntary agreement has been completed. The rehabilitation supplier should propose and review an appropriate plan of services so that all parties will be aware of the services to be rendered.

Rehabilitation suppliers shall function within the limitations of their role, training, and technical competency. In the event the needs of the injured employee exceed the rehabilitation supplier's role or competence, the injured employee shall be referred to a specialist as the needs of the injured employee dictate.

A rehabilitation supplier may contract with an employer/insurer or attorney to review files, give recommendations regarding case management, safety and rehabilitation issues, and perform job analyses of employment positions. All recommendations and reviews must be submitted directly to the employer/insurer or its agent requesting rehabilitation services. Rehabilitation suppliers retained for these purposes are considered to be consultants and shall not communicate, in person or in writing, with the injured employee, the employee's attorney, or the employee's authorized treating physician(s) without prior written consent of

the injured employee. The supplier shall clearly define to all parties the limits of his or her relationship as a consultant and shall provide unbiased, objective opinions.

Rehabilitation suppliers registered with the Board and providing services in voluntary cases may contact the Board's Rehabilitation Coordinators for technical assistance at any time during their case work.

D. Communications in All Rehabilitation Cases

A rehabilitation supplier shall provide copies of all correspondences simultaneously to all parties and their attorneys. A rehabilitation supplier shall provide adequate information to all parties and providers regarding the medical treatment and condition of the injured employee. Rehabilitation suppliers recognize the employee's attorney as the employee's representative.

The rehabilitation supplier shall provide professional identification and shall explain his or her role to the physician at the initial contact with the physician. In all cases, the rehabilitation supplier shall advise the injured employee that he or she has the right to a private examination by the medical provider outside the presence of the rehabilitation supplier.

The rehabilitation supplier shall not obtain medical information regarding an injured employee in a private conference with the physician, unless the rehabilitation supplier has reserved with the physician sufficient appointment time for the conference and the injured employee and his or her attorney were given prior reasonable notice of their option to attend the conference. If the injured employee or the physician does not consent to a joint conference, or if in the physician's opinion it is medically contraindicated for the injured employee to participate in the conference, the rehabilitation supplier shall note this in his or her report and may in those specific instances communicate directly with the physician. The rehabilitation supplier shall report to all parties and the employee's attorney the substance of the communication between him or her and the physician. Exceptions to the notice requirement may be made in cases of medical necessity or with the consent of the injured employee or his or her attorney. The rehabilitation supplier shall simultaneously send copies to all parties of all written communications to medical care providers.

Please see Board Rule 200.1(a) (6) (i)-(viii) for a more detailed explanation of suppliers' responsibilities and communications.

E. Rehabilitation Case Closure

The registered rehabilitation supplier shall submit Form WC-R3, Request for Rehabilitation Closure, with certificate of service completed as indicated on the form, when:

1. The supplier believes that rehabilitation is no longer needed or feasible;
2. The employee has successfully returned to full-time work for at least 60 days and is no longer in need of the supplier's services;

3. A stipulated settlement which does not include further rehabilitation services has been approved; or
4. The Board has issued a decision closing rehabilitation.

In catastrophic-injury cases, rehabilitation may remain open after the employee has returned to work for 60 days, if the employee would benefit from further medical care coordination by the supplier. On all Form WC-R3s submitted for closure, the supplier is required to complete Section V and attach a closure report.

Regardless of any case party's opinion, the rehabilitation supplier is responsible for requesting closure of rehabilitation whenever his or her professional opinion is that rehabilitation is no longer needed or feasible. If the supplier is unsure if a case should be closed, he or she may write to the Board's Rehabilitation Coordinator and request an opinion on the issue. An objection to closure may be filed within 20 days of the certificate of service on the WC-R3 by filing a Form 102d, Objection to Rehab. The Board's Rehabilitation Coordinator will issue an administrative decision on all requests.

Upon review of the file at any time, the Board may determine that closure is appropriate and may issue an administrative decision to close rehabilitation.

A case party may also file WC-R3 requesting the Board close rehabilitation with the certificate of service completed as indicated on the form. The closure request must include an attached statement with specific reasons for closure. Any case party may file a written objection to closure. As above, whether or not an objection is filed, the Board's Rehabilitation Coordinator will make a determination and issue an administrative decision.

F. Change of Registered Rehabilitation Supplier

On any mandatory rehabilitation case, changes in rehabilitation suppliers may be requested only by parties to the case and shall only be made by approval of the Board. The party shall file Form WC-R1 requesting a change in supplier to include the name and address of both suppliers and the specific reasons the change is requested. The requesting party shall send copies of the Form WC-R1 to all parties and both suppliers and complete the certificate of service on the Form WC-R1. WC-R1 forms which do not comply will be returned to the party making the request. Any case party may file a written objection to the request for change by filing a Form 102d, Objection to Rehab. If the Board determines that a rehabilitation supplier should be removed from a case and the Board determines that rehabilitation is still needed, the Board may direct a change of supplier and will notify all parties and involved rehabilitation suppliers of this decision. The replaced supplier shall file a completed Form WC-R3.

In the event of a request for a change of registered rehabilitation supplier, the Board designated rehabilitation supplier shall maintain responsibility for providing necessary rehabilitation services, unless excused by the Board, until all appeals have been exhausted.

G. Approval and Objections

For all properly filed Form WC-R1 initial requests for rehabilitation, absent written objections to the Board, copied to all parties and involved rehabilitation suppliers, within 20 days of the date of the certificate of service on the Form WC-R1, the request for rehabilitation assessment or services will automatically be approved and the Board's Rehabilitation Coordinator will issue an administrative decision.

Whether or not objections are received, the Board will evaluate and issue decisions on all Requests for Catastrophic Designation on a Form WC-R1CATEE.

A rehabilitation supplier is *not* officially designated as the catastrophic rehabilitation supplier on a claim until the Board's Rehabilitation Coordinator issues an Administrative Decision assigning the supplier to the claim.

On July 1, 2004, Rule 200.1(g) (3) was rewritten to allow the parties to bypass the Managed Care & Rehabilitation Division and take the issue of catastrophic designation directly to a hearing: In the alternative to filing an objection, after a WC-RICATEE is filed, within 20 days, either party may file a WC-14 request for hearing to have an Administrative Law Judge determine the catastrophic designation issue.

Refer to Board Rule 200.1(b) (3) and (c) for specific information regarding objections and the appeals process.

H. Employee Failure to Cooperate

An employer/insurer's application to suspend or reduce an employee's income benefits for failure to cooperate with mandatory rehabilitation shall be filed with the Board on Form WC-102D, outlining its contentions and requesting an order on that issue. The employer/insurer may suspend or reduce weekly benefits for refusal of the employee to accept rehabilitation as awarded by the Board only by order of the Board.

A case party may wish to request a rehabilitation conference prior to filing a motion to request suspension of income benefits.

I. Failure of a Party or Counsel to Cooperate

A party or attorney may be subject to civil penalty or to fee suspension or reduction for failure to cooperate with rehabilitation services. Failure to cooperate may include, but is not limited to, the following:

(1) Interference with the services outlined in a Board-approved rehabilitation plan;
(2) Failure to permit an interview between the employee and supplier within 10 days of a request by the supplier or other obstruction of the interview process without reasonable grounds;
(3) Interference with any party's attempts to obtain updated medical information for purposes of rehabilitation planning;

(4) Failure to return the proposed rehabilitation plan signed or file written objections to the plan within 20 days of receipt; or
(5) Failure to attend a rehabilitation conference without good cause.

J. Board Conferences/ Supplier Role in Settlement Mediations

1. Board Conferences

An Administrative Law Judge or Rehabilitation Coordinator may schedule mediation or administrative rehabilitation conference to resolve problems interfering with the rehabilitation process as needed. In addition, a case party, or rehabilitation supplier, may file a completed Form WC-R5 Request for Rehabilitation Conference with certificate of service as indicated on the form, if it is felt that there is a need for a conference. The Board's Rehabilitation Coordinator, in his/her discretion, may schedule the administrative rehabilitation conference. The parties should make all efforts to resolve the problem before requesting a conference. The Rehabilitation Coordinator may try to resolve the problem in other ways before scheduling a conference. All parties and the supplier are required to attend, or be represented by someone with full authority, at Board conferences. Express permission may be sought *in advance* of the conference to be present by phone or absent from the conference. If required and a party fails to attend or to send a representative, then the conference may be held or canceled at the discretion of the Rehabilitation Coordinator. Rehabilitation conferences differ from mediation in that the Rehabilitation Coordinator may issue an administrative decision or recommendation memorandum after a conference, even if no agreement is reached. These documents are sent to all case parties and involved rehabilitation suppliers and become part of the Board file.

See Board Rule 200.1(e) (3) for responsibilities of rehabilitation suppliers and case parties to attend rehabilitation conferences, and possible penalties for failing to do so. Rehabilitation conferences can succeed only if all parties are either present or represented by individuals who have full authority to decide all disputed rehabilitation issues.

2. Rehabilitation Suppliers' Role in Settlement Mediations

When the Board approves a settlement agreement in a catastrophic injury claim, the rehabilitation needs of the injured worker must be considered. When the ADR Unit of the Board schedules a settlement mediation conference, all aspects of an injured worker's claim will be addressed. As the future rehabilitation needs of the injured worker are one of the issues that must be addressed, input from the rehabilitation supplier is often valuable. As such, the Board's preference is for the supplier to attend the settlement mediation if possible.

Usually, the mediator will excuse the supplier after the supplier gives his/her input. The supplier may give a number where the supplier can be reached if questions arise after the supplier's departure. The employer/insurer or self-insurer shall be responsible for paying reasonable costs for the supplier to attend settlement mediations on catastrophic injury cases.

However, the role of a rehabilitation supplier should be limited solely to the rehabilitation aspects of the case. When asked by the mediator, the rehabilitation supplier should give input on the employee's future medical and rehabilitation needs, including costs of future medications, projected surgeries, orthotics, prosthetics, training programs, attendant care, and other rehabilitation and medical expenses. A rehabilitation supplier should never become involved in negotiations regarding how much an injured worker's case should settle for, or whether or not the injured worker should settle. If the injured worker queries the supplier, the supplier should refer the worker to his or her attorney or to the Board if the worker is not represented.

K. Code of Ethics

Each rehabilitation supplier and case manager shall comply with the professional standards and code of ethics as set forth by his or her certification or licensure board. Rehabilitation suppliers shall not provide rehabilitation services until registered with the Board. Case managers operating under a certified managed care organization pursuant to O.C.G.A. §34-9-208 and Board Rule 208 are not subject to Board Rule 200.1 if the case manager is providing services for an employer with a posted WC-P3 W/C MCO panel (§34-9-201(b)(3)) unless the claim is designated catastrophic. Problems or questions concerning ethics should be addressed to the rehabilitation supplier's licensure board. Violations of Board Rule 200.1 or 208 shall be addressed to the Managed Care and Rehabilitation Division of the State Board of Workers' Compensation, unless the information is protected by law.

L. Appropriate Services/Disputed Charges/Rehabilitation Peer Review

Rehabilitation suppliers shall provide appropriate services as needed to return the injured worker to suitable employment consistent with prior occupational levels or to restore the injured worker to optimal physical functioning. Rehabilitation expenses shall be limited to the usual, customary and reasonable charges prevailing in the State of Georgia. In non-catastrophic cases, the Georgia Rehabilitation Fee Schedule guide applies. In catastrophic cases, other than the hourly rate, the supplier's billing for services is *not* limited to this fee schedule. The charges shall be paid within 30 days from the date of receipt of the charges. When the payor disputes the charges, the payor shall file a request for peer review, within 30 days of receipt of the charges, with the rehabilitation peer review organization. Thereafter, the payor may request a mediation conference by filing a Form WC-14 with the Board. Peer review is outlined in the Rehabilitation Fee Schedule Foreword.

M. Rehabilitation Supplier, Case Manager Qualifications and Registration

Rehabilitation suppliers must be certified or licensed as one of the following: Certified Rehabilitation Counselor (CRC), Certified Disability Management Specialist (CDMS), Work Adjustment and Vocational Evaluation Specialist (WAVES), Certified Rehabilitation Registered Nurse (CRRN), Licensed Professional Counselor (LPC), Certified Case Manager (CCM), Certified Occupational Health Nurse (COHN or COHN-S). Case managers providing services pursuant to O.C.G.A. §34-9-208, 34-9-201(b) (3), and Board Rule 208

are exempt from this registration requirement, as they are approved through the certification process of the managed care organization. Any individual, who holds one of the certifications or licenses listed above, regardless of residence, may become registered as a Georgia Workers' Compensation rehabilitation supplier.

Only Board registered suppliers shall be designated as rehabilitation suppliers. Any rehabilitation counselor or nurse who is not registered with the Board as a rehabilitation supplier pursuant to Rule 200.1 will not be eligible to serve as the registered rehabilitation supplier for any Georgia Workers' Compensation rehabilitation case.

If an injured employee does not live in Georgia or a state adjoining Georgia, the assigned rehabilitation supplier or case manager may associate a counselor or nurse who lives near the employee to assist with rehabilitation. However, the Board registered assigned supplier in mandatory cases maintains sole responsibility for the case, all rehabilitation services, reporting to the Board on the case, and must perform personally the initial interview and plan development interviews. The assigned supplier may submit the associated counselor or nurse's reports along with his or her own reports and required forms.

N. Catastrophic Rehabilitation Supplier Qualifications; Procedure for Applying to Become a Catastrophic Rehabilitation Supplier

The State Board of Workers' Compensation encourages rehabilitation suppliers to complete the requirements to become registered as catastrophic rehabilitation suppliers. These requirements are intended to ensure that all registered catastrophic rehabilitation suppliers have a standard knowledge base, are familiar with the documents which control their provision of rehabilitation services to injured employees, and work according to their licensing and/or certifying bodies' Standards of Practice and Codes of Ethics.

Applying to become a registered catastrophic rehabilitation supplier is an ongoing, proactive process. Rehabilitation suppliers who wish to apply for catastrophic registration must notify the Board's Managed Care and Rehabilitation Division of their intent to do so, *before beginning to accrue the required training and experience*. After initial notification to the Board, the applicant will then submit proposals to and receive feedback from the Catastrophic Certification Committee, on an ongoing basis. This committee consists of a group of peers (registered catastrophic rehabilitation suppliers). The Committee reviews all catastrophic supplier applications and application components to ensure that all applicants' experience and education are of the highest quality and relevant to providing effective rehabilitation services for catastrophically injured employees.

Before Applying:

Before **beginning** to accrue the required training and experience to become a registered catastrophic rehabilitation supplier, an applicant shall have been registered with the State Board of Workers' Compensation as a Georgia rehabilitation supplier for a minimum of two years immediately prior to the beginning of the catastrophic application process. The applicant shall notify the Board at the time he or she decides to begin the process of applying to become a catastrophic rehabilitation supplier.

How to Notify the Board of Intent to Apply for Catastrophic Registration:

A rehabilitation supplier who wishes to begin the process to apply for catastrophic registration shall complete a form, ***Notification of Intent to Apply to Become a Registered Catastrophic Rehabilitation Supplier,*** **found as an Appendix to Chapter 7** of the Board's Procedure Manual. The form may also be obtained by contacting the Board's Managed Care and Rehabilitation Division at (404) 656-0849. The applicant shall submit the completed form to this Division. She/he shall certify that he or she has been registered with the Board as a rehabilitation supplier for at least two years immediately preceding this notification, as well as specifying which license(s) or certification(s) s/he holds.

The supplier shall also be required to state on the form

- that s/he has read and has access to a copy of the Standards of Practice and Codes of Ethics of all of his/her licensing or certifying bodies
- that s/he will abide by those Codes of Ethics and Standards of Practice.
- that s/he has read and has access to O.C.G.A. § 34-9-200.1, Board Rule 200.1, and Chapter 7 of the Board's Procedure Manual
- that s/he realizes that O.C.G.A. §34-9-200.1, Rule 200.1, and the Board's Procedure Manual may change yearly, and that it is his/her responsibility to stay abreast of those changes.

Once notified, the supplier may begin the required training and experience as outlined below. However, prior to each component of required training or experience, the applicant should submit a separate completed proposal on the form, ***Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component*** for each disability area of proposed experience. Each proposal should be submitted through the Board's Managed Care & Rehabilitation Division, Hours obtained will not count unless the proposal is approved. The proposal will be approved, rejected, or modified within 60 days of submission and the applicant will be notified in writing.

A total of 190 hours is required for the designation and registration as a catastrophic rehabilitation supplier, divided as explained below:

REQUIRED TRAINING AND EXPERIENCE (190 HOURS TOTAL)

a. Experience: (150 hours total, 50 hours each in three different disability areas)
Each applicant for catastrophic rehabilitation supplier registration shall document at least 50 hours of experience or observation, which may be either paid or volunteer, in ***each*** of **three** of the following disability areas: spinal cord injury, amputation, catastrophic brain injury, burns, and blindness. The experience does not have to be in Georgia Workers' Compensation cases. It is the responsibility of each applicant to find and develop his/her own observation/experience opportunities.

For each disability area chosen, the catastrophic applicant shall choose an inpatient or outpatient facility, program, or professional health care provider specializing in provision of services to individuals with that disability. The applicant shall obtain written consent to observe and/or provide services at that facility or with that health

care professional.

For each disability area, the applicant shall observe services (paid or volunteer) for at least 40 hours. Required paperwork will count for the other ten required hours. The applicant may observe several individuals with the disability, and all of the observation/service provision hours may be counted (once the proposed experience component has been approved). The applicant shall choose one individual with the disability for whom the required initial rehabilitation report, and proposed rehabilitation plan shall be submitted, as though that person were a workers' compensation client, even if he or she is not.

For each experience component, the applicant shall have both an onsite supervisor who shall verify the hours the applicant has spent in observation/experience, and a Rehabilitation Mentor.

Before any experience can count toward catastrophic registration, the applicant must submit a proposal which shall outline

- where the applicant plans to obtain training and/or experience
- which disability is being studied
- what onsite supervisor will monitor and verify the times, dates, and hours which the applicant spent at the facility or program
- an on-site supervisor may only serve in that capacity for a maximum of two of the observation/experiences
- who his/her Catastrophic Rehabilitation Mentor shall be for each experience
- a Catastrophic Rehabilitation Mentor may serve in that capacity for all three observation/experiences

A Catastrophic Rehabilitation Mentor is an individual who has been a Board-registered catastrophic rehabilitation supplier for at least two years, and who has agreed to serve as a telephonic mentor/consultant to the applicant mentoring an experience the applicant is using toward catastrophic registration. The applicant may, but is not required to, have a different Rehabilitation Mentor for each experience component. The Board will send the applicant, upon receipt of the form, *Notification of Intent to Apply for Catastrophic Rehabilitation Supplier Registration,* a list of all catastrophic suppliers who have agreed to serve as Mentors. It is the responsibility of the applicant to find his or her own Mentor(s) from this list; or have a qualified certified catastrophic rehabilitation supplier contact the Board's Managed Care & Rehabilitation Division to have their name added to the list. A Rehabilitation Mentor may accept or refuse to mentor any observation/experience component, at the Mentor's discretion. The applicant and Mentor shall staff each experience at least weekly by telephone. The applicant and Rehabilitation Mentor shall also staff the case of the client for whom the applicant will submit the required reports and proposed rehabilitation plan, on at least a weekly basis.

After receiving approval from the Catastrophic Certification Committee, the applicant

shall begin his/her proposed experience/observation. S/he shall staff the case at least weekly by telephone with his/her Mentor. During or after each experience/observation, the applicant shall complete the following documentation on the client the applicant has chosen for required paperwork. The applicant shall not use the client's real name or social security number on the submitted forms and reports:

- An initial report*****
- A proposed rehabilitation plan on official board form WC-R2A*

***All written as though the affected individual were an injured employee.**

- A brief record of all consultations with his or her Mentor, including the dates and topics of discussion; and a brief signed statement from the mentor attesting that this is an accurate summary.
- A statement signed by the on-site supervisor named in the applicant's original proposal, documenting the times, dates, and hours that the applicant spent in the program.

After completion of the experience required for each separate disability, the applicant shall submit the completed form, ***Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant*** along with all of the required documentation for that component, through the Board's Managed Care and Rehabilitation Division, to the Catastrophic Certification Committee. This committee meets quarterly (**refer to the Division's web page on the Board's web site,** www.sbwc.georgia.gov **, for specific meeting dates).** To be considered at a meeting, the documentation must be submitted at least thirty (30) days prior to the scheduled meeting date. The Catastrophic Certification Committee will review the documentation at the meeting and will respond to the applicant usually within sixty (60) days. The Catastrophic Certification Committee may require revision of an applicant's initial report, narrative, and proposed rehabilitation plan before awarding final credit for each component. Once this component is approved by the Catastrophic Certification Committee, it will count toward the applicant's eventual catastrophic supplier registration.

b. Training (40 hours required)

In addition to the observation/work/volunteer experiences noted above, the catastrophic applicant shall document completion of 40 training hours relevant to catastrophic rehabilitation.

All training must be relevant to catastrophic injury medical issues, and/or catastrophic rehabilitation and case management. Topics may include spinal cord injuries, amputations, catastrophic brain injuries, burns, blindness, accessible housing and workplace design, and/or suitable transportation for individuals with catastrophic disabilities. The 40-hour internship at the Roosevelt Warm Springs Conference and Continuing Education Center (RWS) is pre-approved. The applicant should call Warm Springs directly at 706-655-5231 to make arrangements to attend. Once the applicant has completed the RWS internship, s/he shall send to the Board's Managed

Care and Rehabilitation Division a copy of the completed form signed by the RWS professionals certifying his/her attendance at all of the sessions as well as the completed Board Form, ***Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant***.

An applicant may obtain pre-approval for other proposed training by submitting the Board form, ***Catastrophic Supplier Applicant's Proposal Form for Training*** to the Catastrophic Certification Committee, via the Board's Managed Care and Rehabilitation Division, for review. Preference will be given to in-depth training of at least one day's duration. The Catastrophic Certification Committee will respond to an applicant's request for pre-approval for a training component within 30 days of receipt of the proposal.

If an applicant has an opportunity for **relevant** training before there is time to obtain pre-approval from the Committee, the applicant may elect to attend the training without pre-approval; however, the applicant understands that s/he is **taking the risk** that the training may not be approved. No more than two training days (a maximum of sixteen (16) hours) of non pre-approved training may be submitted. The applicant shall submit the training for approval on the Board Form, ***Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant*** as soon as possible.

ADDITIONAL REQUIREMENTS

When the candidate has successfully completed the 190 hours outlined above, the candidate will be registered as a catastrophic rehabilitation supplier. This status is considered probationary; however, the individual may begin to practice and bill as a catastrophic rehabilitation supplier.

Following registration, the catastrophic rehabilitation supplier will then be monitored and mentored for one probation year. This year of monitoring/mentoring begins when the first Form WC-R1 assigning a catastrophic case to the catastrophic rehabilitation supplier is filed with the State Board of Workers' Compensation resulting in an Administrative Decision designating the supplier as the Board approved catastrophic rehabilitation supplier*. All documents required by the State Board shall also be reviewed by the Catastrophic Certification Committee. The purpose of this additional review process is to provide feedback and guidance from a catastrophic supplier perspective as needed, to help the catastrophic rehabilitation supplier acclimate to all levels of the demands of this new position. If necessary, the Catastrophic Certification Committee may request a conference with the catastrophic rehabilitation supplier for in-person feedback.

