



NEBRASKA WORKERS' COMPENSATION COURT

State Capitol Building; PO Box, 98908; Lincoln, Nebraska 68509-8908

WHEN COMPLETED MAIL TO ABOVE ADDRESS

VOCATIONAL REHABILITATION PLAN

(Read guidelines on page four before completing this form)

1. EMPLOYEE INFORMATION

2. COUNSELOR INFORMATION

Name: _____ Social Security #: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ E-mail: _____ Employer: _____ Job Title:(with DOT code) _____ Hourly Wage: \$ _____ AWW: \$ _____ Attorney? No ___ Yes ___ Name: _____ Phone: _____ Fax: _____	Name: _____ VRC #: _____ Company Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Ext.: _____ Cell Phone: (Optional) _____ Fax: _____ E-mail: _____
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3. INSURER INFORMATION

4. MEDICAL (INJURY RELATED) INFORMATION

Company: _____ Address: _____ City: _____ State: _____ Zip: _____ Claim #: _____ Claim Rep: _____ Phone: _____ Ext. _____ Fax: _____ E-mail: _____ Attorney? No ___ Yes ___ Name: _____ Phone: _____ Fax: _____	Date of Injury: _____ Diagnosis: _____ _____ MMI? No ___ Yes ___ Date of MMI: _____ Injury Related Restrictions (Permanent): _____ _____ _____
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5. TYPE OF PLAN

6. TRAINING/ VOCATIONAL GOAL

<p style="text-align: center;">PRIORITIES</p> <p><input type="checkbox"/> NEW JOB SAME EMPLOYER</p> <p><input type="checkbox"/> NEW JOB NEW EMPLOYER</p> <p style="padding-left: 40px;"><input type="checkbox"/> TRAINING</p> <p style="padding-left: 80px;">Type of Training</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> GED</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input type="checkbox"/> ESL</td> <td><input type="checkbox"/> Diploma</td> </tr> <tr> <td><input type="checkbox"/> ABE</td> <td><input type="checkbox"/> AA Degree</td> </tr> <tr> <td><input type="checkbox"/> OJT</td> <td><input type="checkbox"/> BA Degree</td> </tr> </table> <p><input type="checkbox"/> Other _____</p>	<input type="checkbox"/> GED	<input type="checkbox"/> Certificate	<input type="checkbox"/> ESL	<input type="checkbox"/> Diploma	<input type="checkbox"/> ABE	<input type="checkbox"/> AA Degree	<input type="checkbox"/> OJT	<input type="checkbox"/> BA Degree	<p>A. TRAINING GOAL: _____</p> <p>_____</p> <p>Training Provider: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>B. JOB GOAL (with DOT code): _____</p> <p>_____</p> <p>C. WAGE: Entry Level: \$ _____ Average: \$ _____</p> <p>Source of Wage Data: _____</p> <p>D. PLAN DATES:</p> <p>STARTS : _____ ENDS: _____</p>
<input type="checkbox"/> GED	<input type="checkbox"/> Certificate								
<input type="checkbox"/> ESL	<input type="checkbox"/> Diploma								
<input type="checkbox"/> ABE	<input type="checkbox"/> AA Degree								
<input type="checkbox"/> OJT	<input type="checkbox"/> BA Degree								

7. BILLING INFORMATION Employee: Original Supplement; date:**A. TUITION & FEES:** \$ _____

Authorize to: _____

Address: _____

City: _____ State: _____ ZIP: _____

B. REQUIRED BOOKS: \$ _____

Authorize to: _____

Address: _____

City: _____ State: _____ ZIP: _____

C. GENERAL SUPPLIES: \$ _____ (LIMIT \$15.00 PER TERM)

Authorize to: _____

Address: _____

City: _____ State: _____ ZIP: _____

D. REQUIRED SUPPLIES: \$ _____ (ATTACH ITEMIZED LIST & OBTAIN PRIOR APPROVAL)

Authorize to: _____

Address: _____

City: _____ State: _____ ZIP: _____

E. SPECIAL FEES: \$ _____ (SPECIFY BELOW, e.g., TESTING, PARKING, LICENSING, ETC.)_____
Authorize to: _____

Address: _____

City: _____ State: _____ ZIP: _____

F. TUTOR INFORMATION & FEES: \$ _____ (OBTAIN PRIOR APPROVAL)

Hourly rate: \$ _____ Hours Per Day: _____ Days Per Week: _____ Number of Weeks: _____

Authorize to: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

8. TRANSPORTATION, BOARD AND LODGING INFORMATION

	Job Placement Mileage at the current state rate (Maximum reimbursable mileage is 345 miles/week).
	Training Mileage at the current state rate (Maximum reimbursement will vary by month and by training facility).
	Room and Board on-campus (Will be paid directly to the training facility. Local mileage is not reimbursable with any lodging plans).
	Room and Board off-campus where campus dorms are available (Reimbursed at campus dorm rates. Local mileage is not reimbursable).
	Room and Board off-campus where campus dorms are not available (Reimbursed at average dorm rates. Local Mileage not reimbursable).

9. PLAN JUSTIFICATION

ATTACH A PLAN JUSTIFICATION STATEMENT TO THIS FORM

PLAN JUSTIFICATION SHALL INCLUDE BUT IS NOT LIMITED TO THE FOLLOWING SECTIONS:

Section A: Back ground information
Section B: Vocational Assessment and Testing
Section C: Priority Selection Rationale

Section D: Vocational Goal Selection Rationale
Section E: Labor Market Information Pre and Post-Rehabilitation

SIGNATURES AND CERTIFICATIONS

(Read carefully before signing)

Vocational Rehabilitation Counselor: I the undersigned hereby certify that this is an appropriate form of vocational rehabilitation under Section §48-162.01 of the Nebraska Workers' Compensation Act and that no lesser priority can be used to return this employee to suitable employment.

