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State of California
Division of Workers' Compensation
Rehabilitation Unit

VOCATIONAL REHABILITATION PLAN

SSN (Numbers Only)

Case No.

Date of Birth: MM/DD/YYYY

Claim Number

(Choose only one)

☐ a specific injury on _____ MM/DD/YYYY

☐ a cumulative trauma injury which began on _____ (START DATE: MM/DD/YYYY) and ended on _____ (END DATE: MM/DD/YYYY)

Employee (All information in this section must be completed)

First Name

MI

Last Name

Street Address /PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Employee Representative (All information in this section must be completed)

☐ Law Firm/Attorney ☐ Non-Attorney Representative

First Name

MI

Last Name

Law Firm Name

Street Address /PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Phone Number

Claims Administrator Information (if known and if applicable) (All information in this section must be completed)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer (All information in this section must be completed)

Name (Please leave blank spaces between numbers, names or words)

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Qualified Rehabilitation Representative (if known and if applicable)

First Name | MI

Last Name

Firm Name (Please leave blank spaces between numbers, names or words)

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Phone

SECTION - A (All information in this section must be completed)

Occupation at Injury

Earnings at Injury per Hour ☐ Week ☐ Month ☐

Describe Type of Injury

Summary of Employee's Educational and Vocational Background

Rehab Unit approval is required due to (Please Select One):

☐ Unrepresented Injured Worker

☐ QRR Waiver

☐ Pre 94 Dates of Injury

☐ Discretionary Monies

SECTION - B (All information in this section must be completed)

Vocational Objective

Estimated Weekly Earnings Upon Plan Completion per Hour ☐ Week ☐ Month ☐

Type of plan

With Same Employer (Select One)

☐ Modified Job

☐ Alternative Work

With New Employer (Select One)

☐ Direct Placement

☐ Educational Training

☐ On-The-Job Training

☐ Self-Employment

Describe nature and extent of rehabilitation plan

Date vocational feasibility determined _____ MM/DD/YYYY

Plan commencement date _____ MM/DD/YYYY

Expected completion date (including placement assistance) _____ MM/DD/YYYY

Number of Weeks of training _____

Number of Days of Placement Assistance _____

BUDGET FOR VOCATIONAL REHABILITATION PLAN EXPENDITURES

Identify incurred and estimated costs for this rehabilitation plan. For injuries on or after 1/1/94, the maximum expenditure for vocational rehabilitation expenses shall not exceed $16,000.

Resources To Employee (All information in this section must be completed)

$ _____ Weekly VRMA Rate

$ _____ Withheld for attorney fees

$ _____ Payment to employee

VRMA/VRTD paid prior to plan (including attorney fees)

Dates : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY) Total : $ _____

VRMA/VRTD to be paid during plan (including attorney fees)

Dates : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY) Total : $ _____

Transportation Expenses to be paid as follows:

$ _____ per _____ Total : $ _____

Plan Expenditures

Training/Tuition fees, if any (specify recipient) (All information in this section must be completed)

$ _____ Total :$ _____

Recipient of fees: _____

Other Costs (specific type, recipient and method of payment)

_____ $ _____ / _____ Total: $ _____

_____ $ _____ / _____ Total: $ _____

_____ $ _____ / _____ Total: $ _____

_____ $ _____ / _____ Total: $ _____

Fees For Evaluation, Plan Development & Placement (All information in this section must be completed)

(List Evaluation and Plan Development fees to date and estimated fees for Plan Monitoring and Placement)

Phase I : Evaluation $ _____

Phase II : Plan Development $ _____

Plan Monitoring $ _____

Phase III : Plan Placement $ _____

DOIs on /after 1/1/94 where VR was initiated on/after 1/1/98

Phase A : $ _____

Phase B : $ _____

Total : $ _____

**Total Estimate Of Plan Expenditures :* $ _____

Additional Resources To Employee (All information in this section must be completed)

Permanent Disability Supplement paid to date:

$ _____/ Week Total : $ _____

Permanent Disability Supplement to be paid:

$ _____/ Week Total : $ _____

Other resources to be provided to employee (identify source and amount):

_____ $ _____ /_____ Total : $ _____

_____ $ _____ /_____ Total : $ _____

SECTION - C (All information in this section must be completed)

1. List results of vocational testing, if any, and how they support the vocational objective

2. Describe why this employee will be employable in the vocational objective of this plan. Include assessment of labor market.