At the end of the one-year probation period, should the unlikely circumstances warrant it, the Division Director of Managed Care & Rehabilitation may pursue revocation of the catastrophic rehabilitation supplier registration pursuant to Rule 200.1(f)(5).

*Note: As long as there are no appeals and the individual can actually work the case.

See the following appendices to this Chapter, related to this section:

Flow Chart for Applying to Become a Registered Catastrophic Rehabilitation Supplier

Notification of Intent to Apply to Become a Catastrophic Rehabilitation Supplier

Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component

Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant

Catastrophic Supplier Applicant's Proposal Form for Training

Documentation of Training Attended by Catastrophic Supplier Applicant

O. Application, Registration, Renewal, Denial of Applications, Revocation

See Board Rule 200.1(f) (1) for information regarding application, registration, renewal, and appeal process, disciplinary actions against a supplier, and revocation or suspension of registration.

To register as a rehabilitation supplier or rehabilitation resident, an applicant shall submit a completed, notarized, application form, a copy of his or her applicable licenses and/or certifications (CRC, CDMS, CRRN, CWAVES, LPC, CCM, COHN, COHNS), and a registration fee of one hundred dollars ($100.00) to the Board's Managed Care & Rehabilitation Division.

The registration shall be renewed annually. An applicant shall submit a completed renewal application form, a renewal fee of fifty dollars ($50.00), and documentation of current certification. Rehabilitation suppliers registered prior to July 1, 1985, who are not certified by CRC, CDMS, WAVES, LPC, CCM, COHN, COHNS or CRRN shall continue to renew registration annually. The renewal application for uncertified rehabilitation suppliers shall be accompanied by evidence of at least 30 contact hours of continuing education units that have been approved by one of the certifying Boards. Not later than the 30th day of November, the certified and uncertified rehabilitation supplier shall submit an application for renewal.

To maintain registration as a catastrophic supplier, the supplier must maintain his or her status as a Board registered rehabilitation supplier by obtaining annual registration renewal by November 30th of each year.

P. Managed Care Organizations

The Division of Managed Care and Rehabilitation at the Board provides materials to aid in application and certification of Managed Care Organizations. Included in the materials is a comprehensive checklist that should be followed closely by any organization when submitting documentation for application and certification. Organizations should review O.C.G.A. §34-9-208 and Board Rule 208, thoroughly, prior to submitting documents to the Division for consideration of certification.

1. Geographic Service Area (GSA) Coverage for a particular area of Georgia may be provided by individual county or a service area that includes several counties. Except for some counties that have been declared exempt, each county requested for certification must have at a minimum, two (2) providers from the 'Medical' category as defined in Rule 208(a)(1)(E)(1). Network listings submitted to the Board for certification should only list the required providers referenced in Rule 208(a) (1) (E) (1)-(10). A map demonstrating coverage area, a grid or matrix demonstrating total number of required providers per county or counties in service area, and an individual provider list that matches the matrix are required documents. All sample contracts between the MCO and providers and facilities that will be used must also be submitted. GSAs may be customized for MCO clients. Customized GSAs must demonstrate sufficient choice for the employee and be approved by the Division of Managed Care and Rehabilitation at the Board prior to implementation.

2. Employee Access to Medical Care Certified MCOs must demonstrate that injured employees will have access to any of the providers listed in Rule 208(a) (1) (E) (1)-(10) for their geographic service area. Restricting the employee to only certain categories of providers is not contemplated by the statute and rule. Employees should be able to look at a network listing to make their choice. In order to access the chosen provider, the employee calls the certified MCO's toll free number listed on the posted WC-P3 panel card. Supervisors or managers may call on behalf of the employee only when the employee is incapacitated or unable to get to a phone. For emergencies, care should immediately be sought from the nearest emergency facility or by calling 911. Employee follow-up with the certified Managed Care Organization is completed as soon as possible. An employee is allowed a one-time change of provider within the network without proceeding through the dispute resolution process by notifying the case manager of his or her new choice of authorized treating physician.

3. Dispute Resolution All certified MCOs must provide a Dispute Resolution Process. The procedure and any forms necessary for Dispute Resolution must be provided to providers, employers and employees prior to the need for Dispute Resolution. Any issues related to the certified MCO's administration, medical treatment, or additional changes of authorized treating physician are appropriate for the dispute resolution process. A peer review group may be utilized to review any medical treatment issues. The certified MCO must complete the dispute resolution process within 30 days of written notice of the dispute. After 30 days, the disputing party may request Board intervention if the issue has not been resolved.

4. Utilization Review Utilization Review for certified MCOs encompasses pre-certification, concurrent, and retrospective reviews of treatment provided to injured employees to determine medical necessity and cost effectiveness. Applying and certified MCOs are referred to O.C.G.A. §34-9-205 and Board Rule 205 regarding the Board's definition of medical necessity. The certified MCO is required to detail, in the application, and to customers of the MCO, how reviews are accomplished and by whom, the time required to process a review, and appeal procedures for reviews. All final decisions are to be in writing to the employee, employer, insurer, authorized treating physician, and any facility involved.

5. Peer Review and Quality Assurance All certified MCOs are to provide a Peer Review system in which an individual provider's practice is compared to the provider's peers or against an acceptable standard. The Peer Review is performed by a majority of providers of the same or similar specialty, and is done as often as is necessary to ensure appropriate delivery of services. Results of the Peer Review are returned to the providers in the network for information and as an informal educational tool. Quality Assurance in certified MCOs is usually represented by a committee of both providers and administrators. The committee reviews the quality of care (results of Peer and Utilization Review) and other services (Case Management and Customer Service) and determines where improvements in the delivery of services can be made. Improvement efforts are documented and reportable to the Board.

6. Educational Materials Certified MCOs must provide information and education on the services they offer insurers/employers. An information card must be given to each employee defining access to medical services when injured. Brochures or handbooks further outlining the procedures and services within the MCO are given to all employees. Network listings of providers in the GSA are made available to the employees. Once the employees have been given information, the employer/insurer may post the WC-P3 panel card notice to employees that they are covered by a Board Certified Managed Care Organization. The date the WC-P3 panel card is posted is the effective date for coverage by the certified MCO.

7. Case Management The medical case manager in a certified MCO acts as a patient advocate for the injured employee while coordinating appropriate medical care and return to work with the employer of injury. The primary purposes of this medical care coordination are to ensure high quality care, reduce recovery time, and minimize the effects of the injury. The medical case manager updates medical treatment information with all involved parties, facilitating the appropriate return to work of injured employees. The medical case manager assesses cases from the first notice of injury when the injured employee calls the certified MCO's toll free number. After initial contact with the authorized treating physician selected by the injured employee, the medical case manager ensures an understanding among all parties on a treatment plan and time frame appropriate to the diagnosis. There is ongoing assessment of the injured employee's recovery. Treatment and anticipated recovery period are modified as indicated. Case management in a certified MCO is primarily accomplished telephonically with limited use of on-site case management services. MCOs must

identify when on-site case management is likely to be utilized. In catastrophic injury cases a registered catastrophic rehabilitation supplier must be assigned.

All case managers in the certified MCO must have at least one year of workers' compensation case management experience. They must have one of the following certifications: Certified Case Manager (CCM), Certified Rehabilitation Registered Nurse (CRRN), Certified Occupational Health Nurse (COHN, COHN-S), Certified Disability Management Specialist (CDMS), Certified Rehabilitation Counselor (CRC), Work Adjustment/Vocational Evaluation Specialist (WAVE), or Licensed Professional Counselor (LPC). Per Rule 208(h) (3) all parties to the claim and their representatives shall cooperate with medical case management services provided by a certified Managed Care Organization who has posted a WC-P3 panel card at an employer's site.

8. Monitoring Records The Board's Division of Managed Care and Rehabilitation shall monitor the records and activities of the certified MCOs. Quarterly reporting of statistics is required. Annual re-certification may include an on-site visit by the Division's Managed Care Coordinator, Board questionnaires to all recipients of the organization's services, and will require an update from the certified MCO of information on administrative personnel, case managers and provider lists.

9. For further information or to request application materials, please contact the Board's Division of Managed Care and Rehabilitation, 270 Peachtree St., NW, Atlanta, GA 30303-1299, (404) 656-0849.

Appendices to Procedure Manual

1. Information Required to Process Requests for Catastrophic Designation
2. Flow Chart for Applying to Become a Registered Catastrophic Rehabilitation Supplier
3. Notification of Intent to Apply to Become a Registered Catastrophic Rehabilitation Supplier
4. Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component
5. Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant
6. Catastrophic Supplier Applicant's Proposal Form for Training
7. Documentation of Training Attended by Catastrophic Supplier Applicant
8. Transportation Paper – Considerations for Everyone Involved
9. Housing Paper – Considerations for Everyone Involved
10. Mobility & Assistive Devices Guide - Considerations for Everyone Involved

INFORMATION REQUIRED TO PROCESS REQUESTS FOR CATASTROPHIC DESIGNATION:

- Completed Form WC-R1CATEE (current version can be obtained by calling the Board's mailroom at 404-656-3870) with appropriate box checked at top (when requesting a specific rehabilitation supplier, the supplier must be registered with the Board as a catastrophic rehabilitation supplier)

AND

IF FILING IS BASED ON O.C.G.A. §34-9-200.1(G) (1)-(5) (SPECIFIC MEDICAL DIAGNOSES):

- Current medical diagnoses
- Current (within the past year) medical records from the employee's authorized treating physician(s).
- Hospitalization admission and discharge summaries, if available
- For head injuries, a copy of neuropsychological evaluation, if one has been completed
- For multiple digit amputations, diagrams showing sites of amputations
- For burn injuries, percentage of body burned and what type of burns (first, second, third); whether or not five per cent or more of face or hands incurred third degree burns
- For industrial blindness, documentation of employee's current vision

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IF FILING IS BASED ON O.C.G.A. §34-9-200.1(G)(6) (EMPLOYEE IS RECEIVING SSDI AND/OR IS UNABLE TO WORK DUE TO INJURY):

If the employee IS receiving Social Security disability (SSDI) benefits or Supplemental Security Income (SSI) benefits:

- A copy of the Social Security Administration's findings and award of Social Security Disability (SSDI) or Supplemental Security Income (SSI) benefits

OR

- If a judicial decision or rationale was not issued, documentation from the Social Security Administration listing the diagnoses based on which the employee was found to be disabled, as well as notification that he was approved for SSDI or SSI

OR

- If such documentation is unavailable, an affidavit detailing the disability(ies) on which the Social Security award was based, and information about whether or not each of the disabling conditions was related to the employee's work injury

AND ALSO

- The employee's current medical diagnoses (may be included in SSA award)
- Work history for the past 15 years, including physical requirements of each job (may be included in SSA award)
- Education level (may be included in SSA award)
- Current (within the past year and preferably the last six months) opinion from the employee's authorized treating physician(s) regarding whether or not the employee is released to return to work and if so, with what restrictions (may be included in SSA award)
- Information regarding whether or not the Workers' Compensation injury and its residuals were the sole factor or a contributing factor to the disability used as the basis for the Social Security Administration's award of benefits

If the employee IS NOT receiving Social Security disability benefits:

- The employee's current medical diagnoses
- Work history for the past 15 years, including physical requirements of each job
- Education level
- Current (within the past year and preferably the last six months) opinion from the employee's authorized treating physician(s) regarding whether or not the employee is released to return to work and if so, with what restrictions
- Relevant medical records

• FLOW CHART
for
APPLYING TO BECOME A REGISTERED CATASTROPHIC REHABILITATION SUPPLIER

1. Rehabilitation supplier (who must have been a registered rehabilitation supplier for at least two years) sends the form, ***Notification of Intent to Apply for Catastrophic Rehabilitation Supplier Registration,*** to the Board's Managed Care and Rehabilitation Division. Address is Managed Care and Rehabilitation Division; State Board of Workers' Compensation; 270 Peachtree Street; Atlanta, GA. 30303. The form is an appendix to Chapter 7 of the Board's Procedure Manual, and can be obtained by calling the Managed Care and Rehabilitation Division at 404-656-0849.
2. The Board's Managed Care and Rehabilitation Division reviews the ***Notification of Intent*** form. If the supplier is eligible to begin the process of applying to become a registered catastrophic rehabilitation supplier, s/he is sent a list of Rehabilitation Mentors. The applicant is also sent a proposal form (which can be copied) to use to submit proposals for each experience/observation and training component.
3. The applicant contacts a facility, program, or health care professional specializing in one of the disability areas (spinal cord injury, amputation, brain injury, burns, or blindness). The applicant obtains written permission to observe and/or work (paid or volunteer) at that facility or with that health care professional for at least 40 hours in that disability area. The applicant finds a professional at the facility to serve as an on-site supervisor who agrees to document the dates and hours the applicant spends at/with the program. The applicant contacts a Rehabilitation Mentor (from the list provided by the Board's Managed Care and Rehabilitation Division) who agrees to serve as the applicant's Mentor for the experience/observation component.
4. The applicant submits to the Board's Managed Care and Rehabilitation Division a proposal for obtaining the observation/experience component chosen as described in number 3, above. The Catastrophic Certification Committee reviews the proposal, and responds to the applicant within 60 days. The Committee may approve the proposal as written, may approve it with modifications, or may deny it with a written rationale for the denial.
5. Once the proposal is approved, the applicant begins the observation/experience.
6. The applicant documents and has the on-site supervisor sign the documentation of his/her hours of observation/experience.
7. The applicant consults with his/her Rehabilitation Mentor at least once a week, and documents those consultations.
8. The applicant chooses one individual with the chosen disability, and writes an initial rehabilitation report, proposed rehabilitation plan (on Board Form WC-R2A), and narrative justification for the plan, ***as though the individual were an injured employee. No real identification of the person (name, Social Security number) shall be included on the documentation.*** The applicant reviews the proposed documentation with his/her Rehabilitation Mentor.
9. The applicant submits the following required documentation to the Catastrophic Certification Committee by mailing it to the Board's Managed Care and Rehabilitation Division:
    A. Documentation of hours and dates of observation/experience, signed by the on-site supervisor.
    B. Written summary of weekly consultations with the applicant's Rehabilitation Mentor.

C. Initial rehabilitation evaluation report, written ***as though*** the individual with the disability being studied were a Workers' Compensation client.
D. Proposed rehabilitation plan for appropriate services for this person, as if the person were a catastrophically injured employee being provided mandatory rehabilitation in the Georgia Workers' Compensation system.
E. Written narrative rationale/progress report justifying the services proposed in the plan.

10. The Committee reviews the documentation outlined above, and will respond to the applicant.
    If the applicant is required to revise part or all of the submitted documentation, specific information will be provided as to the reasons why. The Committee will review the revised documentation and respond to the applicant.
    The applicant shall repeat the steps noted above (3 through 10) for each of the three disability areas chosen.
11. The applicant shall submit 40 hours of relevant training.
12. When an applicant has successfully completed all of the requirements to become a registered catastrophic rehabilitation supplier, the Board will issue a card documenting the supplier's status as a catastrophic rehabilitation supplier.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE & REHABILITATION DIVISION
CATASTROPHIC CERTIFICATION COMMITTEE
270 PEACHTREE STREET, NW
ATLANTA, GA 30303-1299
(404) 656-0849

NOTIFICATION OF INTENT TO APPLY FOR CATASTROPHIC DESIGNATION

Name: _____

Business Address: _____

Telephone: _____ FAX: _____

Email Address: _____

Home Address: _____

Georgia Rehabilitation Supplier Registration Number: _____

Are you currently and have you been a registered rehabilitation supplier with the Georgia State Board of Workers' Compensation consecutively for the last twenty-four months?
_____

List all certifications you hold, including expiration dates:

By signing this application, I am verifying that I have read and will abide by the Standards of Practice/Code of Ethics of my specific certifications. I understand that it is my responsibility to meet requirements as outlined in the current O.C.G.A. 34-9-200.1, Rule 200.1 and Chapter 7 of the Procedure Manual, which I have read as part of this application. In addition, I realize that changes occur in the rules and the procedures each year and that it is my responsibility to be aware of these changes.

_____ _____
Signature of Applicant Date

(Revised 5-05)

For each of the three required disability experiences/ **CATASTROPHIC SUPPLIER APPLICANT'S PROPOSAL FORM**

Observation/Experience Component

Applicant must submit a separate proposal observations. Proposals should be submitted prior to completing each component. <u>This form must be legible and complete.</u>

1. **This is my FIRST SECOND FINAL experience/observation *(circle one).***
2. **Applicant's Name:_____Date Submitted:_____**
3. **Address:_____**
4. **Supplier#:_____Fax#:_____Telephone:_____**
5. **E-Mail Address:_____Cell Phone:_____**
6. **Catastrophic Disability to be observed (spinal cord, amputation, brain injury, burns, or blindness):_____**
7. **Site Location or Health Care Professional to be Observed (list name, address, and telephone number):_____**
   _____
8. **On Site Supervisor's Name:_____Title:_____**
9. **Catastrophic Rehabilitation Mentor:_____**
10. **Number of years Cat Mentor has been Catastrophic Supplier?_____**
11. **Cat Mentor's Supplier Number:_____Telephone #:_____**
12. **Describe Proposed Experience:-**
    _____
    _____
    _____
    _____
    _____
    _____
    _____
13. **Applicant' Signature:_____Date:_____**

On Site Supervisor's Signature:_____Date:_____

Catastrophic Mentor's Signature:_____Date:_____

<u>NOTE: PLEASE REFERENCE MENTOR, SUPERVISOR AND SELF BY NAME ONLY ONCE WHERE REQUESTED AT THE BEGINNING OF SUBMISSIONS AS THE REVIEW PROCESS IS ANONYMOUS AND NAMES MUST BE EDITED OUT *EACH ADDITIONAL* TIME THEY APPEAR.</u>

<u>Effective July 1, 2003, the Site Supervisor and the Catastrophic Mentor must be different persons.</u>

Return Completed form to:
State Board of Workers' Compensation
Managed Care & Rehabilitation Division
Catastrophic Certification Committee
270 Peachtree Street
Atlanta, GA 30303-1299
Telephone: (404) 656-0849

Revised 4/05

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

(Rev. 7/09)

DOCUMENTATON OF COMPLETION OF OBSERVATION/EXPERIENCE COMPONENT OF CATASTROPHIC TRAINING

The required documentation may count for up to 10 of the required 50 hours for each specific disability submitted. If additional space is needed, please attach.

APPLICANT INFORMATION

Applicant Name:_____ Supplier #_____

Address:_____

City/State/Zip:_____

Telephone:_____ Fax:_____

****

DIRECTIONS FOR COMPLETION

Client Identification: Confidentiality must be maintained: submit only information that clarifies disability (do not use the individual's real name, Social Security number, address or phone number when submitting data requested).

Document information as though the client were an injured worker (as specified in Chapter 7 of the Procedure Manual, Georgia State Board of Workers' Compensation).

****

This documentation is of my (please circle): FIRST SECOND FINAL observation/experience. It is of (please circle):
SPINAL CORD AMPUTATION BRAIN INJURY BURNS VISION

The following information must be submitted to document completion of the experience/observation. (All information noted below must be submitted for the experience/observation to count toward the applicant's catastrophic supplier registration application):

- **Log documenting contacts with the Catastrophic Mentor including dates, topic(s) discussed, Mentor's signature and date signed.**
- **Log documenting contacts with on-site supervisors and professionals, listing dates/hours of involvement. Log must show specific activities/observations, and must be signed by the involved professionals.**
- **Submission of WC-R2A (a proposed rehabilitation plan) outlining services as though the observed person were an injured worker.**

- **Submission of an initial rehabilitation report, outlining information as though the observed person were an injured worker.**

Page Two

The initial rehabilitation report shall include the following information:

1. Current Medical Status
2. Medical needs and recommendations based on opinions of treating professionals
3. Current and potential levels of independence (include housing, transportation, mobility, attendant care, community re-entry and recreation)
4. Safety issues and recommendations to implement appropriate safety measures
5. Social History including assessment of support systems and knowledge of appropriate resource referrals
6. Prognosis based on assessments of cognitive, behavioral, emotional and physical functioning
7. Educational background including any schooling or educational courses completed since injury
8. Employment history including average weekly wage @ time of injury
9. Current employment status including job analysis, modified work availability, work readiness and restrictions
10. Vocational/Avocational objectives including justification of recommendations
11. Other information pertinent to recommendations in WC-R2A:

Page 3

CLIENT INFORMATION

THE FOLLOWING INFORMATION MUST BE COMPLETE AND LEGIBLE

Specify diagnosis and related impairment(s):_____

_____

_____

_____

_____

Date of Onset:_____ Current Age:_____ Sex:_____ Rural or Urban:_____

Site Location and Address: _____

_____

On-Site Supervisor:_____ Title:_____

On-Site Supervisor's Signature:_____Telephone: _____

Rehabilitation Mentor:_____Supplier Number:_____

Rehabilitation Mentor's Signature:_____
(By signature, the mentor affirms he/she has reviewed the documentation)

Rehabilitation Mentor Telephone:_____

_____ _____

Signature of Applicant Date

Revised 4/05

Rev. 7/09)

CATASTROPHIC SUPPLIER APPLICANT'S
PROPOSAL FORM FOR TRAINING (**)
YOU WILL BE PROMPTLY NOTIFIED OF THE DECISION OF THE CATASTROPHIC CERTIFICATION COMMITTEE

Date Submitted:_____ Supplier Number:_____

Applicant's Name:_____

Address:_____

_____

Telephone:_____ Fax:_____

E-Mail Address:_____

Applicant's Signature:_____

TRAINING PROGRAM

Name of Proposed Training:_____

Location:_____

Address:_____

Telephone:_____

Description of Proposed Training:_____

_____

_____

Hours of Training Proposed:_____
Please include a brochure, if available.

Send completed form to:
State Board of Workers' Compensation
Managed Care & Rehabilitation
Catastrophic Certification Committee
270 Peachtree Street
Atlanta, GA 30303-1299

(**) All training must be pre-approved except the 40-hour courses offered by RWSIR.

Rev. 7/09)

Documentation of Training Attended
By Catastrophic Supplier Applicant

Submit this form when you have completed at least 40 hours of training related to catastrophic injuries. Do NOT use this form to document the required experience/observation components. If you attended the Roosevelt Warm Springs Institute for Training Catastrophic Internship, attach your completed log, verifying your attendance. No other training is required.

Date Submitted:_____ Supplier Number:_____
Applicant's Name:_____
Address:_____
Telephone:_____ Fax:_____

E-Mail Address:_____

I certify that I attended the following training on the dates specified. If the training was pre-approved by the Catastrophic Certification Committee, I have noted that in the applicable space:

Training which was pre-approved by the Catastrophic Certification Committee:

Title of Training Date(s) Attended

Training which was NOT pre-approved by the Catastrophic Certification Committee:
Title of Training (With Description and Brochure, if Available) Dates and Hours Attended:

Submit Completed Form to:
State Board of Workers' Compensation

Rev. 7/09)

Managed Care & Rehabilitation Division
Catastrophic Certification Committee
270 Peachtree St., NW
Atlanta, GA 30303-1299

Documentation of Training Attended
By Catastrophic Supplier Applicant

Submit this form when you have completed at least 40 hours of training related to catastrophic injuries. Do NOT use this form to document the required experience/observation components. If you attended the Roosevelt Warm Springs Institute for Training Catastrophic Internship, attach your completed log, verifying your attendance. No other training is required.

