# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## INDIVIDUALIZED REHABILITATION PLAN

| Board Claim No. | Employee Last Name | Employee First Name | M.I. | SSN or Board Tracking # | Date of Injury |
|---|---|---|---|---|---|
| | | | | | |

## SECTION 1 IDENTIFYING INFORMATION

| EMPLOYEE | Occupation | Catastrophic Injury? ❑ Yes ❑ No | County of Injury | Birthdate |
|---|---|---|---|---|
| | | | | |

Diagnosis & Functional Restrictions

## SECTION 2 PLAN INFORMATION

(Please check the appropriate blocks)

❑ Initial Plan

Date Last Plan Submitted

**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 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 |
|---|---|
| | |

## SECTION 3 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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## SECTION 4 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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## SECTION 5 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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## SECTION 6 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 | Telephone | Address | | |
| E-mail Address | | City | State | Zip Code |

| **EMPLOYEE** | Last Name | First Name | M.I. | Address | | |
|---|---|---|---|---|---|---|
| E-mail Address | | Telephone Number | | City | State | Zip Code |
| **EMPLOYER** | Name | | | Address | | |
| E-mail Address | | Telephone Number | | City | State | Zip Code |
| **INSURER / SELF-INSURER** | Name | | | Address | | |
| **CLAIMS OFFICE** | Name | | | | | |
| E-mail Address | | Telephone Number | | City | State | Zip Code |
| **EMPLOYEE'S ATTORNEY** | Name | | | Address | | |
| E-mail Address | | Telephone Number | | City | State | Zip Code |
| **EMPLOYER'S ATTORNEY** | Name | | | Address | | |
| E-mail Address | | Telephone Number | | City | State | Zip Code |
| **SITF** | Name | | | Address | | |
| E-mail Address | | Telephone Number | | City | State | Zip Code |

Employee Comments about this plan:

| Employee Signature (This indicates you have read or have had read to you the plan, not that you agree with the plan) | Date |
|---|---|

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

## SECTION 7 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.

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