SECTION - D

RESPONSIBILITIES OF THE CLAIMS ADMINISTRATOR:
(All information in this section must be completed)

The claims administrator shall provide in a timely manner all vocational services and benefits necessitated by the agreed upon vocational rehabilitation plan and as required by the Labor Code. I verify that the insurer does not have a proprietary interest in the rehabilitation provider or facilities used in the development or implementation of this plan.

Other : _____

RESPONSIBILITIES OF THE EMPLOYEE :

The employee shall be available and reasonably cooperate in the provision of vocational rehabilitation services. The employee shall arrive on time and participate in all scheduled activities; if for any reason the employee does not, he or she must immediately provide an explanation to the Qualified Rehabilitation Representative.

The employee shall follow the requirements of all facilities and persons providing vocational rehabilitation services. The employee shall notify the Qualified Rehabilitation Representative about anything that may interfere with scheduled completion of this plan.

Other: _____

SECTION - E

VERIFICATION OF THE QUALIFIED REHABILITATION REPRESENTATIVE
(All information in this section must be completed)

1. This plan was developed by me as the Qualified Rehabilitation Representative or as an Independent Vocational Evaluator. It is my opinion that the services contained in this plan will provide the employee with the opportunity to return to suitable gainful employment.

2. The employee was not referred for services for evaluation, education or training to a facility in which I, my spouse, my employer or co-employee has a proprietary interest or which I, my spouse, my employer or co-employee has a contractual relationship.

First Name _____ MI _____

Last Name _____

Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Phone Number _____

Signature: _____ Date _____
MM/DD/YYYY

SECTION - F

PLAN AGREEMENT
(All information in this section must be completed)

Signature of the claims administrator and employee on this plan shall be deemed to be an agreement that claims administrator and employee intend to comply with all the plan's provisions.

Failure of the claims administrator to provide in a timely manner all services required by the plan may result in the employee being entitled to additional services.

Failure of the employee to comply with the provisions and schedules developed for this plan may result in termination of the employer's liability for rehabilitation services.

I have read and understand this plan and agree with all of the plan's provisions.

Employee

First Name _____ MI _____

Last Name _____

Signature: _____

Date _____
MM/DD/YYYY

Employee Representative (if any):

First Name _____ MI _____

Last Name _____

Signature: _____

Date _____
MM/DD/YYYY

Person Authorizing The Provision Of This Plan On Behalf Of The Employer/Claims Administrator

Name _____

Signature: _____

Date _____
MM/DD/YYYY

Rehabilitation Unit
California Division of Workers' Compensation
Form RU-102

VOCATIONAL REHABILITATION PLAN*
PLANS FOR REPRESENTED EMPLOYEES INJURED ON OR AFTER 1/1/94

Purpose:
To document objectives and methods to be used to implement a proposed rehabilitation plan.

Submitted by:
Claims Administrator

When submitted:
The Claims Administrator submits the form with the RU-105 at the completion of the plan.

Where submitted:
With the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Form completion:
See the following page for information on properly completing the form. Please note: This form must be completed using type no smaller than 12 point. All information must be contained within the section provided.

Accompanying documents:
Within 10 days of plan completion, submit the RU-102 along with a RU-105 Notice of Termination. Medical and vocational reports should not be attached.

Rehabilitation Unit action:
Statistical recording.

Copy:
All parties

PLANS FOR UNREPRESENTED EMPLOYEE OR WITH A QRR WAIVER AND ALL PLANS FOR EMPLOYEES INJURED BEFORE 1/1/94

Purpose:
To document objectives and methods to be used to implement a proposed rehabilitation plan.