Date Submitted: _____
Supplier Number: _____
Applicant's Name: _____
Address: _____
Telephone: _____
Fax:_____
E-Mail Address: _____
_____

I certify that I attended the following training on the dates specified. If the training was pre-approved by the Catastrophic Certification Committee, I have noted that in the applicable space:

Training which was pre-approved by the Catastrophic Certification Committee:

Title of Training Date(s) Attended
_____
_____
_____
_____

Training which was NOT pre-approved by the Catastrophic Certification Committee:
Title of Training (With Description and Brochure, if Available) Dates and Hours Attended:
_____
_____
_____
_____
_____
_____

Submit Completed Form to:
State Board of Workers' Compensation
Managed Care & Rehabilitation Division
Catastrophic Certification Committee
270 Peachtree St., NW
Atlanta, GA 30303-1299

Rev. 7/09)

TRANSPORTATION CHECKLIST

PURPOSE OF PAPER

The purpose of this paper is to help clarify the various transportation issues, which exist in catastrophic and non-catastrophic workers' compensation situations. The primary guideline for determining transportation is based on Georgia State Board of Compensation Rule 200.1, which states the understanding that the goal of Rehabilitation Services is to "*provide items and services that are reasonable and necessary for catastrophically injured employees to return to the least restrictive lifestyle possible."* All parties are charged with the fulfillment of this goal.

II. TRANSPORTATION

A. **General Considerations**

The Rehabilitation Supplier needs to identify transportation needs of the injured worker, taking into consideration appropriate options as discussed in this paper.

An injured worker who experiences cognitive and/or physical injuries which impact his ability to drive, will need to be involved in appropriate evaluations to determine cognitive and physical abilities, before being cleared to resume driving and to determine transportation needs. It is preferable for the injured worker to maintain driving independence. However, their previous driving record/history may impact decisions regarding transportation. Driving potential often cannot be determined right after initial injury, due to other medical complications or factors.

Research all positive/negative factors for providing what is medically necessary, as well as appropriate, for the individual's specific needs. Consider safety, reliability, extent of transportation needs, location of individual geographically, resources in the area and costs of each choice, short term and long term.

B. **Rehabilitation Supplier Responsibilities**

1. Identify transportation needs of the injured worker for
    a. Medical and rehabilitation appointments
    b. Personal business
    c. Social/ recreational/health maintenance
    d. Pre-vocational and vocational activities
    e. Avocational activities

2. Assess the need for an evaluation of the injured worker's physical and/or cognitive abilities as related to driving
    a. Physical functions affecting driving ability may include, but are not limited to: range of motion, muscle strength, reaction time, mobility status, transfer ability, sensation and visual skills. These may be associated with conditions such as, but are not limited to: Amputation, Neuropathy, Spinal Cord Injury, Complex Regional Pain Syndrome, Visual Impairments and Extremity Impairments.

Additional visual testing may be necessary to identify visual deficits that may affect driving.

b. Cognitive functions affecting driving ability may include, but are not limited to: processing speed, concentration, attention span, reaction time, visuospatial judgment and ability to generalize. These may be associated with conditions such as, but not limited to: Brain Injury, Stroke, psychological factors and medication issues as determined by the treating physician.

In brain injury/stroke cases, a neuropsychological evaluation will address deficits accurately and give data to help determine ability to drive, make judgments, learn new skills, etc.

The Rehabilitation Supplier must be aware that cognitive functioning is an ongoing, dynamic process, affected by aging, functional changes and technological advances.

3. Coordinate a driving evaluation with Certified Driver Rehabilitation Specialist (www.aded.org) (see section "C" for information re: driving evaluations)

4. Assess and recommend transportation options - consider short-term vs. long term intervention. Injured worker considerations include: age, conditioning, strength, weight, disease progression and overall medical status. Vendor considerations include knowledge, experience, reliability, availability for service and geographic location in relation to the client.

Using adaptive equipment modifiers registered with the National Highway Traffic Safety Administration (NHTSA) is recommended to ensure that Federal Motor Vehicle Safety Standards are met. (www.nhtsa.dot.gov/cars/rules/adaptive/Modifier/Index.csm)

a. Contract taxi or medical transport
    1) Type of transportation (ambulance, medical transport, auto) should be based on the injured worker's mobility needs; i.e. ambulatory or dependence on mobility devices.
    2) Dependability of service, cost, availability in area needed, etc. should be a consideration on an individual basis
    3) Injured worker's level of confidence, competence and safety issues need to be relayed to the transportation company

b. Public transit
    1) *May offer an alternative source for specific appointments an personal* activities
    2) Must consider convenience (travel time, route changes, stops in relation to destination), availability (route schedule), accessibility (does injured worker have mobility/cognitive skills to use system), and safety issues.

c. Rental
    1) Rental of handicapped, accessible vans for short-term transportation may be financially appropriate
    2) Some minimal adaptive equipment, such as hand controls, may be available through car rental agencies. Use of this type of equipment is not recommended prior to the injured worker receiving a driver's evaluation.
    3) Must consider who is to hold the vehicle insurance on the rented unit

d. Modification of vehicle
    1) Should be based on a dependent passenger or driving evaluation, type of mobility device and/or prescribed vehicle equipment needs
    2) Assess and determine cost effectiveness to modify employee's existing vehicle, considering the age of the vehicle, mileage and operating condition. A mechanical diagnostic evaluation may be necessary to determine condition of vehicle and projected life expectancy of vehicle. It is recommended to use an ASE Certified mechanic. In addition, it must be determined that any existing vehicle can be modified safely and within the context of Federal Motor Vehicle Safety Standards.
    3) Average replacement schedule for a new vehicle is approximately 7 – 10 years, depending on mileage and condition of vehicle.
    4) Adaptive Equipment ranges from spinner knobs and left footed accelerators to high tech hand controls and computerized joystick systems. Adaptive equipment training may require 5 to 40 additional hours. In special circumstances, this could be higher.
    5) Rarely are structural modifications (raised roof, lowered floor) performed on older vans. Additional weight could cause accelerated wear and tear and may be dangerous. Some equipment such as hand controls and foot pedals may be moved to another vehicle. Consider cost to move equipment from one vehicle to another.
    6) Financial considerations (see section J)

e. Auto vs. van vs. truck (See section D)

5. Educate all parties (claimant, adjuster, attorneys, etc.) concerning recommendations to be made in the rehabilitation plan. This can include options, costs analysis and medical necessity.

6. Develop and submit proposed Independent Living Rehabilitation Plan (per Rule 200.1 (a)(5)(ii)) incorporating proposed transportation needs. This must be substantiated by documentation, including, but not limited to: driving evaluation, functional evaluations, seating/mobility evaluations, cost projections and physician orders.
    a. A plan should always be in place that allows the injured worker to be transported safely as a passenger, even if he is the primary driver.
        1) A secure lock down should be in place for the wheelchair, even if unoccupied.
        2) An able bodied driver should be able to operate the vehicle, if necessary

3) If the injured worker's vehicle is not modified so that he/she can be transported as a passenger, an alternative transportation service needs to be provided.
4) Likewise, if the modified vehicle is inoperable, alternative transportation needs to be provided.

C. **Driving Evaluation**

1. General Considerations

A driving evaluation will assess physical, visual, perceptual and cognitive skills, as well as identifying safe/unsafe-driving techniques. It will also help identify adaptive equipment needs. Referral for a driving evaluation with a Certified Driver Rehabilitation Specialist (CDRS) is strongly recommended and should be performed by a provider that has both clinical and on-the-road evaluation capabilities available. Specific adaptive equipment should be listed as a result of the evaluation, in order to obtain physician orders and clear and cost effective bids as needed.

a. According to Georgia Law (Code Section 40-5-35) a driver must be seizure free for 6 months.
b. A driver's license or learner's permit is required unless otherwise specified by the Certified Driver Rehabilitation Specialist (CDRS)
c. Both a car and a van may need to be available for assessment. The injured worker should test all equipment being recommended during the "on the road" evaluation
d. The optimal time for referral varies based on physical recovery, ability to learn new tasks/techniques, and the effect of medications on the central nervous system and cognitive function.
e. Information needed includes physician prescription and a brief medical summary (current report addressing functional abilities impacted by disability and medications).
f. If the injured worker does not pass the evaluation, re-evaluation in 6-12 months may be an option. A driver's training/rehabilitation program may assist the injured worker in passing the evaluation.

2. Specific Considerations

a. Physical

If the injured worker uses a mobility device (power or manual wheelchair, scooter) or functional/adaptive aids, this equipment needs to be available for the driving evaluation.

b. Cognitive

A driver's evaluation may not be appropriate for 3-9 months post injury, unless it was a light stroke or minor head/brain injury with few residual deficits. Consult the treating physician regarding the timing of this evaluation.

D. **Vehicle Types/Equipment Needs**

The injured worker's capability to transfer himself/herself, with or without assistance, and ability to load/unload his/her mobility device, must be considered in all aspects of vehicle purchase and modifications (See Decision Tree).

1. Automobile
   Automotive design recommendations will depend upon the physical size and limitations of the injured worker, type and size of mobility device to be utilized and the need for accommodation in driving controls to safely drive vehicle. Many of these questions will likely be addressed as part of the driving evaluation.

   The injured worker should test his/her ability to load and unload the mobility device into the automobile being considered for purchase.

   a. Accommodations may include accelerator and/or brake modifications, hand controls and a power driver's seat. Consideration should be given to automatic windows, door locks and side mirrors.
   b. Assess need for two-door or four-door design to facilitate loading/unloading of mobility device.
   c. Seat height should accommodate both transfers and visibility.
   d. Distance between the steering wheel and injured worker must allow for transfer of mobility device into vehicle. This may require a powered driver's seat.
   e. A bench seat may be more practical than bucket seat for making transfers
   f. Assess the vehicle's capability to bear the weight of adding a loader type lift.
   g. If transfers, loading/unloading and vehicle operation requires significant expenditure of energy from the injured worker, the appropriateness of an automobile versus a van should be reassessed. Future and premature damage to the injured worker's upper extremities should be considered.

   2. Truck
      If a truck is utilized, the structure, height of truck, need for extended cab (particularly for a lift) and a canopy to the truck bed need to be addressed. Lifts are available for putting a wheelchair/scooter into the bed of a truck and also for positioning the injured worker into the driver's seat.

   3. Mini-Van versus Full Size Van
      Structure, weight, tonnage, lift platform options, size of engine, wheelbase, lowered floor and/or raised roof, terrain, individual level of function and technology requirements are all factors that determine appropriate van purchase.

      a. A van has to be large enough to provide easy ingress and egress, as well as maneuverability of interior space.
      b. Family size, cargo capacity, vehicle handling, visibility, fuel economy, maintenance costs, tire replacement, ground clearance and garage access are considerations for any van.
      c. Full size vans, such as the Ford E-250 may be preferred due to the higher gross vehicle weight rating, heavy-duty systems, and overall durability. With modifications, this vehicle can accommodate clear unobstructed entry for individuals with a seated height of up to 60 inches or more. Recommendations

for lowered floors and raised roofs should be obtained through a driver's evaluation

E. **Handicapped Permit and License Plate**

The treating physician will determine whether the injured worker will qualify for a handicapped permit/plate. In the case of a long-term disability, an injured worker has the choice of either a portable handicapped permit or a handicapped license plate. Temporary permits are available for short-term use.

1. Handicapped Permit form is obtained from the local State Driver's License Office and must be completed by the treating physician. Some physicians have this form in their offices. The permit form must be notarized. The permit is portable and can be used in any vehicle in which the injured worker travels.

2. Handicapped license plates are obtained from the local county tag office. The physician must complete the handicapped permit form and it must be notarized. Fees for this license plate are the same as a regular plate. To obtain a handicapped license plate, the disabled person must have the vehicle title in his/her name. This license plate is not portable or transferable.

F. **Outside Carriers, Lifts and Ramps**

Safety, security, exposure to weather, handling and maneuverability of the vehicle, possible damage to mobility equipment, cargo space, injured worker's functioning level, vehicle modifications and cost are all factors to consider in determining the appropriate system.

1. External lifts/trailers
   The vehicle must be retrofitted with an approved hitch and platform. The size of engine and type of vehicle determines if this type carrier can be considered. The wheelchair/scooter is transported outside of the vehicle. This system allows for easy access to equipment and no cargo space is required.

   The injured worker must be able to position and lock down the scooter/wheelchair and be able to ambulate from the back of the vehicle, if no one is available to assist.

2. Inside lift
   An inside system allows the injured worker to transport mobility equipment inside the vehicle.

   a. An unoccupied hoist lift positions the wheelchair/scooter into the bed of a truck or through the rear door of the vehicle. The injured worker must be able to attach the wheelchair/scooter to the lift and be able to ambulate to get into the vehicle, if no one is available to assist.

   b. Fully automated lifts allow the injured worker to be lifted inside the vehicle while occupying his/her mobility device and can be operated independently or with assistance. The type of lift is determined by total combined weight of the injured

worker and the mobility device. This information should be provided through the driving or dependent passenger evaluation.

3. Ramps
   Generally, ramps are used on mini vans only, due to the safety concerns and degree of incline.

   a. Automated Ramp
      Allows injured worker to ingress/egress (enter/exit) while occupying a mobility device and can be operated independently or with assistance.

   b. Manual Ramp
      Manual ramps are available for occupied mobility devices if attached to a vehicle, assuming the ramp angle is safe and that the mobility device has adequate traction and power. Manual ramps require assistance.

G. **Portable Ramps**

Portable ramps are available for wheelchair /scooter users to carry in their vehicles to allow access to areas not handicapped accessible. These ramps are lightweight and available in varying lengths.

H. **Home Ramp System**

Refer to the housing paper regarding ramp specifications for covered areas.

I. **Accessible Covered Areas**

Mobility problems may restrict the speed at which an injured worker may *enter* (ingress) and *exit* (egress) from a vehicle. Exposure to the elements may be particularly hazardous to an injured worker's health and the preservation of the mobility device. In such cases, the Board will require a covered parking area. For example, people with spinal cord injuries have a hard time regulating their body temperature, so exposure to rain/cold, etc., could have medical consequences.

Where feasible, it is preferred that the covered parking area be attached to the home. Parking requirements will vary on a case-by-case basis. The parties should take a common sense approach as to what each injured worker will need, based upon his/her individual factors.

J. **Financial Considerations**

1. Consider purchase versus rental, pre and post injury insurance rates, and maintenance costs for vehicle. Case parties need to determine, prior to the actual purchase and modifications, their financial responsibility in the transportation process and who is paying for what. This must be documented in an Independent Living Rehabilitation Plan.

2. Traditionally, vehicles are considered an ongoing rehabilitation expense due to scheduled replacement of vehicle and ongoing maintenance and repairs related to prescribed adaptive equipment.

3. If a vehicle is purchased or modified and that vehicle is utilized in rehabilitation services, (such as medical appointments, pharmacy, rehabilitation/vocational services, etc), the injured worker is reimbursed for mileage, per the Georgia Worker's Compensation Fee Schedule, unless negotiated otherwise. This reimbursement compensates for gasoline and wear and tear on the vehicle.

4. Maintenance costs to the prescribed adaptive equipment is the responsibility of the employer/insurer.

5. Extended Warranties on the entire vehicle are strongly recommended to protect all parties, increasing the life of the vehicle and adaptive equipment and reducing replacement time.

6. General maintenance for the vehicle remains the responsibility of the injured worker, unless negotiated otherwise.

7. Insurance: generally, the injured worker is responsible for continuing payments of the vehicle insurance premiums, based on pre-injury vehicle insurance costs. The employer/insurer is responsible for additional insurance premium costs due to the increased value of the vehicle and modifications required, unless negotiated otherwise.

8. Cell phone service, as medically prescribed, is essential for persons with the potential to develop a medical or vehicle emergency while driving independently or being transported.

9. The injured worker is responsible for maintaining current tags/ad valorem tax, based on pre-injury vehicle costs, with the employer/insurer being responsible for additional cost due to increased value of the vehicle and modifications, unless negotiated otherwise.

10. Title determination must be addressed by case parties on an individual case basis. To obtain a Handicapped License Plate, the disabled person must have the vehicle title in his/her name.

K. Ethical Considerations

The concept of "normalization" is especially vital to individuals who require adaptive equipment for independent functions. Access to the community is an important aspect of normalization. Rehabilitation Suppliers have an ethical obligation in working with the catastrophically injured worker to ensure that transportation is available, not only for medical appointments and independent living activities, i.e.: shopping, but also for recreational activities.

The Rehabilitation Supplier has a vital role in the process of obtaining appropriate transportation, taking into consideration the injured worker's preferences and the cost

effectiveness for the insurer. Each injured worker has individual physical needs and life-style requirements. The independence offered by the appropriate vehicle and mobility equipment can be life changing.

L. **Disclaimer**

This transportation information is being provided as general information and to assist with giving appropriate solutions for various transportation issues that may arise while working with an injured worker during the rehabilitation process. It is not all-inclusive or specific to an individual injured worker's needs. It is to be used as a guide to explore transportation issues with all parties.

The Board's Managed Care and Rehabilitation Division wish to thank the following people for their valuable input and research in developing this document:

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Pam Arthur
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Development completed 7/2003

ATTACHMENT TO TRANSPORTATION CHECKLIST

DECISION TREE
Car versus van

Can the person transfer independently and efficiently to a car? (If it takes too long or takes too much energy, it might not be worth the effort)

No Consider a van with a person driving from a wheelchair or transfer seat. Skip to #5

Yes Car is a possibility. (If the person owns a vehicle that is not a car, such as a pickup truck, SUV or van, make sure they can transfer into their personal vehicle, not just vehicle) Proceed to next question.

Does the person have a mobility device? (walker, crutches, canes, wheelchair, scooter)

No Car should be possible

Yes Proceed to next question

Can the person load and unload their mobility device independently?

No Proceed to next question.

Yes Car should be possible (If the person owns a vehicle that is not a car, such as a pick up, SUV or van, make sure they can load this device into their personal vehicle, not just any vehicle)

Can the person load and unload their mobility device using adaptive equipment such as a lift or topper? (NOT compatible with all wheelchairs and scooters or with all vehicles)

No Van should be considered

Yes Car can be considered.

Can the person transfer efficiently to a level or downhill surface?

No Consider a van for a wheelchair driver with a lowered floor in cargo and driver's areas and an automatic lockdown.

Yes Consider a van with a transfer seat. This may allow the person to avoid some structural modifications. (Keep in mind they may have to reposition their legs several times while moving into position under the wheel. Tall people or people with bad extensor spasms can have problems with the narrow space between seats)

Is their seated height more than 5'3'? (applies to dependent passengers also)

No Consider flat top or lowered floor minivan.

Yes Consider raised roof and doors.

Is their seated height more than 5'5"? (applies to dependent passengers also)

No Can consider either lowered floor minivan or full size van. See next question.

Yes Should only consider full size van.

Can the person push or drive up a minivan ramp

No Should only consider full size van

Yes Can consider either lowered floor minivan or full size van

The Board's Managed Care and Rehabilitation Division wish to thank the following people for their valuable input and research in developing this document:

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John Sweet
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Gordon Zeese

HOUSING PAPER (2009)

This housing information was prepared by a subcommittee appointed by the Board. It is being provided as general information and to assist with giving appropriate considerations for housing issues that may arise while working with an injured worker during the rehabilitation process. It is not all-inclusive or specific to an individual injured worker's needs. It is to be used as a guide to explore the housing issues with all parties.

PURPOSE OF PAPER

The purpose of this paper is to help clarify the various housing issues which exist in some catastrophic workers' compensation situations. The primary guideline for determining housing needs is based on Georgia State Board of Workers Compensation Rule 200.1, which states the understanding that part of the mandatory Rehabilitation Services is to "coordinate reasonable and necessary items and services to return the employee to the least restrictive lifestyle possible." When necessary, this specifically includes suitable housing. While the catastrophic rehabilitation supplier is required to be the point person to coordinate these services, all parties are charged with the fulfillment of this goal.

OVERVIEW

Rule 200.1 gives little guidance as to what constitutes "reasonable and necessary items and services" and only states that they may include "housing and transportation". Unfortunately, thus far, there has only been one case-law decision rendered on housing in the catastrophic claim setting, Pringle v. Mayor & Alderman of the City of Savannah, 223 Ga.App.751; 478 S.E.2d 139(1996). The essence of this Court of Appeals decision addressed whether the Board had the right to mandate the provision of payments towards housing costs by the employer/insurer. In the Court's analysis, housing accommodation needs could be addressed as a medical need if the authorized treating physician(s) prescribes them. (Id. @ 752). It also found that, pursuant to Rule 200.1 of the Workers' Compensation Act which clearly requires the employer/insurer to provide necessary modifications to the employee's home, it is also a rehabilitation need. While the solution reached in Pringle is specific to the facts of that case, the case highlighted the issue that appropriate accessible housing may require alternative solutions if the employee's prior living arrangement is incapable of being modified. (Id. @ 754). In addition, the Court further held that the Board was within its discretion to mandate the employer/insurer fund additional payment towards housing costs if they result from needs necessitated by the compensable on-the-job injury. Finally, this decision also established the proposition that the employee is expected to contribute towards his/her housing, as well.

There are many shades of grey in the interpretation of "least restrictive lifestyle". Each catastrophic claim, by its very nature, is different. It would be impossible to construct a law or rule on housing that would accommodate the varied needs of individual injuries. However, there is an evaluation process that should be implemented when addressing housing needs. To begin with, although ***payment*** for suitable housing is a claims issue in catastrophic injury cases, ***suitable housing*** itself is a rehabilitation issue. ***Every Catastrophic Rehabilitation Supplier ("Rehabilitation Supplier") is responsible for researching and coordinating appropriate housing for catastrophically injured employees whose injuries necessitate***

special housing accommodations. As such, it is imperative that the Board assigned Rehabilitation Supplier spearheads the implementation of this issue and is *always* kept in the loop. However, parties must recognize that the Catastrophic Rehabilitation Supplier is *not* the housing "expert". The Rehabilitation Supplier's role is the coordination of the consultation of experts and the gathering and dissemination of information of the various options to all parties upon which housing decisions may be made.

This paper is intended to serve as a guideline to suppliers involved in developing proposed housing plans. ***All phases of the housing process should be covered under specific rehabilitation Independent Living Plans***. All the plans should designate responsibilities with timeframes. The Rehabilitation Supplier should share information with all parties as soon as it is obtained.

REHABILITATION SUPPLIER RESPONSIBILITIES

The two guiding principles that should remain in the forefront of the suitable housing evaluation are "safety" and "accessibility". This necessarily contemplates the employee's functional status. It may take several experts in varying fields to reach a reasonable conclusion.

The Rehabilitation Supplier should immediately commence activity to obtain information regarding the injured worker's housing situation and preliminary functional and medical information from the authorized treating physician and/or appropriate healthcare provider.

