GEORGIA STATE BOARD OF WORKERS' COMPENSATION

INDIVIDUALIZED REHABILITATION PLAN

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

	Occupation	Catastrophic Injury?	County of Injury	Birthdate
EMPLOYEE		☐ Yes ☐ No		

Diagnosis & Functional Restrictions

B. PLAN INFORMATION

(Please check the appropriate blocks) ☐ Initial Plan

Date Last Plan Submitted

TYPE OF PLAN: Click or tap here to enter text.

- ☐ Medical Care Coordination (Catastrophic Cases Only)
- ☐ Independent Living
- ☐ Extended Evaluation
- ☐ Vocational Services (select one)
  - ☐ RTW / Same Employer
  - ☐ Job Modification
  - ☐ Graduated
  - ☐ Placement
  - ☐ On-the-Job Training
  - ☐ Formal Training
  - ☐ Self-Employment

The Following Documentation is Submitted for Plan Approval:

- ☐ Initial Rehabilitation Report
- ☐ Pain / Psychological Reports
- ☐ Rehabilitation Narrative Report
- ☐ Physicians' Approval of Job
- ☐ Job Analysis at Time of Injury
- ☐ Transferable Skills Analysis
- ☐ Summary of Labor Market Survey
- ☐ Medical Narrative Report
- ☐ Release to RTW
- ☐ Physical Restrictions
- ☐ Physical Capacities
- ☐ Analysis of Offered Job
- ☐ Vocational Evaluation
- ☐ Other:

Give a statement (individualized to this case) as to why services of a rehabilitation supplier are needed:

Complete this Information for an amended plan:

Type of Original Plan	Date of Original Plan	Type of Previous Amended Plan	Date

If Services were interrupted in the Original / Amended Plan, state reason	If Services are to be a continuation of a Previous Plan, state the need and justification for continuation

C. COMPLETE THIS PART FOR THE CHECKED TYPE OF PLAN

☐ Medical Care Coordination (catastrophic cases only) ☐ Independent Living ☐ Extended Evaluation

State Specific Problems	State Specific Goals

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

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D. COMPLETE THIS PART FOR CHECKED VOCATIONAL SERVICES

1.

- ☐ Job Modification
- ☐ Graduated
- ☐ RTW
- ☐ Placement
- ☐ OJT
- ☐ Formal Training

State Reasons for Type of Plan Selected:

2. Complete Work and Wage Information:

Average Weekly Wage at Time of Injury $ _____ or per Hour _____ Anticipated Wages $ _____ per Week

Wage Loss $ _____ Hours Worked per Week at Time of Injury _____

Proposed Full Time Work _____ or Part Time Work _____

3. State Occupational Objectives:

4. List Educational / Vocational Background:

5. Occupational Objectives Determined by:

☐ Transferable Skills		☐ Vocational Evaluation	
Date	Determined by:	Date	Evaluator

Summary of Vocational Evaluation:

6. Summary of Labor Market Survey (attach report):

Date Completed

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E. SERVICES AND RESPONSIBILITIES REQUIRED TO MEET GOALS

(Attach additional pages as needed)

State Services/Responsibilities	Initiation Date	Completion Date	Estimate Cost	Payer
Total Cost of Proposed Plan:				

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F. CERTIFICATE OF SERVICE

☐ I certify that I have discussed this plan with the employee and other parties to the case and have sent copies on

_____ / _____ / _____ to the following parties at the current addresses below.
Month Day Year

Signature		Registration No.		
Rehabilitation Supplier Name	Phone Number	Mailing Address		
E-mail Address		City	State	Zip Code

EMPLOYEE	Last Name	First Name	M.I.	Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
EMPLOYER	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
INSURER / SELF-INSURER	Name			Mailing Address		
CLAIMS OFFICE	Name					
E-mail Address		Phone Number		City	State	Zip Code
EMPLOYEE'S ATTORNEY	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
EMPLOYER'S ATTORNEY	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
OTHER PARTY OR SITF	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code

Comments about this plan:

Supplier signature (This indicates you have reviewed the plan with the employee)	Date

Is this case applicable for Kid's Chance scholarships? ☐ Yes ☐ No If yes, submit application to Kid's Chance, Inc.

G. APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent objection within 20 days of the date sent, the rehabilitation request is approved effective the date of the Certificate of Service. No further correspondence will be issued by the Board.

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the Georgia State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.