Counselor's Signature	Date
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Employee: I the undersigned hereby certify that I have reviewed this vocational rehabilitation plan and the attached justification statement, and I agree with the vocational goal and the proposed means to attain that vocational goal. I further certify that I will make a good faith effort to complete this proposed plan within the specified time frame with the understanding that failure to do so without just cause may result in cancellation of this plan.

Employee's Signature	Date
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Employer/Insurer: I the undersigned hereby certify that the employer/insurer understands its responsibility to pay and agrees to pay temporary benefits while the employee is participating in and making satisfactory progress toward completing this vocational rehabilitation plan.

Employer/Insurer's Signature	Date
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Workers' Compensation Court Specialist: I the undersigned hereby certify that I have evaluated this plan and approve/deny the plan as an appropriate form of vocational rehabilitation.

Vocational Rehabilitation Plan is:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
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Court Specialist Signature	Date
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GUIDELINES FOR COMPLETING THE VOCATIONAL REHABILITATION PLAN

1. EMPLOYEE INFORMATION:

Complete all applicable items in this section. DOT code is required with employee's time-of-injury occupation. Verify through all parties the time-of-injury wage per hour and average weekly wage including overtime. Agreed upon or stipulated average weekly wages can differ from that reported on first report of injury.

2. COUNSELOR INFORMATION:

Complete all applicable items in this section. Your cell-phone number is optional. It is however, recommended for timely Court/Counselor communications.

3. INSURER INFORMATION:

Complete all applicable items in this section. If employer is self-insured enter the employer's name followed by, (self-insured).

4. MEDICAL INFORMATION:

When completing this section rely on physician authored information that is directly related to the work injury and only report restrictions that are permanent and injury-related. FCE results must be endorsed by a treating physician. Do not rely solely on self-reported limitations.

5. TYPE OF PLAN:

Select and check only one priority in this section. If the training priority is selected then also check the type of training. No higher priority may be utilized unless all lower priorities have been shown to be "clearly inappropriate" and "unlikely to result in suitable employment for the injured employee."

6. TRAINING/VOCATIONAL GOAL:

If Job placement is being proposed complete only Parts B, C and D of this section. If GED, ESL or ABE training is being proposed, complete only Parts A and D of this section. If training other than GED, ESL or ABE is being proposed complete this entire section identifying as the Training Goal in Part A the degree and major/area of focus and attach a detailed Plan of Study. If OJT is being proposed complete this entire section using the same job title for both the Training Goal and the Job Goal. Under wage information (Part C), report the entry level and the average (mean or median) wages for the Job Goal, identifying the geographic coverage area and your resource(s).

7. BILLING INFORMATION:

At the top of this section enter the employee's name and check a box to indicate whether this as an original or a supplemental request. For supplemental requests you will also need to enter the date of the request. Complete all other applicable items in this section. It is understood that information in Parts A and B are cost estimates and subject to revision. Costs associated with Part C are not to exceed \$15.00 per term. All costs associated with Part D must be supported by documentation that the supplies are or would be "required" of all individuals in the same type of training program, an itemized list must be attached and prior approval must be obtained. Special fees listed in Part E may uniquely apply to an individual's plan but must be reasonable and necessary and prior approval must be obtained. Any tutoring services (Part F) require prior approval and should not exceed the number of training facility classroom hours per week. Any request for tutoring services for students in formal academic programs must be accompanied by an instructor's statement of necessity.

8. TRANSPORTATION, BOARD AND LODGING INFORMATION:

Select and check only one item in this section. If room and board is being proposed local commuting mileage from the student's temporary residence to the training facility is not reimbursable. Special one-way mileage between the student's permanent residence and the training facility will be reimbursed at the beginning and end of each term.

9. PLAN JUSTIFICATION:

A clearly legible statement entitled Plan Justification must be attached to this form. The justification statement shall include but is not limited to the following sections:

Background Information: Provide a general summary of information relating to the employee's background, educational and vocational history, the occurrence and nature of the work injury, resulting physical limitations, and any other barriers to employment.

Vocational Assessment and Testing Results: Identify, provide copies of, and summarize the results of all vocational, educational and psychometric assessments administered and/or utilized in the course of developing this plan.

Priority Selection Rationale: Section 48-162.01 states that no higher priority may be utilized unless all lower priorities have been clearly shown to be unlikely to result in suitable employment for the injured worker. Clearly state your rationale for ruling out lower priorities and for selecting the priority proposed in this plan. Describe any research conducted that supports this selection.

Vocational Goal Selection Rationale: Clearly state your rationale for selecting the specific vocational goal proposed in this plan. Describe any research conducted, testing results, and/or other information used in making this selection.

Labor Market Information Pre and Post-Rehabilitation: Clearly describe the injured worker's labor market prior to his/her work injury and residual labor market subsequent to the injury. If training is being proposed describe his/her labor market before and after that training. Provide any statistical data utilized in arriving at these projections and identify your sources. All labor market information should include specific job titles, actual and/or projected openings, actual and/or projected wages (starting wages and average wages). NOTE: If the projected wage after rehabilitation is less than his/her time-of-injury wage, state and or provide documentation that the employee has been advised of this and understands and voluntarily accepts this difference.

SUBMIT COMPLETED PLAN NO LESS THAN 21 DAYS BEFORE THE START DATE