The Rehabilitation Supplier should identify medical and/or functional factors related to the injury, including but not limited to the following, as determined by the authorized treating physician and/or appropriate healthcare provider: **[Note: a formal evaluation of the employee's functional abilities and deficits may be required to obtain all of the necessary information listed below.]**

Working diagnosis(es).
Level of independence or dependence with activities of daily living (ADLs).
Fine and gross motor dexterity.
Strength and endurance capacity.
Cognitive function and any cognitive related deficits.
Sensory deficits (auditory, tactile, visual).
Trunk and lower extremity function.
Gait and balance.
Prognosis and timeframe for improvement.
Co-morbid factors including any age-related factors.
Projected discharge date.
Projected home health care and/or nursing care upon discharge to home.
Projected surgeries and/or rehabilitation treatment.

At the initial appointment, the Rehabilitation Supplier should obtain information from the injured worker and/or the injured worker's family/friends as to the injured worker's housing arrangement, including but not limited to the following:

Address, including county and state.
Type of dwelling (home, trailer, apartment, condominium, etc.).
Number of floors (ranch, 2 story, split-level, etc.).
Cost of rent or mortgage.
Identify the people who reside in the dwelling.
Age of dwelling.
Number of bedrooms and number of bathrooms including half baths.

Flat lot or uneven, hilly terrain.
Location of exterior doors.
Presence of interior/exterior steps or stairs and handrails.
Type of vehicle injured worker drives and where it is parked at the dwelling.

The next step for the Rehabilitation Supplier is to visit the residence to perform a preliminary assessment of needs.

If adaptations are necessary, and it appears that the dwelling can be modified:

The Rehabilitation Supplier will discuss with the authorized treating physician (ATP) to obtain a prescription for a home evaluation by a professional who is experienced in home accessibility issues (i.e. O.T., P.T. etc.).

The Rehabilitation Supplier should then proceed to coordinate and attend the home evaluation to determine:

If modifications can be completed to the dwelling.
Specifications of what modifications should be done.
If modifications will be suitable for long-term housing needs.

The Rehabilitation Supplier will then coordinate the acquisition of bids by licensed contractors and then present the bids to the parties.

The parties will determine if the modifications are economically feasible.

When a decision has been reached and if a contractor is selected (See Section VI), the modifications should be implemented.

If it appears that the dwelling cannot be modified for long-term accessibility, the Rehabilitation Supplier should then proceed with these additional steps:

Discuss with all parties preferences for suitable long-term (permanent) accessible housing options, taking into account all of the variable considerations (See Section V below).

If there is an agreement among the parties on a specific option, focus research and availability on that type of long-term (permanent) housing selected. Research should include costs for comparative purposes. Present research to all parties. If all parties agree on a selection, proceed to implementing the necessary steps to bring it to fruition.

If there is not an agreement among the parties as to which long-term (permanent) accessible housing option is appropriate, then the Rehabilitation Supplier must research all of the appropriate options, given the specific needs of the injured worker. Research should include costs.

If the parties do not agree on any aspect of long-term (permanent) housing, the Rehabilitation Supplier should immediately request a rehabilitation conference (WC-R5) to have the issues addressed by the Rehabilitation Coordinator overseeing the claim.

Prior to the rehabilitation conference, the documentation, reflecting the results of the research, should be distributed to all parties so informed discussions may be held and decisions made at the conference.

The Rehabilitation Supplier will develop an Independent Living Rehabilitation Plan (WC-R2a) which outlines the rehabilitation services, specifically focusing on the housing needs. This should include performing all of the research necessary to address the housing issue. This may require an addendum to an existing plan.

Regardless of the permanent housing decision, if the employee is ready to be discharged from in-patient care, if he/she cannot return to his/her prior living arrangements, and the permanent housing is not yet identified or ready, then temporary housing must be considered and addressed. Likewise, if an employee has already returned to his/her home and it is subsequently being modified, the employee may need to leave the premises during the construction. Temporary housing must be

addressed. It is imperative for the Rehabilitation Supplier to identify this issue as early as possible to avoid decisions having to be made on an emergency basis.

The Rehabilitation Supplier will discuss with all parties the possible Temporary Housing options. The Rehabilitation Supplier will discuss with the ATP to obtain a prescription for temporary housing while permanent housing is being established.

TEMPORARY HOUSING

All parties must be clear that the term "TEMPORARY HOUSING" is not to be confused with long-term (permanent) placement of the injured worker and family of the injured worker. It is considered a "stop-gap" while long-term (permanent) solutions are contemplated and implemented. It should ***never*** be used as an excuse to delay the provision of suitable permanent housing.

GENERAL CONSIDERATIONS

It is the Rehabilitation Division's expectation that a family unit, whenever possible, will stay together to include both family and pets. A motel room and/or rooms are not acceptable long term housing except while necessary home modifications are being completed or pending closing on permanent accessible housing.

Prior to exploring options for Temporary/Interim Housing, at *least* the following should be considered:

Disability Type
- What modifications are necessary?
- Will there be attendant care needs?

Family Composition
- Is there a spouse/significant other?
- Are there children living at home? If so, who provides childcare or is there a need for children to be kept in a specific geographical area to attend school?
- Who will care for the pets: i.e., will family/friends or is boarding the pets required?

Pre-Injury Housing
- Are temporary modifications possible?
- Should other accessible properties be considered?

Geographical Convenience
- Medical appointments.
- Community Services.

OPTIONS TO CONSIDER

Assisted Living

Assisted Living may be a consideration for individuals aged 50 and above, if minimum assistance with transfers and ADLs is required. Advantages are socialization and ongoing planned activities, as well as transportation for both medical and non-medical outings. Some also have onsite therapies, pools, hair salons, and physical therapy or gyms. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

Corporate Rental Properties

Furnished apartments that are accessible are available with short-term lease options. These may be appropriate to consider while one's permanent housing needs are being addressed via home modifications or purchase of accessible housing.

Group Home

Group Home may be appropriate for temporary housing for individuals who need accessible housing as well as continuing Medical Services provided by a Specialty Facility outside of the geographical area of permanent housing needs: i.e., for individuals w/dual diagnoses: spinal and traumatic brain injuries. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

Independent Living

Another option for individuals aged 50 and above, with or without a spouse and without dependent is independent living. This option allows for the injured worker to reside in a private apartment and utilize the amenities that are available onsite: i.e., planned onsite and offsite daily activities, available scheduled transportation for outings for medical appointments, as well as leisure activities.

Long Term Stay Motels

Extended stay motels are available that include usually one bedroom, living area with sleep sofa, small kitchenette, and laundry facilities onsite. Accessible rooms are available with roll-in showers in many of these. Rentals can be weekly versus monthly or long-term contracts. The needs of not only the injured worker to include attendant care requirements but also the family unit and /or pets must be considered. This option may require the need for multiple rental units.

Skilled Nursing Facility

If the injured worker requires ongoing licensed nursing care, this type of restrictive facility may prove beneficial during the research for permanent placement. However, this option should truly be limited to individuals that are medically impaired and require that level of nursing care on a continuous basis. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

LONG-TERM (PERMANENT) HOUSING

Permanent housing options must be thoroughly explored and considered with the goal of providing reasonable and necessary accommodations to return the injured worker to the least restrictive lifestyle possible.

GENERAL CONSIDERATIONS

Long-term/permanent housing is often the most difficult task the injured worker and the Rehabilitation Supplier will face as a team. There are numerous options to explore and evaluate. A rehabilitation Independent Living Plan needs to be drawn up and submitted to the State Board, even if all parties do not agree. The task of reaching a decision and finalizing the needs is often time consuming. The attending physician and various experts should be consulted for support and ideas on the choices for housing. These guidelines should enable the Rehabilitation Supplier to begin working with the client and family appropriately as soon as possible on permanent housing needs. Of course, in all cases, the insurer and attorneys need to be involved. The Independent Living Plan should include all steps to accomplish the chosen long-term (permanent) housing solution and should be amended, as needed.

Parties need to remember that housing needs are disability driven and based upon residual functional capacities. Present housing needs are *not* defined by an injured worker's prior living arrangements (e.g. value of home, size of home, number of rooms, etc.). Likewise, design and/or

material upgrades, unrelated to safety, function, or accessibility, are not the responsibility of the employer/insurer. Parties are cautioned to anticipate potential changes in functional levels (See Section IX below), especially if resolving by partial settlement (See Section XII below).

OPTIONS TO CONSIDER

It is the responsibility of the Rehabilitation Supplier to investigate multiple options simultaneously to enable the parties to determine which is most appropriate.

Apartment Accommodations

Sometimes an apartment is the best long-term option for housing. The Fair Housing Amendments Act of 1998 prohibits discrimination in housing on the basis of disability. It also states that certain multi-family dwellings designed and constructed for first occupancy after March 13, 1991 must be built in a manner that makes them accessible to persons with disabilities. The Act established design and construction requirements to make these dwellings readily accessible and usable by persons with disabilities. On March 6, 1991, the department published final Fair Housing Accessibility Guidelines to provide builders and developers with technical guidance on how to comply with the Fair Housing Act. Rental offices and sales offices for residential housing are by their nature open to the public and are places of public accommodation. Individuals with disabilities may ask the housing provider to make a reasonable accommodation to a "no pets" policy. Tenants may be required to provide proof of disability and substantiate the need for the service animal. A tenant and the Rehabilitation Supplier should keep in mind the following when looking at an apartment:

Distance from parking.
Age of apartment (newer apartments may require less modification).
Accessibility features of the apartment amenities.
Design features.
Flooring.
Size of and maneuverability between rooms.
Two accessible exits/entrances that may be utilized for emergency or evacuation needs.
Lighting.
Storage.
Accessible bathroom location.
Washer/Dryer locations.
Access to public transportation.

Condominium

The apartment accommodation section gives valid information which is applicable to choosing a condominium. The Rehabilitation Supplier would obtain written verification that the modification can be made.

A condominium is a form of home ownership in which individual units of a larger complex are sold, not rented. These units may be renovated apartments, townhouses, or even commercial warehouses. Contrary to popular belief, the word "condominium" does not apply to the type of unit itself, but the legal ownership arrangement.

Those who purchase units in a condominium technically own everything from their walls inward. All of the individual homeowners have share rights to most common areas, such as the elevators, hallways, pools, and club houses. Maintenance of these areas becomes the responsibility of a condominium association. Every owner owns a share of interest in the

condominium association, plus an obligation to pay monthly dues or special assessment fees for larger maintenance problems.

A condominium arrangement is not the best option for every potential homeowner. There can be a noticeable lack of privacy in the common areas—the pool must be shared with every other condominium owner, for example. Those who would prefer to own all of their amenities and maintain their own lawn and garden may want to pursue single home ownership options instead of a condominium. It can also be more difficult to sell a condominium unit as opposed to a home with acreage. Condominium owners only own their units, not the ground beneath them.

Those who may benefit the most from condominium living are veteran apartment renters who don't mind having close neighbors. Others may not be capable of external maintenance or the responsibility of lawn care. The overall price of a condominium townhouse may be much lower that an equivalent single-unit home. Buying a condominium does allow equity to build, unlike paying monthly rent in an apartment complex.

One thing to be aware of, when living in a condominium setting, is the political reality of an owner's association. Decisions may be made in monthly meetings which will cost individual owners more money, but not necessarily deliver equal benefits for all. The potential increase for assessment of fees needs to be considered and agreed upon by the paying party. It can be nearly impossible to avoid being affected by at least one condominium board decision, so active participation in meetings and discussions may be more compulsory than you might expect. Condominium living may be more advantageous financially than apartment rentals, but it does require more active participation in community events.

Modification of an Existing Home

The following is applicable to either the employee's current home or an existing home that will be purchased. Prior to determining if an existing home is a viable option, there are many variables that need to be considered:

Injured worker's desire to be in the home.
Condition of the home.
Size of the home (room sizes that will be utilized by the client).
Size of lot.
Slope of lot.
Levels of the home.
Need for public transportation.
Need for school district for children or jobs.
The building of an addition versus elaborate reconstruction.
The cost effectiveness of the modifications and/or additions. Proper analysis by the necessary experts is required for this determination. Remember, these steps need to be included in an Independent Living Plan.

New Home Construction

For the purpose of this housing paper, three building systems will be considered. These include Site-built, Modular, and Manufactured Homes. (See ADDENDUM: Comparative Chart).

Site-built (traditional stick-frame) Home

Homes are built to specifications on site by construction workers, carpenters, electricians, plumbers, etc., who are supervised by the building sub-contractor or general contractor. Homes are built to meet or exceed local/regional code regulations.

Modular Home (pre-fabricated)

Homes are built to the same building codes as Site-built homes, but are constructed off-site usually in a factory setting. Sections of the home are constructed in separate components or modules, which are later assembled on-site, on a foundation which would be similar to a site-built home. Because of the controlled environment during the construction of individual modules, there is a reduction in overall pricing for modular homes, as well as a reduction in the time required to complete the overall construction project.

Manufactured Home (aka mobile home)

The Federal Construction Safety Standards Act (HUD/CODE) requires manufactured homes to be constructed on a non-removable steel chassis. Manufactured homes are built in an assembly-line or factory environment. The building codes are not the same as the building codes for modular or site-built homes. The manufactured home would be transported on wheels, in a single or double-wide configuration, to the land on which it would be placed. Based on the HUD definition, a "mobile home" is a manufactured home which was built prior to the effective date that the Housing and Urban Development (HUD) code went into effect on June 15, 1976.

Facilities

The Rehabilitation Supplier should visit the facilities that are being considered for long-term living options, determine that the needs of the injured worker will be met, and coordinate with the family and the doctor. The following options for long-term housing may be appropriate or not appropriate based on individual needs. Another issue concerns family circumstances and pets. As indicated above, the Rehabilitation Supplier must obtain a referral from the ATP for these options to be considered.

Assisted Living/Nursing Homes

Assisted Living facilities have services available to the residents and a monthly fee is paid often with additional fees for services, such as, cooking, laundry, reminder to take medications, etc. For individuals, aged 50 and above, Assisted Living may be a consideration if the injured worker needs minimum assistance. A clear definition of any and all assistance needed will dictate whether the assisted living facility is appropriate or not. Advantages are socialization and ongoing planned activities, as well as transportation for both medical and non-medical outings. Some also have onsite activities, pools, hair salons, and physical therapy or gyms.

There are several resources available to assess the quality of skilled nursing facilities. MemberoftheFamily.net provides an annual survey rating system for actual potential for (resident) harm, violations, and repeat violations. The Georgia Nursing Home Association (www.gnha.org) offers a comprehensive checklist of what to observe (during a visit), questions to ask yourself and facility staff, and nursing home statistics. Finally, www.Medicare.gov/NHCompare has a five star rating system detailing information about the past performance of every Medicare and Medicaid certified nursing home in the country which can be researched at www.Medicare.gov by geography, proximity, and name. Medicare and Medicaid certified nursing homes are rated as to their last inspection in the Nursing Home Compare Section. The Rehabilitation Supplier should not rely on this report alone because minimum standards are reflected in the report and conditions change frequently. The Ombudsman in the area of the home may be contacted for the most current information. The Rehabilitation Supplier should perform a site visit prior to the recommendation of a specific facility. The Rehabilitation Supplier should consider that all nursing homes are not appropriate for patients, with tracheotomies, for example. Individualized assistance will need to be addressed and provided separately per

physician and physical or occupational therapist recommendations. For example, specific assistance with ADLs or transfers may be indicated. In addition, alternatives to nursing homes may be located at Elder Care Locator at 1-800-677-1166.

Board and Care Homes

Board and Care homes are designed for people who do not meet the needs of independent living but do not require nursing home services. Most provide assistance with some ADLS, for example, eating, walking, bathing, and toileting. Many of these facilities do not take Medicare and Medicaid and are not strictly monitored. The Rehabilitation Supplier would have to carefully research and monitor these facilities.

CCRCS (Continuing Care Retirement Community Services)

The Rehabilitation Supplier would need to use these facilities carefully and determine that the geographic requirements are met. CCRCS housing communities provide different levels of care based on the individual needs from independent apartment to skilled nursing. CCRCS are usually appropriate for ages 50 – 55 and over. The Rehabilitation Supplier would have to check the quality of the facility and nursing home. Most of these facilities require a large payment prior to admission and then no fees are charged. This would be a long-term arrangement and would need to be agreed upon by all parties and care would need to be taken in ensuring that the injured worker's best interest is served.

Specialized Facilities

Long-term specialized facilities would include those meeting the needs of injuries including brain injury, burns, spinal cord, etc. These exist locally and nationwide.

CHOOSING THE CONTRACTOR

There are a few guidelines to explore to avoid an unhappy experience with the contractor. The best way to avoid additional stress and to ensure a good outcome is to choose the correct contractor. The parties are responsible to perform a due diligence investigation of any contractors considered to participate in the housing project.

As a reminder, it is the Rehabilitation Supplier's responsibility to gather all information and documentation regarding the housing project, to include the parties, third party vendors, general contractors and all subcontractors. The Rehabilitation Supplier must distribute it all to the parties to the claim. This includes, but is not limited to , licensure, insurance, reports, bids, and designs.

CHECK LIST

All contractors must be licensed through the State of Georgia. It is suggested that the parties require the contractors to produce his/her verifiable license with the submission of any bid. The contractor should have experience building handicapped accessible homes. The parties should ensure that the contractor states in his/her contract that all of the subcontractors utilized will be licensed and insured. For more information you may contact the licensing board for residential and general contractors at their website, www.sos.state.ga.us/plb/contractors .

Check references; ask questions; try to see their work; get as much information as possible.

Did the contractor keep the schedule and contract terms?

Were they pleased with the work?

Did the contractor listen to requests and respect these?

Would they hire the contractor again?

Check the contractor out with the Better Business Bureau, Chamber of Commerce, the Consumer Fraud Unit and/or the District Attorney.

Secure two to three bids that specify the scope of their work so they may be comparable. The bids should specify the duration of their validity.

Obtain a copy of the selected contractor's General Liability Insurance and Workers' Compensation coverage, if required. Parties are advised to verify their validity.

For large scale housing modification or building projects, parties might want to consider including, as part of the contract, a "performance bond". A "performance bond" is additional insurance the general contractor may purchase to cover the cost of the project in the event the general contractor is unable to complete the project (due to illness, death, or bankruptcy). The general contractor must pass both a criminal background and credit evaluation in order to obtain this insurance bond. There is a fee for purchase of the "performance bond", based on value of the project, which may be shown as an option in itemized costs of proposed contract.

The contractor is responsible for knowledge and adherence to all pertinent City/County/State building and zoning codes. Likewise, he/she is also responsible for securing all required building permits and inspections. Parties should include this in the contract.

Make sure that the contract is specific and clear. Some particulars to look for are draw schedules, permits, inspections, and dates to start and complete the project. A "spec sheet" should be attached to the contract, which spells out the specifics of the building project in detail, including, but not limited to, materials to be used, type of faucets, door sizes, water heater, appliances, flooring, paint grade, etc.

The contract should specify requirements for a final payment, i.e., a lien clearance letter, certificate of occupancy, or other necessary documents.

RED FLAG CLUES CONCERNING CONTRACTOR

Cannot produce a valid address or phone number.
Uses undue pressure.
Does not give references.
Prices the project substantially lower compared to other bids.
Quotes a "special price" for anything.
References do not check out.
Unable to verify license and insurance coverage.
Asks for pay 100% up front or an unusual first advance.
If you are asked to sign a completion certificate before the job is done.

GENERAL ACCESSIBILITY

In terms of housing for the catastrophically injured worker, "accessibility" can be generally described as: The provision of specific modifications to the present or future home that will allow the injured worker to function safely within that environment, where possible, as closely to that which was enjoyed prior to the injury.

GENERAL CONSIDERATIONS

Board Rule 200.1 notes that housing is most appropriately addressed in an Independent Living Plan (WCR2-a). Board Rule 200.1 (5) (ii) states "An Independent Living Plan encompasses those items and services, including housing and transportation, which are reasonable and necessary, for a catastrophically injured employee to return to the least restrictive lifestyle possible."

Limitations associated with physical injuries are the most common, and usually the most obvious, issues to be addressed. Less obvious, however, are the limitations associated with cognitive or "unseen" injures and their residual impact on the injured worker and their ability to deal with their environment.

The *Americans with Disabilities Act of 1990 (ADA)*, as amended, was drafted primarily to address commercial and public buildings, employment and related issues. While not mandatory for private residences, this act does, however, provide important and basic guidelines for the design and construction of housing that is compatible with the needs of individuals experiencing physical and/or cognitive impairments. There are no ADA codes applicable to private residences. Primary issues of concern in the development of accessible housing of any type should include, but not be limited to:

General safety.

Fire safety: The ability to enter and exit home in a safe and efficient manner, preferably, the ability to exit the home from two (2) distinctly different areas.

The ability to access the various areas of the home to perform ADLs. These areas include, but are not limited to, the bathroom (including the commode, shower/bath and vanity), the kitchen (including cooking and storage areas), the bedroom (including dresser and closet areas), and the driveway (including a garage or carport).

The ability to communicate with others outside of the home should a problem develop (police, fire, family).

Consideration of the injured worker's lifestyle, hobbies, interests, and other avocational activities that were performed prior to the injury.

The need to relocate for easier access to support programs, medical treatment and/or suitable transportation.

Family makeup.

Financial responsibility.

The types and extent of any home modifications are dependent upon the type of injury, the functional limitations associated with the injury, aging factors, and the anticipated level of independent living which the injured worker will likely attain. As such, they are individualized to each case and require the input of multiple experts.

Modifications and issues common to all disability groups include:

Safety – Preferably two (2) accessible exits from the residence that lead to separate outdoor areas.

Structural and electrical wiring meeting acceptable building practices and state/local codes.

Maximized ability to access, use, and move about the residence freely without obstruction or hazard.

The need to develop creative approaches to individual problems uniquely associated with the injured worker and their functional limitations.

ARCHITECTURAL BARRIER REMOVAL AND OTHER PHYSICAL MODIFICATIONS

Modifications may be necessary to the physical environment for injured workers with mobility, cognitive, visual limitations, and/or other functional limitations. The goal of these modifications is to allow the injured worker to return to the home environment and function independently, as close to the pre-injury level as possible.

Modifications in this area include external ramps, lowered and/or raised countertops, widened doorways, modifications to the bath area to facilitate maximum access and use, in-home ramps and/or lifts, elevators, landscape design and grade, flooring material, etc.

Consideration should also be made for covered access and egress for injured workers who are mobility impaired. Additional consideration should be made regarding modifications to home

workshops and other avocational areas that will maximize the injured worker's return to a level of activity enjoyed prior to the injury.

HOUSING CONSIDERATIONS IN ATTAINING AN ACCESSIBLE AND/OR LEAST RESTRICTIVE ENVIRONMENT

Not all injured workers will require these items. Any home modifications should be individualized to that injured worker and the type and level of his/her residual functional limitations.

Ramps – Recommended run and rise should be no greater than 1:12 (one inch of rise for every one foot of run). If runs exceed 30 feet, a resting platform will be required with a 5' square platform. Ramps with a grade of 1:12 should have one handrail. Ramps with a grade of 1:10 should have two handrails. These handrails should be placed at 2'8" and a lower guardrail should be centered 7" to the inside of the ramp.

Doorways – Recommended 36" minimum clearance, especially for new construction, for injured workers requiring wheelchairs for mobility. (Width may vary with the type of wheelchair and size of the individual). Maximum 1/2" beveled threshold with 5' x 5' level platform in front of doors and at top of ramp are recommended. Lever type handles are recommended 36" to 38" from the floor.