Submitted by:
Claims Administrator

When submitted:
Immediately upon development of a rehabilitation plan which has been agreed to by the parties. If a waiver of Qualified Rehabilitation Representative is requested, whether represented or not, the plan must be submitted for approval.

Where submitted:
With the applicable Rehabilitation Unit district office. The Rehabilitation Unit's venue is the same as the WCAB's. If no WCAB case exists, file with a Rehabilitation Unit within the county where the injured employee resides.

Form completion:
See the following page for information on properly completing the form.
This form must be completed using type no smaller than 12 point. All information must be contained within the section provided.

Accompanying documents:
Include all supporting medical and vocational reports not previously submitted.

Rehabilitation Unit action:
If disapproval is not made within 30 days of a properly documented plan, the plan is deemed approved. A notice of approval will issue in instances where disapproval previously issued.

Copy:
All parties.

INFORMATION ON HOW TO PROPERLY COMPLETE THE FORM RU-102

Form completion:
Submit only if the employee is a Qualified Injured Worker. The RU-102 is prepared by a Qualified Rehabilitation Representative (QRR). In filing out the form, avoid continuation of information to additional sheets. An extension of the information requested on the RU-102 to additional sheets should be limited to only the situation where there is an OJT agreement which describes the responsibilities of the parties and details of training.

The QRR completes the required information. Employee level of participation must be described.

The QRR completes the information and the parties initial the page. The RU-102 is used for modified or alternative work plans when the offer of modified or alternate work is made subsequent to the initiation of rehab services. If training, education, or tutoring is a part of the plan,the counselor must select a facility or program approved by the council for Private Post Secondary and Vocational Education.

Budget for Vocational Rehabilitation Plan Expenditures:

For injuries before 1/1/94-- This page describes expected costs of the plan. There is not a legislatively required limit of $16,000 on total costs.

For injuries on or after 1/1/94--The purpose of the budget is to plan the estimated expenditures. The total budget for rehabilitation services may not exceed $16,000 including QRR fees. For QRR's fees, please refer to the fee schedule in the administrative rules.

This page may be helpful as a counseling tool to show the injured worker that greater expenditures in one area must be balanced with savings in others areas or the development of additional monetary resources.

Description of specific items in this section.

VRMA/VRTD to date - refers to the rate and sum of VRMA payments made since the claims administrator sent the notice of potential eligibility and the injured worker requested rehabilitation services.

VRMA/VRTD to be paid refers to the rate and sum of VRMA payments during the plan.

If the claims administrator is withholding for attorney fees, then it should be calculated along with the actual weekly benefit payment so the worker will know how much he or she actually receives.

Any allocation for **TRANSPORTATION EXPENSES** such as gas money or public transit tickets must be calculated.

Any **TRAINING/TUITION FEES** and the training provider must be listed.

OTHER COSTS - such as clothing, tools, books, babysitting, relocation costs, or any other plan costs not itemized above on the form should be listed.

FEES FOR EVALUATION, PLAN DEVELOPMENT AND PLACEMENT and other expenditures from the fee schedule must be listed.

To insure that total plan costs do not exceed $16,000 add the following:
1) VRMA/VRTD paid to date -- total
2) VRMA/VRTD to be paid -- total
3) Transportation expenses -- total
4) Total of plan expenditures
5) Total of fees for evaluation, plan development, and placement

The injured worker must insure that he can meet his living expenses during the plan by adding the total weekly benefit payment to employee to the permanent disability supplement to be paid and any other confirmed financial resources which are listed. In addition, the injured worker can calculate expenditures for legal and rehabilitation fees by adding the total of amount withheld for attorney fees and the total of fees for evaluation, plan development and placement.

Section C:
Regarding section C-2, labor market surveys are not required. Labor market assessment should include information from the California Occupational Information System if it is available.

Section F:
This is the signature page. Please note: The claims administrator is expected to sign space in Section F

Please note: Any plan, whether the employee is represented or not, which provides funds to the employee to be disbursed at the employee's discretion or on a non-specific basis must be submitted for review to the Rehabilitation Unit to determine whether the plan is in conflict with Labor Code Section 4646 as required by AD 10126(b)(4).