# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## INDIVIDUALIZED REHABILITATION PLAN

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

| Board Claim No. | Employee Last Name | Employee First Name | M.I. | Date of Injury |
|---|---|---|---|---|
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## A. IDENTIFYING INFORMATION

| | | | | |
|---|---|---|---|---|
| **EMPLOYEE** | County of Injury | Birthdate | Catastrophic Injury? ☐ Yes ☐ No | Occupation |
| Mailing Address | | | Diagnosis & Functional Restrictions | |
| City | State | Zip Code | Initial Plan ☐ Yes ☐ No | |
| Phone Number | E-mail | | New Plan Expectation Date: | Date Last plan Submitted: |
| **EMPLOYER** | Name | | **INSURER/ SELF-INSURER** | Name |
| Mailing Address | | | **CLAIMS OFFICE** | Name |
| | | | Mailing Address | |
| City | State | Zip Code | City / State / Zip Code | |
| | | | SBWC ID# (five digit no.) | Insurer/Self-Insurer File # |
| Phone Number | E-mail | | Phone Number | E-mail |
| **ATTORNEY FOR EMPLOYEE/ CLAIMANT** | Name | | **ATTORNEY FOR EMPLOYER/ INSURER** | Name |
| Mailing Address | | | Mailing Address | |
| City | State | Zip Code | City / State / Zip Code | |
| Phone Number | E-mail | | Phone Number | E-mail |
| **OTHER PARTY** | Name | | | |
| Mailing Address | | | | |
| City | State | Zip Code | | |
| Phone Number | E-mail | | | |

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## B. PLAN INFORMATION

(Please check the appropriate blocks)

**TYPE OF PLAN:**

- ☐ 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 Reports
- ☐ 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:

| State Specific Problems | State Specific Goals |
|---|---|
| | |

## C. COMPLETE THIS PART FOR CHECKED VOCATIONAL SERVICES

1. 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: (At least one)

| ☐ Transferable Skills | | ☐ Vocational Evaluation | |
|---|---|---|---|
| Date | Determined By | Date | Evaluator |
| | | | |

☐ Summary of Vocational Evaluation (Please attach report)

☐ Summary of Labor Market Survey (Please attach report)

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## D. SERVICES AND RESPONSIBILITIES REQUIRED TO MEET GOALS

(Attach additional pages as needed)

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

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## E. 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 above.
Month Day Year

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

## F. 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.