Hallways – It is recommended that hallways be at least 36", and preferably 42" wide, allowing a mobility- impaired injured worker and a non-mobility impaired individual to be able to pass safely.

Countertops – Desirable height for countertops for mobility-impaired individuals is 34".

Cabinets – Recommended height for mobility-impaired individuals is 44".

Sinks – Top of sink is recommended to be at a height of 33". Faucet sets should be single lever, or, if separate hot/cold, use 2 ½" blade handle.

Flooring – Mobility-impaired injured workers utilizing wheelchairs are best accommodated by hardwood or similar type floors. Linoleum tends to wear excessively.

Lighting – Additional lighting will assist injured workers with low vision limitations in regard to their mobility. Mobility-impaired injured workers would best function with light switches mounted between 36" and 40" from the floor. Outlets should be no less that 18" to 20" from the floor.

Heating and Air Conditioning – For mobility-impaired injured workers, controls should be 36" to 44" from the floor, preferably with lever or push button controls.

Appliances – For mobility-impaired workers, appliances should have front mounted controls. Consider a countertop range and separate oven with side hinge door, and side-by-side refrigerator and freezer.

Bathrooms – Considerations include: Tub vs. shower, handheld shower, single lever mixing, roll in shower, and additional hose length for the handheld showerhead (must be tailored to the individual and the extent of injury and functional limitations). Step-in baths or lifts for entering the bathtub may need to be considered.

Toilets – Recommended toilet height for mobility-impaired individuals is 20" – 22". Toilet centered 18" from sidewall.

Fixtures – Recommendations include: 30" x 48" approach in front of all fixtures. Grab bars should be considered for the tub and shower. There should be knee space under the lavatory with lever type faucets.

Bedrooms – Attempt to insure a 5' turning radius in the bedroom, with furniture in place for mobility-impaired injured workers. Closet bar heights are recommended to be no higher that 54" from the floor, 52" preferred. Beds must be tailored to the individual and the type of injury. Chairs should be sturdy and stable.

HOUSING CONSIDERATIONS RELATED TO SENSORY DEFICITS

In addition to many of the modifications noted above, particular attention should also be paid to:

Visual cues for those individuals experiencing industrial deafness.

Blinking lights for the telephone, doorbell, etc.

Accommodations to appliances and other home devices that will allow the injured worker to "see" rather that hear alarms, etc.

Modifications to communication devices. This would include telephones, televisions, computers, etc.

Auditory cues for the injured worker experiencing industrial blindness, cognitive disorders, or other disorder affecting sight and/or attention and concentration.

"Talking" watches, appliances and other devices that allow the injured work to hear rather than see actions taking place with microwaves, and other kitchen appliances.

Creating a "lack of clutter" home space that will allow the injured worker the maximum freedom to fully utilize their home.

Tactile cues for injured workers who are visually and/or cognitively impaired.

Cueing for appliances and/or electronic devices via raised numerals, Braille patterning or similar configurations.

Ridges and/or other texture changes approaching doorways, halls, or other various areas.

HOUSING CONSIDERATIONS SPECIFIC TO BURN INJURIES

While considering many of the accommodations noted above, workers who have experienced severe burns will also often require:

Environmental control systems that maintain a constant temperature and humidity range.

Wheelchair access may need to be considered if the injured worker has mobility impairments. (See specifics above).

Inside laundry facilities are imperative to keep sheets and other materials clean. Infection can spread if laundry is taken outside the home.

The burn patient may also require a separate room if he/she has open wounds that are infected. The room must be large enough to accommodate specialty equipment, such as suctioning devices, Pegasus type beds, wheelchairs, etc.

Specialized wiring if custom computer equipment is required to communicate with the hospital, physicians, etc.

Consideration given to building a small, enclosed porch (based upon the need and severity of the burn) with windows so that the person could "be outside" but still not exposed to the sun or in a non-environmentally controlled area.

ASSISTIVE TECHNOLOGY

These are supplemental devices and/or equipment, not necessarily modifications, that allow maximum independent functioning to be reached by mobility, cognitively, visually and/or hearing impaired injured workers.

Computers, computer software, environmental controls, automatic dialers and other similar equipment.

Emergency services contact equipment.

Cell phones, pagers, and other equipment that allow communication during emergencies or medical crisis.
Power doorways and other technological aides to assist in maximizing independence.

MOVING & STORAGE

These issues should be reviewed with parties as part of the planning for accessible housing and included as part of the proposed independent living rehabilitation plan (WC-R2a), when appropriate:

STORAGE

The renovation of an existing living space or building of a new accessible living space may require that the injured worker's (and his/her family's) household goods be stored in a public facility. Resources include "you store it" facilities found in most communities. The moving company that is moving the contents of the household may offer storage as an added service. Storage costs are based upon size of the space needed. Most spaces can be leased on a monthly basis. A contract with the storage facility is usually required. The Rehabilitation Supplier will need to discuss the contract and arrangements for funding with the injured worker and insurance carrier prior to the signing of a contractual agreement.

MOVING

Local professional household moving contractors may be needed to move the injured worker's/family's household contents to a storage facility during renovation of living space, temporary housing arrangements, or during construction of a new accessible living space. When obtaining bids for moving the injured worker's household contents, the Rehabilitation Supplier needs to obtain proof of the moving company's vehicle and liability insurance. Parties should consider insuring the contents of the household against damage and loss. The Rehabilitation Supplier will need to discuss specifics of the moving contract (i.e., spacing arrangements, moving boxes purchase, storage, dates/times, and arrangements for payment of contract) with the parties and include the information in the plan.

LONG TERM FACTORS TO CONSIDER FOR AGING INJURED WORKER

As time passes, everyone is affected by the aging process. However, it has been shown that individuals experiencing various types of disabilities may, and often do, encounter these problems much earlier in life and with more dramatic impact upon their ability to function independently than would occur in the general population.

GENERAL CONSIDERATIONS

In general, it is expected that the aging population will include the presence, development and/or increase of the following:

Need for help with ADLs.
Fatigue.
Weakness.
Arthritis.
Decreased stamina.
Decreased brain function.
Psychological issues.

Change in nutritional needs.
Development of Diabetes.
Increased orthopedic disorders.
Decreased mobility.
Hypertension.
Cardiovascular disease.
Urinary and/or bowel problems.
Skin changes.
Changes in need for and sensitivity to medications.
Increased reliance on assistive devices and personal care services.
Social isolation.
Increased potential for further injuries.

DISABILITY AND AGING

As stated above, individuals with disabilities tend to age faster.[1] A general principal of this concept is the "40/20" rule. This means that functional issues begin to emerge when a person reaches 40 years of age or has been disabled 20 years, whichever comes first. Additionally, a combination of this rule 50/10, 55/5, etc. also seems to carry forth the validity of this phenomenon.

Experts in the field of rehabilitation medicine indicate that individuals with a severe disability age faster.[2] Over the years, the organ system capacity declines gradually, over a 50 to 60 year period, until it reaches 20% to 40% of peak, at about age 75. In people with disabilities, this decline is accelerated from an average of 1% per year in the non-disabled person to between 1.5% and 5% per year depending upon the organ system. Adults who have a disability after maturity seem to age at a rate faster than normal from that point forward. Those who sustain a disability prior to maturity may never reach that peak capacity.[3]

SPECIFIC DISABILITIES

Each disability has increased areas that appear to be affected more during the aging process.

Spinal Cord Injuries

About 40% of persons with spinal cord injury under the age of 60 need some help with self care, but as they age, this need for assistance increases to 70% at age 75.[4]
Loss of lean muscle mass (sarcopenia).
Shoulder impingement (shoulders "wear out" after pushing a manual wheelchair for years).
Osteoporosis secondary to the inability to bear weight and/or exercise properly.
Earlier onset of arthritis.
Decreased stamina with the need to utilize power devices such as power wheelchairs.

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[1] Forman, Lawrence S., et al (2007) Aging and Life expectancy with a Disability.
[2] Kemp, B.J. (2005) What the rehabilitation professional and the Consumer need to know, *Physical Medicine Rehabilitation Clinics of North America*, 16:1
[3] Kemp, B.J. (2005) *Living with a Disability: A different way of aging*. UCI Medical Center, Irvine, CA.
[4] *Aging and SCI*, (February 1997). University of Washington, Rehabilitation Medicine, Northwest Regional Spinal Cord Injury System.

Long term care relationships often become strained and there is a need to change providers.
Psychological changes such as depression, isolation and/or avoidance of the public.
Change in nutritional needs secondary to lowered metabolic rate, changes in hormones, and less muscle mass.
Increased spasticity. Overuse injuries such as carpal tunnel, shoulder and elbow bursitis, potential fractures, kyphosis and scoliosis.
Hypertension. Hypertension is nearly twice as common in individuals with paraplegia as in able-bodied verified by controlled studies.
Cardiovascular disease. As much as 200% higher incident in individuals with spinal cord injuries.
Skin fragility. Aging decreases skin tone and thickness thus leading to an increase in decubitus ulcers and difficulty in healing.
Urinary tract infections. 400% higher rate of developing bladder cancer with a long term indwelling catheter.
Increased injury potential. Extremity fractures occur in approximately 40% of individuals with long term spinal cord injury.

Brain Injuries

Long term relationships often become strained and there is a need to change providers.
Fatigue and loss of stamina due to deconditioning and restricted mobility.
Sleep disturbances add to fatigue.
Late onset psychosis and possible post-traumatic epilepsy.
Decreased sense of smell and tastes cause changes in diet and nutrition.
Decreased physical activity can lead to the development of adult onset diabetes.
Impaired gait secondary to brain injury lead to back and hip problems requiring surgical and/or equipment intervention.
If seizures present, neurotoxic effects of long-term anti-convulsants must be considered.
Psychological stress and/or depression develop from the increasing dependency needs, feelings of powerlessness and isolation.
Social isolation secondary to the inability to participate in physical and social activities.
Increased risk of repeat traumatic brain injury.

Amputations

Fatigue occurs sooner with limb loss.
Weakness and loss of muscle mass due to improper fit of prosthesis.
High risk for increased arthritis.
May require equipment for mobility assistance.
Issues of overuse of unaffected limbs.
Personality and other psychological changes secondary to traumatic loss of limbs.
Nutritional changes.
Impaired gait stresses back and non-impaired leg.
Loss of muscle mass may necessitate frequent changes in the prosthesis itself.
Skin fragility in the amputation area leads to skin breakdown and decreased ability to heal.
Higher risks of frequent falls causing additional injuries.

Burns

There is a high incidence of cancer in burn patients. The scars cause an inflammatory reaction that can lead to malignant lesions. The scar tissue then becomes malignant.
The grafted skin also thins out over time and peels off. Hands are especially susceptible to open areas, tenderness and loss of fine motor function.

Facial and hand burns can be the most disabling over time. Burns of the feet also present long term problems due to pressure from shoes and scar breakdown.
Facial scars can become very tender over time especially if the person does not wear sun protection every day. Hair may stop growing over scarred areas even though it comes back right after the burn.
Nerves are trapped in the scars, and many people have chronic pain in some areas of grafting which may increase over time.
Scar tissue may change, become infected and/or inflamed and close monitoring of the burn area is required especially as the individual ages.

Vision

Traumatic vision loss increases in individual's potential to develop coronary artery disease by 2-3 times over non-traumatic vision loss subjects.[5]
Travel becomes more difficult secondary to cognitive changes associated with aging.
Co-morbid factors, osteoporosis, vascular disease, or other health problems may decrease the ability to perform ADLs previously performed with little or no difficulty.

ADDITIONAL THINGS TO CONSIDER AND DISCUSS

LOCATION OF ACCESSIBLE LIVING SPACE

Consideration should be given to the proximity of the living arrangements of the injured worker to medical care, community services, school districts (if there are children in the family), and access to public transportation. The safety of the proposed neighborhood should also be considered, especially when the injured worker's mobility has been compromised.

POWER GRID/GENERATOR

Consideration should be given to the injured worker's specific need for life sustaining electrical medical equipment, power wheelchair, and/or heating/cooling of the living space. When such conditions exist, serious consideration should be given to living in a location which has access to multiple sources of power or circuits (power grid). In addition, a backup generator for crisis situations should be considered.

WATER VS. SEPTIC TANK

Many areas within the State of Georgia do not have access to city or county sewer systems. Sewer systems may provide advantage of less upkeep in future, and may be consideration if choice is available. If septic tank is necessary, each county has specific requirements for "perk" tests for the land where building is proposed. Each county may require specific type of septic tank system to be used, how the "fill lines" will be placed, etc. The Rehabilitation Supplier must be sure that housing contractor who will be completing housing project is considering these needs as part of the overall bit/projected costs.

GARAGE VS. CARPORT

A carport gives protection from the weather, but presents exposure to the elements when going into the home. A large enough garage with a direct entry into the home eliminates this exposure. However, this issue may be creatively addressed on other ways (i.e. awning extended from garage).

NEED FOR FENCING

[5] *Archives of Physical Medicine and Rehabilitation* , Volume 86, Issue 5, May 2005.

The injured worker may have pets that will require fencing. Negotiation regarding funding of fencing needs to be undertaken during the planning phase of the accessible housing project.

UNIVERSAL DESIGN

More of a conceptual approach to accessible housing rather than specific criteria found in the General Accessibility subsection, the theory of universal design is the design of products and environments to be usable by all people, to the greatest extent possible, without adaptation or specialized equipment. It was developed by a group of design advocates at the North Carolina State University, College of Design, Center *for Universal Design*, in Raleigh, North Carolina and incorporates a number of principles:

Equitable Use – The design is useful and marketable to people with diverse abilities.

Flexibility in Use – The design accommodates a wide range of individual preferences and abilities.

Simple and Intuitive Use – Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

Perceptible Information – The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.

Tolerance for Error – The design minimizes hazards and the adverse consequences of accidental or unintended actions.

Low Physical Effort – The design can be used efficiently and comfortably and with a minimum of fatigue.

Size and Space for Approach and Use – Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.

FINANCIAL CONSIDERATIONS

There is no singular solution as to how to address the funding dilemma surrounding the costs for accessible housing. There are as many potential solutions as there are ideas. The solutions are only limited by the creativity of, and negotiation by, the parties to the case. When addressing this aspect of housing, there should be careful attention in regard to the injured employee's present housing status as it is impacted by his/her functional needs and available resources. After the assessment of these needs and availabilities are completed, a course can then be charted to fully address funding for the eventual specific housing needs. Everyone is encouraged to brainstorm the issue and be prepared to compromise.

The employer/insurer must provide accessible, safe housing suitable for the injured worker's post-injury condition. However, there is no requirement anywhere that the employer/insurer must build or buy a house for an injured worker. The injured worker and the employer/insurer both have a responsibility to contribute to the injured worker's suitable housing (Pringle case; see General Considerations, pg. 1, for essence of that decision). An injured worker should not be placed in the position of having to declare bankruptcy because of their need for post-injury accessible housing.

The Rehabilitation Division believes that, under the principle of normalization, an injured worker (and his family members who live with him) should not have to pay more that 25 percent of his/their permanent income toward all housing costs (including utilities).

Household income should include **permanent** income of the injured worker and others who reside in the home.

Consideration should be given to additional housing costs beyond the basic rent or mortgage (e.g. taxes, insurance, homeowner association fees, upkeep of yard, maintenance of home, etc.).

Payment for specialists' evaluations required prior to permanent housing decision must be paid by the employer/insurer as part of the housing process.

If an injured worker has equity in a home which is no longer suitable for him, and the employer/insurer does not buy or build a suitable home form him, the injured worker generally contributes the value of the equity in the pre-injury home toward the new home.
Employer/insurer is responsible for costs of title search, moving expenses, inspections, and closing costs.
Responsibility for payment of fees for any required funding for storage of the injured worker's possessions/equipment is determined on a case by case basis.
Each case involving housing is different, and there is no "one size fits all" resolution. The Rehabilitation Division is available to hold rehabilitation conferences to help parties reach agreements and decisions regarding housing and the financial aspects of suitable housing for injured workers.

PARTIAL STIPULATED SETTLEMENTS FOR HOUSING

The State Board can never force parties to settle all or any part of an injured worker's case. A housing stipulated settlement is considered a partial settlement and resolves only the housing portion of an injured worker's workers' compensation case. It does not effect other benefits or resolve an injured worker's claim in its entirety. Anything parties agree to which is reasonable may be approved. Generally, insurers wish to end all responsibility for housing by agreeing to a stipulated settlement. The employee normally gets a suitable house which he/she could not otherwise afford, and the insurer relieves itself of any future responsibility for housing for the injured worker.

GENERAL CONSIDERATIONS

Because housing stipulated settlements usually, permanently resolve all issues relating to housing, the stipulation must spell out quite clearly, exactly what is and what is not covered by the stipulation, including, but not limited to, temporary housing, moving, storage, maintenance of the yard, maintenance of the house, and taxes/insurance.

The Rehabilitation /Managed Care Division does not feel that any injured worker should pay more than 25 percent of total family income toward total housing costs, including utilities, on a monthly basis. The Board's Rehabilitation Coordinators are available to hold conferences to discuss possibilities/ramifications of housing stipulations which are being considered by the parties. All proposed housing stipulated settlements should come to the Board's Rehabilitation/Managed Care Division for review prior to final approval. All housing stipulations must consider end of life issues, as well as what happens if later in the claim the injured worker is medically required to live in a nursing home, rehabilitation facility, or assisted living home as a result of residuals from his injury.

ISSUES TO CONSIDER

It is not true that anytime an injured worker settles the housing portion of his case, the employer/insurer pays in full for the building of a new home for the employee, although this may be the case if all parties agree, or an ALJ orders it.
If the injured worker has equity in a pre-injury home which is not suitable for his current medical condition, and parties agree that a new, suitable home will be bought or built, generally the injured worker is expected to contribute the value of the "old" home's equity toward the cost of the new home.
Who holds title to the house is a matter for parities to negotiate.
What happens to the house when the injured worker dies is also a matter of negotiation.

All standard real estate closing procedures must be followed even in cases of stipulated housing settlements.

If there is a probable need for future attendant care, then sufficient space for an attendant should be included in any long-term housing arrangement.

If modifications or building are considered, it is always better to plan for reasonable foreseeable long-range needs so that a one-time renovation or build will be sufficient for the injured worker's lifetime.

Will temporary housing be needed pending the modifications or building? If so, the stipulation should address this issue.

Housing must take into account the family configuration, including pets, children, grandchildren, and/or relatives who visit and stay with the injured worker.

The possibility of a divorce between the injured worker and his spouse, or other major family change, should be addressed in the stipulation. Normally the home is titled in the name of the injured worker, but if the employee and his/her spouse jointly owned a pre-injury home, that may not be the case.

Stipulated settlements for housing are not, as of this writing, subject to attorney fees.

ADVANTAGES TO THE EMPLOYER/INSURER

May be more cost-effective than providing a rent subsidy for the injured worker's life.

In most circumstances, ends the employer/insurer's responsibility for housing for the duration of the injured worker's workers' compensation case.

Helpful for planning housing costs for the duration of the case.

ADVANTAGES TO THE INJURED WORKER

Gives a much greater sense of independence and control.

Allows the injured worker to have suitable, accessible home which he/she might not otherwise have been able to afford.

HOUSING SETTLEMENT FORMAT

There are almost unlimited ways for a housing settlement to be developed. It must be agreed upon by the parties and is always specific to the circumstances of each individual case. The following is not an exhaustive list:

Parties may decide upon a one-time payment by the employer/insurer to the injured worker to cover all anticipated housing costs. The employer then uses the money to build a suitable house.

Parties may agree upon periodic payments, such as those from an annuity, to assist the injured worker with mortgage payments, if the injured worker holds a mortgage on the house. In those circumstances, the Board's Rehabilitation Division recommends that monthly housing cost, including utilities, not exceed more than 25 percent of a family's income.

Parties may agree that the employer/insurer will purchase a house and retain title to it, allowing the injured worker to live there for the rest of his/her life. If that route is chosen, the following questions must be answered:

- Will the employee pay rent?
- What will happen when the employee dies?
- Who will be responsible for maintenance, upkeep, insurance, etc., of the house? (In general, if parties "stip out" housing and the house is in the injured worker's name, the employee is responsible for maintenance, insurance, taxes, etc.).

Parties may agree that the employer/insurer will retain a lien of the house purchase, rather than holding title.

ETHICAL CONSIDERATIONS

Certain principles of ethics apply in all healthcare settings. Familiarity with Rule 200.1 (i), Professional Responsibilities of a Rehabilitation Supplier, and the Code of Ethics mandated by the varying underlying certifications required to be registered with the Board, can provide useful guidance in confronting the diverse ethical issues arising in accessible housing. During the process to obtain accessible housing, the Rehabilitation Supplier should be guided by principles of autonomy, beneficence, non-malfeasance, fairness, and veracity.

The Rehabilitation Suppliers have an ethical obligation in working with the catastrophically injured worker to ensure that accessible housing, when needed, is available. If fact, if it is an issue, the Board *requires* that Rehabilitation Suppliers develop an Independent Living Rehabilitation Plan that addresses the housing process. The injured worker's need for reasonable, appropriate accessible housing must be kept as the primary focus. Given the challenges and complexity of housing issues, the Rehabilitation Supplier should strive to do an excellent job as opposed to a merely acceptable one with requirements. The Rehabilitation Supplier's actions should reflect the role as advocate for the injured worker's safety, function, and accessibility.

Remember, the Rehabilitation Supplier is *not* the housing "expert". The Rehabilitation Supplier's role is the coordination of the consultation of experts and the gathering and dissemination of information of the various options to all parties upon which housing decisions may be made. All parties and the Rehabilitation Supplier have the responsibility to approach and implement the accessible housing process in an ethical manner.

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HOUSING GUIDELINES
ADDENDUM

Stick-Built (Traditional Home)		**Modular Home**	**Manufactured (Mobile) Home**
Foundation, Floors, Walls and Roofing	Concrete block, or poured concrete walls with floors, walls & roofing constructed to meet or exceed local and state building code requirements. Construction occurs on-site.	Same as stick-built with exception that construction includes modules delivered to site and construction is completed on-site, which may include use of crane for placement of modules.	Steel I-beam framing system with wood wall and sub-flooring, all of which is constructed in assembly line in manufacturing plant. Completed product is transported on wheel system to building site. Foundation system may be added but is not necessary.
Accessibility	Accessibility is available through customized construction of doorways, halls, bathrooms, kitchens, floor, etc., including special lighting, sound, and ramping systems.	Accessibility is reported to be available. Customized construction would alter assembly-line production of modules, which will increase costs. Customized construction may not be practical due to additional costs.	Accessibility may be available, but manufacturer will need to be contacted for specific customization needs. Typical manufactured housing is not accessible. Flooring may need to be upgraded.
Codes	Construction will meet local and state building code requirements.	Construction of modules and completion of construction on-site will meet local and state building code requirements.	Construction satisfies H.U.D. building code specifications, which are not equivalent to local or state building codes.
Appreciation and Depreciation	Homes appreciate through approximately 80 years. Depreciation typically begins at 80 years, sometimes earlier, dependent upon quality of construction and materials, as well as frequency of adequate maintenance.		Depreciation occurs more quickly, depending on quality of product. If placed on a masonry foundation, appreciation is possible for many years.
Maintenance	All homes require maintenance. The frequency and expense of maintenance will be dependant upon the original quality of the product and workmanship.		
Garage	Built on-site as part of house, or as a separate garage	Built on-site, either attached to house, or as a separate garage	Built on-site as a separate garage. The manufactured home is not built to withstand the load of an attached garage.
Safety	Built on fixed foundation with quality product	Built on fixed foundation with quality product	Homes may be “tied” to ground through tie-down system.
Longevity	Longevity has a direct relationship to the quality of the original product and associated maintenance over years.		
Cost	Accessibility accommodations will increase the cost of any building system. Researching costs for each specific accessibility modification situation will be necessary.		

