GEORGIA STATE BOARD OF WORKERS' COMPENSATION
INDIVIDUALIZED REHABILITATION PLAN

Board Use Only	
Reviewer	
Date	Status

County of Injury

SECTION I. IDENTIFYING INFORMATION

1. _____ Employee Name
2. _____ Social Security Number
3. _____ Date of Injury
4. _____ Occupation
5. _____ Date of Birth
6. No ❑ Yes ❑ Catastrophic Injury
7. Diagnosis & Functional Restrictions _____

SECTION II. 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
_____ RELEASE TO RTW
_____ PHYSICAL RESTRICTIONS
_____ PHYSICAL CAPACITIES
_____ PAIN/PSYCHOLOGICAL REPORTS
_____ REHABILITATION NARRATIVE REPORT
_____ PHYSICIAN'S APPROVAL OF JOB

_____ JOB ANALYSIS AT TIME OF INJURY
_____ ANALYSIS OF OFFERED JOB
_____ TRANSFERABLE SKILLS ANALYSIS
_____ VOCATIONAL EVALUATION
_____ SUMMARY OF LABOR MARKET SURVEY
_____ MEDICAL NARRATIVE REPORTS
_____ 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 _____

_____

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).

SECTION III 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

SECTION IV. 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:

AVG 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. OCCUPATIONAL OBJECTIVES _____

4. EDUCATIONAL/VOCATIONAL BACKGROUND _____

5. OCCUPATIONAL OBJECTIVES DETERMINED BY:

_____ TRANSFERABLE SKILLS Date _____ Determined by _____

_____ VOCATIONAL EVALUATION Date _____ Evaluator _____

SUMMARY OF VOCATIONAL EVALUATION _____

6. SUMMARY OF LABOR MARKET SURVEY (ATTACH REPORT) DATE COMPLETED _____

SS# _____

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SECTION V. Services and Responsibilities Required to Meet Goals (Attach additional pages as needed)	Initiation Date	Projected Completion Date	Estimated Cost	Payer
Proposed Cost of Plan			$ _____	

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SS# _____

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SECTION VI. CERTIFICATE OF SERVICE (THIS SECTION MUST BE COMPLETED BY THE PRINCIPAL SUPPLIER)

I CERTIFY THAT I HAVE DISCUSSED THIS PLAN WITH THE EMPLOYEE AND OTHER PARTIES TO THE CASE AND HAVE MAILED COPIES ON _____ TO THE FOLLOWING PARTIES AT THE CURRENT ADDRESSES BELOW.
DATE

Employee _____ **Telephone** ( ) _____
Address _____
_____

Employer _____ **Telephone** ( ) _____
Address _____
_____

Insurance _____ **Telephone** ( ) _____
Adjuster _____
Address _____

Employee's _____ **Telephone** ( ) _____
Attorney _____
Address _____

Employer's _____ **Telephone** ( ) _____
Attorney _____
Address _____

Subsequent _____ **Telephone** ( ) _____
Injury Trust _____
Fund Address _____

SIGNATURE _____ Registration No. _____
Rehabilitation Supplier _____ Telephone _____
Address _____
EMPLOYEE COMMENTS ABOUT THIS PLAN: _____

DATE _____ EMPLOYEE'S SIGNATURE _____
This indicates that you have read or have had read to you the plan, not that you agree with the plan.

DO ALL PARTIES AGREE TO THIS PLAN? YES ❑ NO ❑

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

SECTION VII. APPROVAL/OBJECTIONS, TWENTY (20) DAY NOTICE

ABSENT WRITTEN OBJECTIONS WITHIN 20 DAYS OF THE DATE MAILED, 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 IN WRITING.**
(2) **IT 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 WRITTEN OBJECTIONS WERE PLACED IN THE MAIL TO ALL PARTIES AND THE PRINCIPAL REHABILITATION SUPPLIER THE SAME DATE AS THE CERTIFICATE OF SERVICE**

ANY OBJECTIONS RECEIVED BY THE BOARD WILL BE PROCESSED IN ACCORDANCE WITH O.C.G.A. §9-11-6 (e).

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