MOBILITY & ASSISTIVE DEVICE PAPER 2005

1. PURPOSE OF PAPER

The purpose of this paper is to help clarify the various mobility and assistive device issues, which exist in catastrophic and non-catastrophic workers' compensation situations. The primary guideline for determining mobility needs is based on Georgia State Board of Worker's Compensation Rule 200.1, which states the understanding that the goal of Rehabilitation Services is to "provide items and services that are reasonable and necessary for Injured Worker to return to the least restrictive lifestyle possible." All parties are charged with the fulfillment of this goal.

2. GENERAL CONSIDERATIONS

The Rehabilitation Supplier needs to identify the mobility and assistive device needs of the Injured Worker, taking into consideration appropriate options as discussed in this paper. In the assessment and recommendation of mobility options, consider short-term vs. long-term intervention. Injured Worker considerations include: age, conditioning, strength, weight, height, disease progression, overall medical status, home and work environments, and transferability of device. Vendor considerations include knowledge, experience, reliability, availability for service and geographic location in relation to the client.

3. REHABILITATION SUPPLIER RESPONSIBILITY

It is expected that the Rehabilitation Supplier will make a home visit upon opening a case and when there are significant changes in the Injured Worker's functioning level and aging. Aging combines with disability to create greater needs and impacts function. These visits are to assess for possible needs regarding DME, assistive devices, accessibility and to determine if there are barriers to independence.

- Needs should be discussed with the authorized treating physician, obtaining prescriptions as necessary.
- Research all positive/negative factors for providing what is medically necessary, as well as appropriate, for the individual's specific needs.
- Consider safety, reliability, extent of mobility needs, terrain, individual usage, resources in the area and costs of each choice (short term and long term), with input from professional evaluations.
- Consider all aspects of the Injured Worker's life, including medical and rehabilitation appointments, personal business, social, recreational and health maintenance, pre-vocational and vocational activities, and maximum functioning in the home environment.
- Caregivers and Injured Workers need to have clear instructions and understanding as to the use, care, and storage of equipment.
- It is recommended that the Injured Worker/caregivers demonstrate the ability to use the equipment.
- All mobility assistive equipment should be included in a formal rehabilitation plan, including maintenance and repair.

4. WHEELCHAIRS AND ACCESSORIES

4.1 General Considerations

There are many different types of wheelchairs available to an Injured Worker today. Years of modifications to design have led to improved performance and functionality, including weight reduction, smaller turning radius, and enhanced durability

Wheelchairs initially breakdown into two distinct categories: power or manual. Power and manual wheelchairs breakdown further into subcategories that specify weight, frame type, and drive-wheel position. Options and accessories such as lateral supports, customized seating, and specialty controls enable the supplier to customize a chair to an Injured Worker's specific needs. In fact, there is very little that cannot be done to accommodate the needs of an Injured Worker.

While wheelchairs and scooters provide the same basic function (motorized transportation), wheelchairs offer the advantages of greater customization and better maneuverability in small areas. The following is a list of things to consider when choosing a wheelchair, but ultimately, the decision is made through a Licensed Physical Therapist, specializing in seating evaluations.

4.2 Wheelchair Considerations

- Physical characteristics and cognitive abilities
- Environments in which the chair will be used (Indoors, Outside Terrain, Work Environment)
- Home environment (refer to home modification section)
- Power vs. Manual
- Length of need
- Purchase vs. Rental
- Transportability (refer to lift section and transportation paper)
- Vocational/Avocational activities of the Injured Worker
- Backup wheelchair

4.3 Power vs. Manual Wheelchair: Questions to Consider

Injury level: C1 – C5	Yes___No____
Injury level: C6 – S1	Yes___No____
Does Injured Worker have good upper body strength and balance?	Yes___No____
Does Injured Worker have good control of hands, arms, and shoulders?	Yes___No____
Are there co-morbid or pre-existing conditions that affect function?	Yes___No____
Has there been a change in functional mobility?	Yes___No____
Are there special considerations for vocational and avocational use?	Yes___No____
Will Injured Worker be using mobility device to cover long distances?	Yes___No____
Will Injured Worker have to navigate steep or rough terrain?	Yes___No____
Is Injured Worker an amputee?	Yes___No____

4.4 Power Wheelchair vs. Scooter: Questions to Consider

Can Injured worker operate/steer scooter?	Yes___No____
Can Injured Worker operate a joystick?	Yes___No____
Will Injured Worker drive while sitting in the equipment, now or in the near future?	Yes___No____
Does Injured Worker require specialty controls (i.e. sip & puff, head controls, chin control, etc.)?	Yes___No____
Does Injured Worker require specialty seating (i.e. tilt, recline, solid seat pan, etc.)?	Yes___No____
Where will the equipment be used?	Inside___ Outside ___

If outside, what type of terrain will the equipment have to transverse? Rough____
Even _____

Does Injured Worker need mobility assistance inside the home? Yes___No____

4.5 Types of Wheelchairs

	Manual	Power
Description	***Wheelchair propelled by the user or someone else. Non-powered***	***Wheelchair that uses a motor for propulsion***
Pros	***Lightweight*** • *Range of chair only limited by physical stamina of the person propelling it* • *Easier to transport than power wheelchairs* • *Minimal maintenance* • *More options for recreational activities and community activities*	• *Preserves and conserves user's energy* • *Handles slopes better than a manual chair* • *Frees one hand* • ***Allows mobility options for individuals who cannot use manual chairs*** • ***Less demand on upper extremities*** • ***Makes power tilt and recline an option***
Cons	• ***Dependent upon user's stamina*** • *Long-term use will cause wear on shoulder joints, wrists, and elbows* • *May require assistance overcoming steep angles or long inclines*	• ***Difficult to transport*** • *Range is dependant upon battery life* • *More responsibility for maintenance, upkeep, and use*

4.6 Types of Manual Wheelchairs

There are two main categories for manual wheelchairs: Folding and Rigid. Beyond this distinction, manual wheelchairs are classified by weight. The following is a brief description and comparison of the frame type

Types of Manual Wheelchairs cont'd

	Folding	***Rigid***
Description	***Standard wheelchair - Seat and back are made to fold "sling style." Folds in half by pulling straight up on the middle of the seat***	***Back typically folds down onto seat and wheels may have a quick release axle to remove the wheels and make the frame as small as possible***
Pros	• ***Chair becomes very narrow when folded and this makes it easy to transport***	• *Lightweight – eliminating the crossbars necessary in a folding chair helps reduce the weight* • ***Allows more options for specialized backs***
Cons	• *Heavier* • *Fewer customization options*	• *Can be difficult to transport*

4.7 Power Wheelchair Wheel Placement

Power wheelchairs fall into three main categories: Rear-Wheel Drive, Mid-Wheel Drive, and Front-Wheel Drive. Each main category can be subdivided into groups specifying weight capacity and ability to modify the seating system. The following is a brief description and comparison of the main categories for power wheelchairs:

	Rear-Wheel Drive	**Mid-Wheel Drive**	**Front-Wheel Drive**
Description	Drive wheels are located at rear of chair and push the occupant. Front casters swivel.	Wheels are located in center of chair. Chair usually has front and rear casters. Front casters may or may not touch ground.	Wheels are located at front of chair. Motors pull the occupant. Chair has rear casters that act as anti-tippers.
Pros	• Steering and handling performs most like a car with regards to steering and handling • Tends to be more stable at high speeds (offers the highest speeds available) • Best front stability though some chairs have a tendency to wheelie • Driving stability makes this the best choice for people with reduced coordination or specialty controls (i.e. sip-n- puff, etc.)	• The best turning radius available • Easy to maneuver in confined area • Does not tend to wheelie and has good rear stability • Models with front and rear casters on ground offer the best front and rear stability available • Performs better than rear-wheel drive chair when climbing obstacles	• Because the drive wheels are closest to occupant's feet, feels more natural and for many is easier to maneuver around corners or tables. • Excellent climbing capability • Handles well on soft ground • Best rear stability (will not wheelie)
Cons	• Next page		

	Rear-Wheel Drive	Mid-Wheel Drive	Front-Wheel Drive
Cons	• Poor turning radius • Front casters can sink in soft ground or become entrapped on obstacles while trying to climb over them	• Slower speeds than rear-wheel drive chair • Tends to fishtail at high speeds and starting off • Depending on how front anti-tippers are arranged, may tilt forward while descending a hill or stopping suddenly • Front and rear casters may have tendency to hang-up if driving off of a paved surface • Less adaptable for outdoor use	• Slowest maximum speed • Tends to fishtail, especially at higher speeds • Controls may have to be modified if steering presents a problem due to fishtailing • If front anti-tippers are present, may tend to tilt forward while descending a hill

4.8 Tires

Tire choice is important because it can determine the type of ride and handling the user will experience and the amount of maintenance necessary for proper upkeep of the chair

	Pneumatic	Solid or Flat-Free
Description	*Air filled*	*Tire with solid insert, foam filling, or one complete solid unit*
Pros	• *Softer ride* • *Better traction*	• *No flats* • *Last longer* • *Less maintenance*
Cons	• *Flats* • *Does not last as long* • *Pressure must be monitored.*	• *Heavier* • *Depending on tread, less traction.* • *Rougher ride*

4.9 Seating Evaluation

Seating and positioning can be very complicated and involved. Only a Licensed Therapist should evaluate a particular Injured Worker for his/her mobility needs through a formal seating evaluation. Wheelchairs, scooters, cushions, backs, supports, shower chairs, and specialty options will be based on an Injured Worker's physical condition and injury level.

Seating may have to be readdressed periodically due to pressure areas and changes in function or physical condition (i.e. amputation, weight, age, strength, activity level, etc.). A physician's order is needed for the seating evaluation. Once the specifications are determined for the mobility device, a physician's order is needed, specifying that piece of equipment. The equipment must be reflected in the rehabilitation plan.

4.10 Seat Cushions

Cushions can be very complicated and involved. For this reason, only a Licensed Therapist should prescribe a cushion for an Injured Worker. Cushions are typically prescribed at the initial seating evaluation. Often a second cover and/or cushion, for back up, are requested as a precautionary measure.

On a basic level, cushions serve two purposes: pressure relief and postural support. When choosing a cushion, it is important that the physical needs of the Injured Worker are met, but comfort has to be considered as well. Despite the fact that a cushion meets the physical requirements of relieving pressure and providing support, the Injured Worker may not feel comfortable sitting on it. Because there are so many options available today, there is usually more than one type of cushion that will meet the necessary physical requirements and comfort requirements of the Injured Worker.

4.10.1 Types of Cushions

	Foam	**Gel/Solution**	**Air**
Description	*Foam cushions can be made of a single density or layers of different densities.*	*Can be made as a bladder of gel or solution, or typically it is used in combination with a forming material such as foam.*	*Often uses balloon-like cells or air-foam flotation to provide additional support.*
Pros	• *Lightweight* • *Easy to modify in the field to the Injured Worker's needs.* • *No risk of leakage.* • *Selection of densities makes it easy to customize.*	• *Weight is distributed evenly over gel due to its ability to conform to the shape of the body – better pressure relieving properties.* • *Helps maintain a comfortable temperature.*	• *Lightweight* • *Depending on design, air offers better weight distribution by contouring to the body and dispersing weight.*
Cons	• *Not as durable; may need changing once a year or less.* • *If it becomes compressed, it can impair skin integrity.* • *Can insulate skin, increase temperature, adding moisture and increasing the chance of skin breakdown.*	• *Will leak when punctured.* • *Heavier* • *Does not offer maximum stability for users without good postural control.* • *Chance of bottoming-out as gel is dispersed.*	• *May leak* • *High maintenance. Must frequently check air pressure to ensure proper inflation.* • *Depending on design, offers less postural support than other types of cushions (Although, the introduction of chambers and new designs offer better support).*

4.10.2 Combinations

Over time, several companies have combined different materials to enhance their efficiencies. Examples include: cushions that utilize air with gel or foam. This combination provides a cushion with more stability that retains the pressure relieving benefits of gel and air. Some cushions utilize the combination of air and foam in a way that allows the user to mold the cushion to their body through the use of a valve.

4.10.3 Custom Cushions

Several companies have gone so far as to provide a way to perform on-site cushion customization. Using different materials in combination with an adhesive, the seating technician can create a customized mold, and with certain products the actual cushion can be developed while the Injured Worker waits. These cushions are expensive and require someone who is well trained. In some cases a customized cushion will best meet the specialized needs of the Injured Worker.

4.11 Tilt & Recline

Tilt, recline, and tilt & recline, are options available for some power and manual chairs. These features are used by themselves, or in combination, to provide help with weight shifts, comfort, and transfers.

4.11.1 Tilt

Typically used for weight shifting, this feature helps reduce the risk of pressure sores by allowing the user to adjust his/her center of gravity and therefore the point at which most pressure is exerted. It can also be used to help control spasms and provide better seating by creating a proper fit and stability in the chair that might be useful on steep ramps.

4.11.2 Recline

The recline feature is commonly offered, in a limited form, on most chairs as an added comfort feature. This feature can also provide better support and when full recline is available, help with weight dispersion and transfers.

4.12 Wheelchair Backs

The back of a wheelchair is an important component because it provides comfort, support, and helps maintain correct posture. The following is a brief description and summary of use:

Types of Backs	***Description***	***General Use***
Sling	*Standard back on a folding wheelchair. Typically made of vinyl or nylon.*	*Manual wheelchairs and power wheelchairs. Mostly for people with posture control.*
Tension Adjustable Sling	*Similar to standard sling back, but has straps that allow the user to adjust the tension for better support.*	*Manual wheelchairs and power wheelchairs. User needs to have good posture. Adjustability adds comfort and allows user to remain in chair for longer periods of time*
Rigid	*Made of non-flexible material, such as plastic or metal, with some type of cushion for comfort. Many are slightly concave to "cradle" user and provide some lateral support. Depending on style, may allow for attachments such as lateral supports or headrests, to be mounted to them.*	. *Manual and power wheelchairs. Provides a high level of support. Typically prescribed for users who need additional support to someone who needs a high level of postural support.*

Deep Contour Rigid	*Made of non-flexible material, such as plastic or metal, with some type of cushion for comfort. Back has a very aggressive concave shape that "hugs" the user and offers greater lateral support. Depending on style, may allow for attachments such as a headrest to be mounted to it.*	*Manual and power wheelchairs. Provides a high level of support. Typically prescribed for users who need a high level of postural support, especially lateral support.*
Custom Specialized	*Custom backs are made specifically for the user. Many use a solution with an activator to mold the cushion in the exact shape of the user's back.*	*This type of back offers the highest level of support and is typically prescribed for users with special needs.*

4.13 Specialty Options

The vast selection of accessories and options available today allow for various combinations to meet the needs of the Injured Worker. Through standard options and accessories, it has become easier to customize chairs. The following is a brief listing of some options available today:

- Lateral Supports – Using a combination of such supports reduces the risk of scoliosis. Additionally, improper seating positioning can be avoided. This helps reduce the risk of further injury, including skin breakdown.
- Headrest – Headrests are needed for proper posture, comfort, and can help the Injured Worker breath and swallow. There are a wide variety of designs available and it should be easy to find one that best meets the Injured Worker's needs.
- Drive Controls – Buttons, used on the side, head, or even the footrest, are just a few of the many ways to provide alternate means of controlling different mechanisms of a power chair. Chin controls, attendant controls, and sip-n-puff are others. With today's technology, if an Injured Worker has control over even the smallest muscle, it is highly likely that a device is available, or can be modified, to allow the Injured Worker independent use of his/her power wheelchair.
- Environmental Controls – Fairly new to the market, allows the Injured Worker even more independence by allowing him/her to control different environmental functions from his/her wheelchair, such as lighting, remote control doors, computers, phone, and TV.

4.14 Backup Wheelchair

A backup wheelchair is necessary for various reasons, such as necessary repairs that require the primary chair to be out of commission for an extended amount of time. The backup wheelchair does not have to be an exact replica of the primary wheelchair. It needs to meet the basic functions of the primary chair, keeping in mind that it is not intended to be used for long periods of time. A manual wheelchair that can be operated with the assistance of an aide may suffice for an Injured Worker with a power wheelchair, but it may be necessary to provide a power wheelchair.

4.15 Wheelchair Repair & Maintenance

There are a number of ways to estimate repair and maintenance, but keep in mind all of them are guesses. The truth about repair and maintenance is that it mostly depends

on the user. Just like a car, the amount of maintenance required depends on how it is driven and the environment in which it is driven.

On wheelchairs the most common items replaced are:

- Tires and Tubes – typically last from 6 months to 1.5 years
- Arms and Arm pads – typically last from 1 – 2.5 years
- Batteries – typically last from 1 – 2 years
- Footrest – typically last from 1 – 2 years
- Batter chargers off board and onboard-replacement times vary

Items such as joysticks, motors, gears, etc. are usually warranted for 18 months to 2 years, but depending on use and whether the damage was caused by user error, they may or may not be under warranty.

5. SCOOTERS

5.1 General Considerations

Scooters provide the benefit of being more discreet than wheelchairs and many people feel like they do not project the image of being disabled in the same manner that a wheelchair might. They come in two distinct forms: three-wheel and four-wheel.

5.2 Types of Scooters

	a. Three-Wheel Scooter	b. Four-Wheel Scooter
Description	*Scooter with two wheels in the back and a single wheel in the front, controlled by a tiller.*	*Scooter with two wheels in the back and two in the front, controlled by a tiller.*
Pros	• *Better turning radius* • *Weighs less than four-wheel model.* • *Easier to transport than four-wheel model.*	• *Better performance outside the home and on uneven terrain.* • *More stable* • *Maximum possible weight capacity is usually higher.*
Cons	• *Tips easier than four-wheel model.* • *On the higher end of the spectrum, the maximum weight capacity is usually less.*	• *Poor turning radius. Does not perform well indoors.* • *Heavier*

5.3 Scooter Repair & Maintenance

Repair and maintenance are very similar to a power wheelchair. Again, the amount of maintenance required depends on how the scooter is driven and the environment in which it is driven. Just like chairs, the most common items replaced are:

- Tires and Tubes – typically last from 6 months to 1.5 years
- Arms and Arm pads – typically last from 1 – 2.5 years
- Batteries – typically last from 1 – 2 years
- Battery chargers off board and onboard-replacement times vary
- Throttle and speed potentiometer

Items such as motors, potentiometers, control boxes, etc. are usually warranted for 18 months to 2 years. However, depending on use and whether the damage was caused by user error, they may or may not be under warranty.

6. PROSTHESES – UPPER AND LOWER EXTREMITY

6.1 General Considerations

The purpose of prosthetics is to maximize function, independence, and mobility, to promote quality of life, and to maintain physiological health while minimizing complications.

6.2 Referral Process

The Rehabilitation Supplier should:

- Secure referral for prosthetic evaluation from the authorized treating physician
- Coordinate assessment by a Certified Prosthetist
- Counsel with Injured Worker in selection of prosthesis throughout the decision making process
- Work with Prosthetist to identify option(s) dependent upon the Injured Worker's level of amputation, joint function, weight bearing mechanics, medical status, and level of activity and physiological integrity of residual limb.

6.3 Interdisciplinary Team (may include)

- Injured Worker, family member(s) and/or caregiver
- Physician (i.e. PMR, Plastic Surgeon, Orthopedic Surgeon, Vascular Surgeon)
- Rehabilitation Supplier
- Certified Prosthetist/Orthotist (CPO)
- Physical/Occupational therapist

6.4 Prosthetic Issues/Concerns

The Rehabilitation Supplier should consider the following issues:

6.4.1 Function versus Cosmetic/Aesthetic

- Dependent in large part upon primary functional objective for prosthesis use. For example, a prosthesis for a wheelchair user would be both cosmetic and functional, decreasing medical complications, increasing balance in wheelchair and supporting the amputated limb, while improving overall appearance.

- The Prosthetist should educate the Injured Worker on possible trade-offs between a functional and cosmetic prosthesis, as applicable.

- At times, both functional and cosmetic prosthesis may be appropriate, but this issue should also be determined by the treating physician and Prosthetist.

- The Rehabilitation Supplier should be aware that at times the only prosthetic option may be a cosmetic device, secondary to nature of the amputation injury. But, this issue should ultimately be assessed and determined by the Prosthetist and treating physician.

6.4.2 Basic versus High Tech

- The Prosthetist needs to create a prosthesis that will work best for the Injured Worker based on his/her specific needs and current/future prosthetic technology.

- The Rehabilitation Supplier, in conjunction with the Prosthetist, needs to identify the Injured Worker's employment demands and home and recreational environments.

6.4.3 Component Options

- Rehabilitation Supplier needs to be aware that prosthetic options can range from basic body powered to myoelectric and other future technologies.

- The Rehabilitation Supplier should ensure the Prosthetist identifies component options as related to the Injured Worker's employment demands and home and recreational lifestyle.

6.4.4 Weight of Prosthesis

- The weight of the prosthesis may be an issue for the Injured Worker and should be evaluated by the Prosthetist as part the assessment.

6.5 Psychosocial Factors

The Rehabilitation Supplier should be aware of the possible interplay of psychosocial factors such as body image, gender issues, and cultural factors that may impact the Injured Worker's desire to use the prosthesis.

6.6 Back-up Prosthesis

A back-up prosthesis may be required if daily prosthesis is in need of repair and/or maintenance, so as not to impede work and lifestyle.

6.7 Replacement and Repair Schedule

The Rehabilitation Supplier should secure, from the Prosthetist, a projected schedule of repair and replacement of the prosthesis and disseminate said information to the Injured Worker.

6.8 Driving Equipment Needs (refer to Transportation Paper for additional details)

The Rehabilitation Supplier should be aware that the Injured Worker may require adaptive driving equipment, and/or instructional training, to operate a motor vehicle. This is dependent upon the type of prosthetic device and residual functional level.

6.9 Need for Assistive Aids with Prosthesis (refer to canes/walker section)

- Address with the Prosthetist and/or treating physician the need for possible assistive aids, that when used with the prosthesis, would promote the Injured Worker 's ADLs, quality of life and work potential

- Coordinate a formal occupational therapy evaluation to identify specific needs

6.10 Return to Work Considerations

The Rehabilitation Supplier, in conjunction with the Injured Worker and employer, should complete a comprehensive job analysis and provide same to the Prosthetist for consideration of return to work in the assessment process.

6.11 Housing/Home Modification Needs

The Rehabilitation Supplier should conduct a home visit to the Injured Worker's home pursuant to State Board Rules (Refer to Home Evaluation Section) consult with the Prosthetist, treating physician and accessible housing experts to discuss and identify home modification needs.

6.12 Supply Needs as Related to Prosthesis

- The Injured Worker may require supplies to maintain and use the prosthesis, including socks and shrinkers for reduced limbs, body powder/ointments, small tool kit, skin dressings, and medications for skin breakdowns.
- The Rehabilitation Supplier should obtain said recommendations from the Prosthetist and/or treating physician and coordinate provision of supplies, as needed, including these items in the rehabilitation plan

6.13 Physical Rehabilitation/Training for Amputee

The following are issues the Rehabilitation Supplier should address in coordination therapy for the amputee, once a referral is obtained from the authorized treating physician:

- Identify Certified/Experienced OT and/or PT program
- Maintain communication between OT/PT, Prosthetist, Physician, and Injured Worker to address concerns and proceed with agreed upon goals
- Physical rehabilitation may need to include training in use/care for prosthesis
- Cardiovascular training and strength/endurance training
- Development of a home exercise program for long-term health maintenance

6.14 Potential Complications/Challenges

The Rehabilitation Supplier should be aware of and/or identify potential complications as related to the amputation injury and address same with the Treating Physician, Prosthetist, Injured Worker, and other treatment provider(s). Complications /challenges may include, but are not limited to:

- Weight changes
- Co-morbid medical diseases/factors (i.e. Diabetes, Peripheral Vascular Disease)
- Limb volume changes (weight, atrophy, edema)
- Skin ulcerations/break down
- Phantom limb pain/sensation
- Contractures
- Scoliosis
- Compromised integrity of sound limb
- Bony overgrowth/spurs
- Neuromas
- Matching skin tones, when applicable

7. VISION IMPAIRMENT (Appendix for additional information)

7.1 General Considerations

The purposes of vision impairment equipment are multifaceted, but usually perform one of the following general functions: improve sight, increase mobility, and/or enhance communication. Rehabilitation Suppliers assist vision-impaired workers who have experienced a work-related injury. Vision Impairment may result from a variety of work injuries, including, but not limited to, physical trauma to the eye, optical nerve damage, and/or traumatic brain injury. It is important that the Injured Worker

participates in an evaluation by a Visual-Impairment Professional. Assistance for the Visually Impaired is available through many local sources (Refer to the Appendix).

7.2 Vision Products For Visually Impaired

There are many products for the visually impaired, which can be classified as Computer Software/Accessories, Personal Mobility, Wayfinding, or Recreational. Examples of each would include, but are not limited to:

- Computer Software/Accessories – including voice activation/recognition, screen magnifiers, talking computer screens, Braille displays/printers, speech technology for Windows and Internet accessibility, etc., (refer to the appendix for specific examples of available equipment).

- Personal Mobility - aids which include guide dogs, (Refer to Service Animals Section) a variety of canes, flashlights, reflective tape, wheelchair/scooter accessories, raised strip patterns, directional bar mats, etc

- Wayfinding – talking map and global positioning system (GPS), Braille/tactile directional signage, MotionPAD messages, STEP-SAFE(R) warning system, rubber tactile warning strip, etc.

- Recreational – Tandem tricycle, swimming goggles with panoramic vision, etc. (Refer to the Recreational Section.

8. HOME MODIFICATIONS TO ACCOMMODATE MOBILITY NEEDS

(Refer to Housing Paper for more details)

8.1 General Considerations

The planning of appropriate housing and/or home modifications to match the specific accessibility needs of the Injured Worker is one of the most important parts of the mobility process. Immediately upon determination of the appropriate mobility device, the Rehabilitation Supplier should identify potential barriers to use and storage of equipment.

Rehabilitation Suppliers are not housing experts, but with planning and appropriate consultations, housing plans can be developed. Determining if the existing home is accessible and functional for the Injured Worker's needs may require a formal home evaluation (see home evaluation section). The Rehabilitation Supplier should be aware that there are a variety of home evaluations, ranging from preliminary, informal assessments by the Rehabilitation Supplier to a specialized assessment by a qualified Occupational Therapist, Physical Therapist, or other Accessibility Housing Professional.

Decisions should be based on an individual's functional abilities, his/her needs, as well as those of others in the home, and the design of the home. The goal is to increase function and safety for the Injured Worker, allowing as much independence as possible.

8.2 Home Evaluations

The Injured Worker's return to independent living requires planning and intervention. To ease this transition, a home evaluation may ensure a successful, safe return and future.

The goal is to facilitate the highest level of independence, resulting in a purposeful and meaningful life. Each Injured Worker's home is unique, so there is not a set formula for solutions. Therefore, the home evaluation is specific to each individual.

An assessment is made of the function and accessibility of everything in, or around, the home from the Injured Worker's new perspective. The general approach of the home evaluation is to work from outside to inside, concentrating on areas and rooms that are used most often. After identifying the structural barriers at the home and physical limitations of the Injured Worker, structural changes, adaptive equipment, and adaptive techniques to enhance the Injured Worker's self-sufficiency and safety are recommended.

8.2.1 Areas Typically Addressed

- Are there structural barriers or physical limitations which challenge the Injured Worker's independence at home?
- What are the Injured Worker's strengths and weaknesses?
- Assessment of the Injured Worker's ADL including grooming, hygiene, dressing, bathing, cooking, cleaning, child care, work, hobbies, etc.

8.2.2 Information Necessary May Include, But, Is Not Limited To

- Injured Worker's specific goals and primary needs for evaluation. (ex. bathroom renovations)
- Prescription from physician for specialized home evaluation.
- Injured Worker's medical information, including diagnosis, restrictions, special needs, etc.
- Discharge summaries from OT and PT, if applicable. If Injured Worker's physical restrictions and functional capabilities are unclear, schedule OT/PT evaluation(s) prior to home evaluation.
- Is it rental or owned property?
- Immediately upon determination of the appropriate mobility device, the Rehabilitation Supplier should identify potential barriers to use and storage of equipment.
- Have there been any major structural modifications made to the home as a result of the Injured Worker's recent change in health status? If so, furnish the name and phone number of the contractor who completed the home modifications.
- Indicate any large Durable Medical Equipment such as a shower chair, Hoyer lift, etc. that the Injured Worker already owns. Furnish the name and number of the vendors that provided the DME.
- Time parameters, should be determined, and documented if applicable, in scheduling and completing the home modifications.

8.3 Exterior Considerations

- Climate conditions in the region, need for outdoor protection against adverse weather conditions
- Terrain and exterior approach (rocky, grassy, hilly)
- Paving, concrete, rock, or paving stone
- Parking availability
- Accessible route from parking to the home
- Garage or carport - Measurements, including clearance, of garage door when open
- Garage door opening automatic or manual

- Porch, patio, balcony size, entrances, surfaces
- Steps – number, height, and width
- Access aisles should measure a minimum of 32 inches at any point.
- Need to reconfigure outside furniture
- Entrance doorways (allow clearance of 32" wide or more), direction of door swing, in or out
- Thresholds up to ½" should be beveled, and over ½" should be ramped.

8.4 Accessible Covered Area

Mobility problems may restrict the speed at which an Injured Worker may enter and exit from a vehicle. Exposure to the elements may be particularly hazardous to an Injured Worker's health and the preservation of the mobility device. For example, people with spinal cord injuries have a hard time regulating their body temperature, so exposure to rain/cold, etc., could have medical consequences, in such cases, the Board will require a covered parking area.

Where feasible, it is preferred that the covered parking area be attached to the home. Parking requirements will vary on a case-by-case basis. The parties should take a common sense approach as to what each Injured Worker will need, based upon his/her individual factors. A two-car garage might need to be used as a single-car garage with unloading area

8.5 Ramps for Homes

- Ramps can be made from various materials
- Ramps – standard ratio is 1 foot of ramping for each 1 inch in height.
- Recommended width is 36 inches
- Landings should be 5 feet square
- For every 20 feet of ramp a landing is required
- Landing should be in front of any exterior doorway

8.6 Interior Considerations (refer to Housing Paper for more details)

Include assessment of bathrooms, kitchen, turning space, doors, secondary exits, steps and walkways, bedroom, laundry room, flooring, environmental controls, etc.

8.6.1 Bathrooms Considerations

- Storage for supplies
- Faucet controls
- Appropriate grab bars, including consideration of pole from floor to ceiling with swing arm, etc.
- Shower chairs, transfer tub benches and built in shower seats/benches need to be considered for safety
- Handicapped toilet – raised threshold lift toilet
- Roll in showers, with rolling shower chair
- Scald guard shower heads and faucets
- Flooring (see below)
- Work spaces compatible height for wheelchair access
- Roll under spaces in areas Injured Worker needs access(sink, countertops)
- All exposed water pipes need to be insulated to prevent burns

8.6.2 Kitchen Considerations

- Faucet controls
- Work spaces compatible height for wheelchair
- Roll under spaces in areas to which the Injured Worker needs access(sink, countertop)
- Stove, cook top, dishwasher, microwave and refrigerator need to be accessible
- All exposed water pipes need to be insulated to prevent burns
- Accessible cabinets and storage
- Flooring (see below)

8.6.3 Turning Space Considerations

- Consider turning space needed for particular mobility device
- Appropriate turning space should be considered in all rooms, especially kitchen and bath.

8.6.4 Door Considerations

- All doors should be wide enough to accommodate the mobility device in areas which Injured Worker needs easy access
- Levered handles for easy opening, when appropriate
- Thresholds are recommended to be ½ inch high or less (bevel up to ½", ramp over ½")
- Automatic doors, when appropriate

8.6.5 Secondary exit

- Safe, easy exit, preferably from the bedroom area, or close proximity**,** which does not require going through kitchen or utility closet, avoiding main sources of fire
- All exits should provide a safe, expedient surface for access to a safe area outside of the home

8.6.6. Steps and Walkway Considerations

- Hand rails for steps, walkways**,** hallways and interior walls, when appropriate
- Walkway should be wide enough to accommodate mobility device
- Stair lifts and elevators are appropriate in some situations

8.6.7 Bedroom Considerations

- Adjustable bed to facilitate care and transferring
- Accessibility to clothes closet, drawers and storage
- Armoire is option if structure does not allow closet access

8.6.8 Laundry Room Considerations

- If Injured Worker wants to participate in the laundry process
- Folding table/ironing board that is accessible height
- Determine front loading washer/dryer versus standard washer/dryer
- Accessibility of supplies
- Easily accessible switches, faucets, etc.

8.6.9 Flooring Considerations

Injured Worker's who have difficulty walking or maintaining balance and/or who use crutches, canes, or walker, are particularly sensitive to slipping and tripping hazards. For

these individuals, a stable and regular surface is necessary for safe walking, particularly on stairs.

- Wheelchairs can be propelled most easily on surfaces that are hard, stable, and regular
- The best surfaces are hardwood flooring, laminate flooring, and ceramic tile
- Linoleum tile does not hold up well under wheelchair use
- Tighter weaves and shorter piles (i.e. commercial, Berber the most appropriate when carpet is used, due to wear and tear and maneuverability
- Carpet designed with weave that causes a zig zag effect is strongly discouraged
- When both carpet and padding are used, it is desirable to have minimum movement (preferably none) between the floor and the pad and the pad and the carpet (prevents carpet from buckling or stretching)
- A thick, plush pad, particularly in combination with long carpet pile, makes it difficult for individuals in wheelchairs and those with other ambulatory disabilities to get about
- Firm carpeting can be achieved through proper selection and combination of pad and carpet
- With proper installation, the pad can sometimes be eliminated
- Polished floors are not acceptable for external areas, bathrooms, toilets, indoor pool areas, industrial plants and other spaces where water or other similar materials are likely to give rise to danger

8.7 Environmental Control Units- ECU (refer to resource section)

When the Rehabilitation Supplier evaluates the needs of the disabled individual they need to take into account their physical and cognitive capabilities. ECU's are essential to enable an individual with limited uses of upper extremities (e.g. high injury spinal cord injuries/amputees), to maintain some degree of independence in their home and work environment.

- ECU can be either voice or switch activated
- The Injured Worker should be evaluated to be certain that he/she has the cognitive and physical capabilities to operate the unit.
- ECU's can range from a simple remote control to operate a light and control room temperature, to the more sophisticated, voice-activated computer-based systems, which can control fax machines, answering machines, telephones, radio, televisions, lock and unlock doors, and operate elevator doors.

9. WORKSITE CONSIDERATIONS FOR MOBILITY

9.1 General Considerations

When considering worksite accommodations for Injured Workers with mobility limitations, the process must be conducted on a case-by-case basis, with input from the person with the disability. When necessary a detailed job analysis should be provided by qualified professionals (i.e. OT's, PT's, Ergonomic Specialist, etc). Each individual has different abilities and limitations that should be considered. Also, essential job functions may vary from office to office, so they need to be defined and problematic job tasks identified.

It is difficult to generalize possible accommodation needs because each individual has unique abilities and limitations. However, this section should serve as a general

starting point by giving useful questions to ask and accommodation possibilities to consider.

9.2 Worksite Evaluation

Before conducting a worksite assessment, it is important for the rehabilitation professional to become familiar with the industry, e.g., its terminology, processes, work methods, materials, products, machines, equipment, and key occupations. This provides the basis for conducting a worksite assessment and makes it possible to communicate effectively with workers and supervisors. Such information is most easily obtained by touring the plant or office.

When performing a work site evaluation, observe the entire work cycle. Ensure that all required tasks are understood and described, even those tasks performed infrequently. Interviewing incumbent employees is probably one of the best ways to obtain reliable information about a job. Front-line supervisors are also important sources of information about job expectations. Taking photographs and/or videotapes to record the job being performed can aid understanding and provides documentation of the job's requirements.

The Injured Worker with mobility limitations is most likely to require accommodations in the form of modifying the physical environment of the workplace to ensure that he/she can access the work area. Keep in mind that this area includes not only the individual's workstation, but also the

Washroom facility, cafeteria, conference rooms, and the areas where he/she is expected to go in order to do the assigned work tasks effectively.
If the Injured Worker has ever performed the job being evaluated, he/she should review the work site evaluation report and any other documentation for accuracy. If there are any issues, they need to be addressed with all parties.

9.2.1 Worksite Accessibility Guidelines (Refer to Appendix for "Checklist for Worksite Accommodations")

In relation to mobility/accessibility issues, the basis for making decisions regarding worksite accessibility comes from the ADA Accessibility Guidelines (ADAAG) http://www.access-board.gov/indexes/accessindex.htm. These guidelines were established to set standards for assuring that adequate access and safety is created and maintained in commercial facilities. These guidelines cover all areas of the physical environment and guide both new construction as well as modifications. Generally, the following areas should be considered:

- "Handicapped Parking" spaces should be available and located at the shortest distance possible to the entrance of the facility. These spaces should comply with the ADAAG requirements regarding the number available, dimensions of the space, signage, and passenger access out of the vehicle and to the entrance. Where possible, there should be a space reserved for the Injured Worker.

- Adequate space should be provided at the entrance to allow for safe access into the facility. Door clearance should be at least 32 inches to allow for easy access for wheelchair users. Railing should be provided where steps are installed. If ramping is required for wheelchair access, it should comply with ADAAG regulations (see

Ramps). It is sometimes preferable to install a vertical lift at the main entrance versus a ramp (see Porch/Vertical Lift).

- For individuals with limited upper extremity function, an automatic door opener should be considered. Opening systems can be activated either by a strike plate mounted in front of the door or the individual can use an activator that can be mounted to the wheelchair or worn on the body.

- Adequate space should be provided throughout the workplace.

- Obstacles blocking access should be removed.

- Proper lighting should be provided.

- There should be a well marked emergency/secondary exit available.

- Bathroom access should be suitable for individuals with special needs and meet the guidelines for wheelchair access. (Refer to Checklist for Worksite Accommodations)

- Workstation features should be ergonomically sound. Proper seating must be provided using task chairs and/or wheelchairs that meet specifications for adequate adjustments.

- Accessible shelving and material storage will help to reduce unnecessary strain for the worker with limited upper mobility. In addition, all office equipment should be placed in the proper arrangement to promote good body posture.

- If computer technology is used, provide hardware and software modifications to maximize the functional capacities for the individual. (Refer to Appendix for Checklist for Worksite Accommodations and Computer Equipment for Visually Impaired)

- In some cases, the most effective way to accommodate the workplace is to consider strategies that might include accommodations that preclude the need for structural change to the environment. These strategies can include restructuring the work tasks, eliminating non-essential duties and using telework/telecommuting as an alternative to utilizing the primary worksite. However, when considering home-based employment, aspects of socialization needs of the Injured Worker must be addressed.

10. EMERGENCY ISSUES (refer to addendum for websites for checklist and escape plan)

10.1 General Considerations

There are a large number of potential solutions for emergency issues that may face Injured Workers and other individuals with mobility problems. Rehabilitation Suppliers should encourage Injured Workers with mobility problems to plan carefully for emergencies, both at home and at the work place, and assist as necessary. The Rehabilitation Supplier needs to ensure that the Injured Worker and caregivers understand the use of emergency equipment and the emergency plans.

An emergency plan should include a written plan for emergency escape. The Rehabilitation Supplier should encourage the Injured Worker to register with the local fire department or emergency management office.

10.2 Other Responsibilities of the Rehabilitation Supplier

- Check with the personal care agency or caregiver to identify special provisions/protocols for emergencies
- Develop a plan for each type of emergency possible in the community and plan for alternative shelter, which should be wheelchair accessible, if necessary
- Make sure there is more than one exit available for a wheelchair (see Secondary Exit)
- Recommend practice of emergency plan by Injured Worker and caregivers
- Recommend a list of models and serial numbers of all specialized medical equipment be kept in a watertight, fire proof container
- Evaluate power supply and need for back up power supply, based on Injured Worker's needs, medical equipment and physician recommendations
- Assess need for a medical alert system
- Assess need for evacuation chair if Injured Worker lives or works in a building with more than one story
- Assess need for wireless intercom for the home (see Environmental Controls)
- Review emergency procedures and equipment condition periodically and make provisions for any repairs, upgrades or replacement
- Cell phone service, as medically prescribed, is essential for persons with the potential to develop a medical or vehicle emergency.
- Monitored systems such as On Star provide numerous services: information, directions, roadside assistance, remote door unlocking, and stolen vehicle tracking.
- GPS (Global Positioning Systems) can keep track of an individual's position via satellite. These devices can be configured as telephones or watches and can be very helpful for individuals who might have some confusion due to brain injury or dementia.

11. TRANSFER DEVICES

11.1 General Considerations

There are many types of transfer devices both portable and permanently installed. Prior to selecting a transfer device one should consider the following: immediate needs versus the long term needs of the Injured Worker based upon diagnosis, prognosis, age and housing (permanent vs. transitional) to allow the Injured Worker maximum independence in safe transfers. The weight of the individual should also be considered, especially if one is totally dependent for care.

11.2 Overhead Lifts

- Ceiling track lifts can be used to transfer an individual from bed to wheelchair or into the bathroom from bedroom.
- Wall to Wall Lift Systems can be used in areas with small space: (i.e., toilet to bathtub, or bed to wheelchair), if the ceiling will not accommodate a ceiling lift. This type of lift can also be used as a portable lift system, thereby allowing it to have multiple functions.

11.3 Hoyer Lifts

- Mobile and Stand Up Lifts are available and are operated as hydraulic, battery or electric powered
- Types of seating available for Hoyer lifts vary to include slings designed to meet the individual needs of the injured worker: (i.e., slings w/headrests, openings for toileting, full body, as well as size)-(Bariatric)
- Sling free sit/stand lifters
- Trapeze Bar with or without bases
- Stand Assist Lifts to enhance circulation, for supported walking and weight bearing exercise

11.4 Personal lifts

- These lifts are similar to Hoyer seats or can actually be a swiveling car seat which swings out of the vehicle and then back in again, after the inured worker is seated in it.
- Allows an Injured Worker to be lifted from a chair or to transfer into a vehicle when not able to transfer, and does not require other stabilizing devices to sit in standard car seat.

11.5 Pool Lifts

- Automatic and/or water-powered lifts are available and can be used in pools or in-ground spas with built in benches
- Water hose powered lifts with built in seats
- Portable aquatic lifts that are battery charged
- Pool lifts can be used to lower individuals into a pool or whirlpool

11.6 Miscellaneous Transfer Aids

- Lift vests to assist an individual with transfers from wheelchair or to assist with ambulating using a mobility device

12. MOBILITY AIDES

12.1 General Considerations

The Rehabilitation Supplier should consult with the Authorized Treating Physician, Prosthetist, and/or Physical/Occupational Therapist to secure medical opinion as to whether or not the Injured Worker requires a walker, cane, crutches, or other mobility device.

12.2 Canes, Walkers, and Crutches

- The Rehabilitation Supplier should consult with the Authorized Treating Physician, and/or Physical/Occupational Therapist to secure medical opinion as to what type of devices would be most appropriate.

Canes

- Straight canes
- Adjustable height straight canes
- Adjustable height quad base canes
- Ortho-grip adjustable height quad canes
- Wood versus metal versus Lucite

Walkers

- Standard walker
- Standard walker with wheels
- Rollite walker with wheels, seat, & brakes
- 4-wheel Rollator walker
- 3 wheel Rollator walker (no seat)

Crutches

- Fixed, standard crutches
- Wooden or aluminum adjustable height walkers
- Forearm crutches with adjustable height

12.3 Power Lift Chairs/Recliners

- Designed for individuals who have difficulty rising from a seated position
- Available in various fabric and styles to blend easily with any décor
- Raise up and tilt forward to assist an individual in getting out of chair
- Can recline into a nap position, allowing for weight shifts when they are used for long periods of time
- The weight, height, and grip/grasp of the individual need to be taken into consideration
- Arm rests, varying chair back heights and seat heights are available\
- Eating trays can be attached and stored in enclosed compartments when not in use.

12.4 Shower Chairs (stationary and rolling) and Shower Benches

- Available for users who can either transfer onto a shower seat or who need to shower in a chair rather than being able to sit or stand to shower
- Shower chairs and benches are assessed according to the size and weight of the individual user
- Turning radius of the shower chair in a bathroom should be considered
- Shower benches should be stable enough to support the user as he/she moves to bath.
- Benches can be built into shower surrounds, be freestanding or attached to a bathtub.

12.5 Porch/Vertical Lifts, Pool and Chair Lifts

- Porch/Vertical lifts may be used when a ramp is not feasible due to space or as a personal preference. They lift individuals and their mobility devices level with porches, etc., when feasible, they should be covered.
- Stair chair lifts require a stairway wide enough for the lift and should have additional clearance for other individuals in the residence to use the stairway also. These lifts generally require space at the bottom and/or the top of the staircase to swivel to get onto or off the lift.

13. SERVICE ANIMALS

13.1 General Considerations

Service animals are animals that perform tasks for individuals with disabilities. Although service animals and their owners develop strong relationships, service animals are considered working animals, not pets. While other animals may function as service animals, the most prevalent are service dogs. A dog meets the definition of a "service dog" if it has been "individually trained to do work or perform tasks for the benefit of a person with a disability."

Service Animals are legally defined within the ADA. Federal laws protect the rights of people with disabilities to be accompanied by their service animals in public places. While therapy animals and companion animals work with the disabled, they are not included in the ADA definition. These animals are considered pets.

13.2 ADA Guidelines

- Businesses may ask if an animal is a service animal or ask what tasks the animal has been trained to perform, but cannot require special ID cards for the animal or ask about the person's disability.
- People with disabilities who use service animals cannot be charged extra fees, be isolated from other patrons, or treated less favorably than other patrons. However, if a business, such as a hotel, normally charges guests for damage that they cause, a customer with a disability may be charged for damage caused by his or her service animal.
- A person with a disability cannot be asked to remove his service animal from the premises unless: (1) the animal is out of control and the animal's owner does not take effective action to control it (for example, a dog that barks repeatedly during a movie) or (2) the animal poses a direct threat to the health or safety of others.
- In these cases, the business should give the person with the disability the option to obtain goods and services without having the animal on the premises.
- Businesses that sell or prepare food must allow service animals in public areas even if state or local health codes prohibit animals on the premises.
- A business is not required to provide care or food for a service animal or provide a special location for it to relieve itself.
- Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.
- Violators of the ADA can be required to pay money damages and penalties.

13.3 Service Dog Recipients

Service dogs are trained to provide various services for people with disabilities associated with many diagnoses, including, but not limited to:

- Arthritis
- Cardio/Pulmonary Disease
- Cerebral Palsy
- Disabilities
- Hearing Deficits
- Multiple Sclerosis
- Muscular Dystrophy
- Psychiatric
- Seizure Disorders
- Spinal Bifida
- Spinal Cord (paraplegia, quadriplegia, and others)
- Traumatic Brain Injury
- Visual Deficits

13.4 Service Dog Functions

Service dogs can be trained to perform many tasks, depending upon the recipient's needs, including, but not limited to:

- Leading a person who has a visual impairment
- Sound discrimination to alert a person with a hearing impairment to the presence of telephone, alarms, timers, knocks at the door, etc.
- General assistance with balance and manual chair propulsion
- Aid in retrieval of objects otherwise out of reach
- Opening/closing doors
- Operating light switches
- Carrying items
- Acting as a buffer in a crowd
- Barking to alert for help
- Seizure alert
- Going to retrieve help
- Interprets and aids in environmental awareness
- Acting as an "icebreaker" in social functions
- Companionship with recipient

13.5 Training & Location of Service Dogs

An extensive training period is required to train the service dogs. Service dogs can be located through many sources. In Georgia, there are several programs that provide service dogs, including, but not limited to:

- Canine Assistants, Inc.
- Canine Vision, Inc.
- Comprehensive Pet Therapy, Inc.
- Cosby's Therapy Animals, Inc.
- Georgia Dog Institute
- Lifeline Assistance Dogs

13.6 Obtaining Service Dog

- Obtaining a service dog from a program requires an application process. In addition to the medical diagnoses, other factors are considered when assessing a person's candidacy for a service dog.
- A person's stamina, safety, social interaction, level of functioning with activities of daily living (ADLs), and other general benefits may be evaluated when determining the appropriateness of using a service dog.
- The ultimate goal is to make sure that the service dog is a nearly perfect fit or match for the person with disabilities who is requesting the service dog
- Simultaneously, the program will want to assure that the service dog will be placed in a safe, caring environment and treated appropriately.

14. TRANSPORTATION (Refer to the Transportation Paper for more detail)

14.1 General Considerations

A plan should always be in place that allows the Injured Worker to be as mobile as possible, including transported safely as a passenger, even if he is the primary driver. Educate all parties (claimant, adjuster, attorneys, etc.) concerning recommendations to be made in the rehabilitation plan. This can include options, costs analysis, and medical necessity.

If the Injured Worker will be driving a vehicle, a driving evaluation will assess physical, visual, perceptual, and cognitive skills, as well as identifying safe/unsafe-driving techniques. It will also help identify adaptive equipment needs. Referral for a driving evaluation with a Certified Driver Rehabilitation Specialist (CDRS) is strongly recommended and should be performed by a provider that has both clinical and on-the-road evaluation capabilities available. Specific adaptive equipment should be listed as a result of the evaluation, in order to obtain physician orders and clear and cost effective bids.

14.2 Alternatives

- Contract taxi or medical transport
- Public transit
- Rental
- Auto vs. van vs. truck (refer to Transportation Paper, Section D)
- Modification of vehicle (refer to Transportation Paper, Section II, B, d)

15. CARRIERS, LIFTS, AND RAMPS

15.1 General Considerations

Safety, security, exposure to weather, handling, and maneuverability of the vehicle, possible damage to mobility equipment, cargo space, Injured Worker's functioning level, vehicle modifications, and cost are all factors to consider in determining the appropriate system. If the Injured Worker is going to operate the rear lifts/trailers independently, the Injured Worker must be able to position and lock down the scooter/wheelchair and be able to ambulate from the back or side and enter the vehicle. For the overhead lift/carrier, the Injured Worker must be able to transfer into the vehicle from the mobility device and operate the controls for the system to automatically lift and stow the chair. Not all of these devices are covered. An appropriate evaluation of the exposure of the mobility device to the elements must be considered.

15.2 External Trailers/Lifts/Carriers

The wheelchair/scooter is transported on a lift or trailer on the rear of the vehicle, in the bed of a truck or on the top of the vehicle (wheelchair lift/carrier). These systems allow for easy access to equipment and no cargo space is required.

- Lifts fitting on top of a vehicle are only suitable for manual chairs and have strict weight restriction
- Vehicle must be retrofitted with an approved hitch and platform for rear end carriers
- Size of engine and type of vehicle determines what type of carrier can be considered.

15.3 Inside Lift

An unoccupied hoist lift positions the wheelchair/scooter into the bed of a truck, trunk of a car, or through the rear or side door of the vehicle. The Injured Worker must be able to attach the wheelchair/scooter to the lift and be able to ambulate or transfer into the vehicle, if no one is available to assist. Fully automated lifts allow the Injured Worker to be lifted inside the vehicle while occupying his/her mobility device and can be operated independently or with assistance.

- These lifts are usually found on modified full-sized vans
- The type of lift is determined by total combined weight of the Injured Worker and the mobility device

- Raised roof and/or lowered floors may be necessary (This information should be provided through the driving evaluation or dependent passenger evaluation).

15.4 Vehicle Ramps

- Generally, ramps are used on mini vans only, due to the safety concerns and degree of incline
- Even with lowered floor availability, there are height restrictions
- Automated Ramps allow an Injured Worker to enter/exit while occupying a mobility device and can be operated independently or with assistance
- Manual Ramps are available for occupied mobility devices if attached to a vehicle, assuming the ramp angle is safe and that the mobility device has adequate traction and power (Manual ramps require assistance).

15.5 Portable Ramps

Portable ramps are available for wheelchair/scooter users to carry in their vehicles to allow access to areas not handicapped accessible.

- These ramps are lightweight and available in varying lengths
- It is recommended that this equipment be considered for wheelchair dependent Injured Worker

16. EXERCISE EQUIPMENT

16.1 General Considerations

Rehabilitation Suppliers should coordinate with an Authorized Treating Physician and Physical or Occupational Therapist regarding the needs for the Injured Worker. Specific exercise/conditioning needs and equipment can be addressed in formal therapy, local gym, and home environments. Mobility impaired Injured Worker benefit from strength, cardiovascular, balance, flexibility, and proprioceptive training. Additional benefits may include: range of motion, physical and cardiovascular endurance, improving and maintaining physical functions, avoiding complications of immobility (i.e. obesity, diabetes, hypertension, skin problems, contractures, muscle weakness, decreased function, etc.)

A prescription should be obtained from the physician and the equipment should be included in the Rehabilitation Plan. Specify in the Plan that the Injured Worker is to use the equipment. The Rehabilitation Supplier needs to ensure that the Injured Worker and the caregivers understand and can demonstrate the use of the equipment. The Rehabilitation Supplier should address the repair and maintenance of any and all equipment purchased. Ample storage for exercise equipment in a home setting is often problematic and the storage requirements need to be considered in equipment and housing decisions.

16.2 Tricycles, Lower and Upper Extremity Equipment, and Total Body Conditioning Equipment

- Tricycles are available as hand propelled and with recumbent seats
- Some total body conditioners are wheelchair accessible and may have variable length hand cranks that can be configured to simulate rowing motions. The user can passively work the lower body while actively working the upper body.
- **Numerous hand cycle table models allow the Injured Worker to remain in the wheelchair or seated.**

- **Some have optional foot pedals to exercise the lower extremities**
- Multi-station weight training can be provided with some models
- Equipment designed for C4-C5 quadriplegics allow performing all necessary upper body exercises without assistance, models can be developed with slings or seats
- Some equipment provides swivel seats, which allows transfers directly from wheelchairs.
- Recumbent equipment offers a safe and challenging workout for exercisers of all ages and abilities, because it provides back support and a more comfortable positioning.

16.3 Standing Frames

Standing frames are utilized in facilities and homes to facilitate bowel and bladder function, muscle tone, prevention of osteoporosis, improved circulation, etc.

- Allows the Injured Worker to go from a sitting to standing position
- Some provide dynamic leg motion
- Can be used for work accommodations

16.4 Additional Equipment

- Elliptical
- Functional Electronic Stimulator (FES)
- Hand Putty
- Treadmill
- Theraband
- Water resistant equipment for Aquatic Therapy
- Weights

17. RECREATIONAL MOBILITY ISSUES

17.1 General Considerations

Therapeutic recreation focuses on improving self confidence, as well as physical, cognitive, emotional, and/or social functioning and returning the Injured Worker to as independent, active, and healthy of a lifestyle as possible. Attitude and activity strongly affect a person's health and well being. Meaningful recreational activities and socialization help decrease dependence and medical complications. The goal is to help overcome barriers that prevent or limit a person from enjoying leisure activities.

The National Center on Accessibility provides resources, consultations, and referrals to professionals seeking the most current information on accessibility standards, recreation rule making, program modifications, equipment, vendors, and requirements of the Americans with Disability Act and Section 504 of the Rehabilitation Act.

17.2 Assessment

An assessment of an Injured Worker's current mobility status and his/her ability to re-enter the community at the current functional level can be done through a Recreational Therapist. The Recreational Therapist may utilize information from other disciplines, (i.e. OT, PT, and Speech,) including physical and cognitive functioning. This assessment should determine realistic goals and interventions to maximize functioning and independence at home and in the community, taking into account pre-injury interests.

17.3 Areas of Therapeutic Intervention

Counseling and education should focus on issues relevant to having a disability:

- Assertiveness
- Available resources
- Barrier awareness
- Disability rights and ADA laws
- How to handle discrimination
- Individual limitations
- Problem solving techniques
- Safety Awareness
- Self advocacy
- Self help groups
- Societal attitudes/stereotypes
- Stigma management
- Transportation options

The Injured Worker needs to learn how to fulfill past or new recreational interests through the use of:

- Adaptive equipment
- Adaptive techniques
- Compensatory strategies
- Transferable skills
- Activity modification through various resources

17.4 Adaptive Equipment & Recreational Opportunities

The advent of technology has opened up almost every area of recreation through modified and adaptive equipment. In addition, most recreational activities have developed specialty groups that focus on disabled inclusion.

17.5 Recreational Opportunity

There are numerous recreational opportunities available in such areas as:

Art	Gardening	Para Olympics
Basketball	Golf	Performing Arts
Bicycling	Horseback riding	Scuba Diving
Dancing	Hunting	Tennis
Fishing	Music	Water Skiing

17.6 Travel

For travel, there are accessible motor homes, cruise tours; disability coordinators at airports and many other opportunities open to the disabled. (Refer to resource page for article on travel/disabled)

It may be worthwhile to carry an emergency medical kit and a bag of small parts for equipment repair when traveling. Also, it may be beneficial to purchase SOS medical coverage when traveling abroad. SOS provides an English speaking MD and air ambulance transport back to the USA if needed.

18. FINANCIAL CONSIDERATIONS

- Consider purchase versus rental, long term needs versus short term needs, and maintenance costs for equipment. This must be documented in an Independent Living Rehabilitation Plan.
- Traditionally, mobility devices are considered an ongoing rehabilitation expense due to scheduled replacement and ongoing maintenance and repairs related to prescribed adaptive equipment.
- Maintenance costs for the prescribed adaptive equipment is the responsibility of the employer/insurer.
- Extended warranties on some adaptive equipment are strongly recommended to protect all parties, increasing the life of the adaptive equipment and reducing replacement time.
- Cell phone service, as medically prescribed, is essential for persons with the potential to develop a medical or vehicle emergency.

19. ETHICAL CONSIDERATIONS

Rehabilitation Suppliers have an ethical obligation in working with the Injured Worker to ensure that adaptive mobility equipment is available for independent living and avocational activities. The Rehabilitation Supplier has a vital role in the process of obtaining appropriate mobility equipment. Each Injured Worker has individual physical needs and life-style requirements. The independence offered by the appropriate mobility equipment can be life changing.

20. DISCLAIMER

This mobility and assistive devices information is being provided as general information and to assist with identifying appropriate solutions for various mobility and assistive device issues that may arise while working with an Injured Worker during the rehabilitation process. It is not all-inclusive or specific to an individual Injured Worker's needs. It is to be used as a guide to explore mobility and assistive device issues with all parties.

21. ACKNOWLEDGEMENT

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22. RESOURCES

Extensive information can be researched through the Internet by logging into Google, Yahoo or other search engines

22.1 Accessibility

National Center on Accessibility

22.2 Emergency Plans/Information

http://www.fema.gov and www.redcross.org

22.3 Service Animals

http://www.deltasociety.org/nsdc/sdbasic.htm

Canine Assist, Inc.	770.664.7178
Canine Vision, Inc.	770.459.4872
Comprehensive Pet Therapy, Inc.	770.396.6433
Cosby's Therapy Animals, Inc.	770.735.3828
GA Dog Institute	770.926.0003
Lifetime Assistance Dogs	706.273.Dogs (3647)

22.4 Useful Miscellaneous References

www.alimed.com (wide variety of mobility aids as well as a catalog of specially designed equipment for over-sized patients)
www.amerivans.com (Chevrolet/Pontiac luxury conversions)
www.bmedical.com (wide variety of mobility aids)
www.braunlift.com (lifts)
www.bruno.com (lifts and independent living aids)
www.eclipseconversions.com (Ford luxury conversions)
www.emc-digi.com (digital control pads for driving)
www.ezlock.net (wheelchair restraint systems)
www.harmarmobility.com (scooter lifts)
www.kinedyne.com (securement systems)
www.mobilityproductsdesign.com (hand, foot controls, and extensions)
www.norcalmobility.com (out of sight lift system)
www.silverstarmobility.com (scooters, lifts, carriers)
www.specialneedsvehicles.com (transfer seat bases)
www.riconcorp.com (lifts)
www.viewpointmobility.com (wheelchair accessible minivans)

22.5 Resources for Housing Information

- Housing Checklist – Considerations for Catastrophic Rehabilitation Suppliers – GA SBWC procedure manual
- Local County Fire Department
- Rehabilitation Division GA SBWC
- Architectural specialist
- Occupational and Physical Therapist
- Equipment Specialist
- Accessibility Experts
- Universal Design

22.6 Resources for Environmental Control Units

http://opensesamedoor.com/
www.qtiusa.com
http://www.guldmann.com/
http://www.makoa.org/ecu.htm
http://www.1stvoice.com/quartet.html
http://www.barrierfreedoorautomation.com/
http://www.interactplus.com/oyw_ecu.htm

http://www.abledata.com/text2/icg_spin.htm
http://www.web-helps.net/loan/step1.asp

22.7 Assistance for the visually impaired is available through many local sources, including, but not limited to:

- Center for the Visually Impaired, 763 Peachtree Street NE, Atlanta, GA 30308 (404) 875-9011.
- DOL/Rehabilitation Services, 1700 Century Circle, Suite 300, Atlanta, GA 30345, and (404) 657-3000.
- Georgia Industries for the Blind, 1080 Sylvan Road, Atlanta, GA 30310, (404) 756-4485.
- Georgia Lions Lighthouse Foundation, Inc., 1775 Clairmont Road, Decatur, GA 30033-4005, (404) 325-3630.
- Georgia Regional Library for the Blind & Physically Handicapped, 1150 Murphy Ave., SW, Atlanta, GA 30310 (404) 756-4619.
- Georgia Tech Center for Assistive Technology & Environmental Access, 490 Tenth Street NW, Atlanta, GA 30318, (800) 726-9119.
- Prevent Blindness Georgia, 455 East Paces Ferry Road, Suite 222, Atlanta, GA 30305, (404) 266-0071

22.8 Computer Equipment for the Visually Impaired

The selection of computer equipment and software to assist the visually impaired and blind is growing. For example, the following provides a partial list of adaptable equipment available:

- JAWS for Windows provides speech technology that works with your Windows 95/98/Me or Windows NT/2000 operating system to provide access to today's popular software applications and the Internet. JAWS uses an integrated voice synthesizer and your computer's sound card to output the contents of your computer screen to speakers. JAWS also outputs to refreshable Braille displays.

- ZoomText combines a screen magnifier with a screen reader and includes support for all Windows platforms.

- MAGic combines magnification features with low vision screen reading when purchased with the speech option. It gives a person the ability to choose the information you want read from the screen as you navigate applications MAGic is easy to use with its talking large print installation, new color-coded user interface and hot keys that avoid conflicts with Windows and popular software applications.

- Aladdin Genie Pro can be used with most computer monitors or televisions to create a color magnification system that best suits an individual's unique viewing needs. Other features include split screen viewing and shadow mask to help track text and reduce glare.

- Clarity AF Travelmate is a video magnifier which allows students with low vision to read, write, view pictures and work with three-dimensional objects by enlarging images on a monitor. It can be stationary or used as a portable system in the classroom.

- OPENBook is software developed to read, edit, and manage scanned images from books, magazines, manuals, bills, newspapers, and other printed documents.

- Merlin Desktop System is an auto focus desktop magnifier, which allows images or text to be viewed in color, black and white, or high contrast positive or negative. Voice activation is available.

- JORDY System is a head worn device that looks like a pair of glasses and magnifies objects up to 30 times. An optional desktop stand increases flexibility.

- The Max Family of digital magnifiers connects directly to a TV or monitor for easy viewing on any surface.

- The Braille Note is a note taker for people with blindness. The ergonomically designed portable system includes a built-in modem and e-mail package to provide worldwide connectivity, high-quality, and low-power Braille cell technology with highly intelligible, responsive speech and integration with Word files that maintain original formatting. The Braille Note features a unique calendar and scheduler, address list manager and scientific calculator with the ability to merge data between different applications.

- INDEX Basic-D Braille Printer can be used with a PC or as an independent copier.

22.9 Recreational Resources

Wheelchair bowling: BOWLAWBA@JUNCO.COM
Wheelin' Sportsmen program: www.nwtf.org or 800-THE NWTF
Wheelchair Fencing: http//sites.netscape.net/wheelchairfencer/homepage
American College of Sports Medicine (tips on finding a trainer & free exercises): www.acsm.org
American Council on Exercise: www.acefitness.org
USA Boxing (trainer certified): www.usaboxing.org
US Masters Swim Club: www.USMS.org
Road Runners Club of America: www.rrca.org
United Spinal Association & it's programs: www.unitedspinal.org
Amputee Resource Center: www.usinter.net/wasa/index.html

*Local rehabilitation facilities may be an excellent resource for recreation & fitness programs.

22.10 Travel

Department of Transportation Aviation Consumer Protection Division (To assist with consumer complaints): 800.778.4838. (voice); 800.455.9880 (TTY)
Air Carrier Access (Rules & regulations): www.dlrp.org/html/guide_to/acaa.html
How to get around a city- local Center for Independent Living: www.virtualcil.net/cils
Society for Accessible Travel & Hospitality (SATH): www.sath.org
Open Doors Organization: www.opendoorshfp.org
Frommer's: hHp:www.frommers.com/destinations/usa/024802008.html
Rent an Accessible Van:
Wheelchair Getaways @ 800.642.2042 & www.wheelchairgetaways.com
Wheelers @ 800.456.1371 & www.wheelersvanrentals.com

22.11 CHECKLIST FOR WORKSITE ACCOMMODATIONS

1. **Physical Environment**

A. Entering/exiting facility - Mobility from parking lot through exterior entrance

___ Is there adequate "handicapped" parking available?
___ Is there an accessible route to the facility?
___ Will ramp construction / vertical lift system be required?
___ Are handrails needed on exterior steps?
___ Is a door threshold modification needed?
___ Is a door width modification needed?
___ Is a door handles/hardware modification needed?
___ Is an automatic door installation required?

B. Traversing through Work Environment - Mobility in the destination areas, e.g. office space, bathroom, community space, path to gain access to specified destinations

___ Will obstacles need to be relocated?
___ Will structural change be required to improve maneuvering space?
___ Are emergency egresses available and well marked?
___ Are hallway and/or door width modifications needed?
___ Is proper lighting available?
___ Is there adequate temperature control?

C. Accessing Bathroom Features - Components used within the public bathroom space including sink, stall, commode

___ Are proper door width modifications needed?
___ Are door handles/hardware modifications needed?
___ Are door swing side changes needed?
___ Is the door closer timing adequate to allow time for exiting?
___ Are structural changes needed for improved maneuvering / turning radius requirements?
___ Is the sink height / depth / clear space / controls adequate?
___ Is the sink hot water pipe insulation adequate?
___ Is the mirror height adequate?
___ Is the stall width / clear space / hardware adequate?
___ Is the toilet seat height adequate?
___ Are grab bars available and do they conform to ADAAG guidelines?

D. Accessing Workstation Features - Creating a functionally appropriate space where the individual resides to complete primary job duties

___ Are door threshold and width modifications required?
___ Are structural changes needed to improve maneuverability?
___ Will obstacles need to be relocated: furniture, shelving, equipment?
___ Will proper seating need to be provided?
___ Will workstation modifications be required to improve proper postural positioning, (i.e. raising the surface for wheelchair access?

2. **Assistive Technology and Equipment**

A. Using work tools and furnishings - Devices/equipment necessary to complete job tasks to include communication and computer equipment modifications

___ Will tool and equipment placement and/or modifications be required?
___ Will writing aids be necessary to improve upper extremity mobility?
___ Is telephone headset needed?
___ Is telephone placement and/or mounting needed?
___ Are telephone alternatives required?
- ___ Speaker phone
- ___ Voice activated phones
- ___ Computer software/onscreen dialing
- ___ Telephone amplifiers

___ Is alternate computer placement needed?
___ Is replacement or upgrading of computer equipment needed?
___ Are adapted controls and switches needed?
___ Is improved interface capacity required?
- ___Accessibility feature within word processor
- ___Trackball
- ___Head mouse
- ___Joystick mouse
- ___Touch screen
- ___Keyboard alternative

___ Are software alternatives required?
- ___ Speech recognition
- ___ Speech synthesizer
- ___ Word prediction
- ___ Screen reader
- ___ Optical character recognition (OCR)
- ___ Screen magnification
- ___ Memory and attention aids
- ___ On screen keyboards

3. Adaptive Strategies

A. Environmental Access - Access to facilities without structural modifications

___ Can alternative routes be used?
___ Is Telework/Telecommuting an alternative?
___ Can the work schedule be adjusted?
___ Can the job tasks be restructured?
___ Can non-essential duties be eliminated or re-assigned?
___ Can work materials be arranged more consistently?

Resources:

- The Access Board http://www.access-board.gov/indexes/accessindex.htm
- AbleData http://www.abledata.com/text2/ramps.htm
- The Center for Assistive Technology & Environmental Access http://www.catea.org/index.html
- The Job Accommodation Network http://janweb.icdi.wvu.edu/