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| http://inside.lni.wa.gov/Director/resources/GraphicIdentity/BlackPrint.png  Fax completed form to: 360-902-4567  ***Or*** mail completed form to: PO Box 44291  Olympia WA 98504-4291 | **Job Modification**  **Assistance Application** |

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| Worker Name | Job Title | Claim Number(s) |

Submit this application if ***all*** of the following criteria are met:

* The worker’s claim is or was open at the time of the modification.
* The equipment accommodates restrictions imposed by the accepted condition(s) on the claim(s).
* An employee-employer relationship exists.
* The request does not exceed benefit maximum of $10,000 unless there are multiple jobs or job sites.
* Time-loss (or loss of earning power) benefits or full wages were paid while the worker was off work.
* The requested items are not above and beyond necessity or for convenience.

**Required Attachments:**

1. Consult report and/or 1 page narrative report.
2. Vendor bid (include a 2nd bid if a single item including tax, shipping, and delivery is over $2,500).
3. Signed *Job Modification Ownership Agreement* (2nd page of this form).

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| List the work restrictions related to claim and this request. |  |
| List of requested equipment, training, and tools. |  |

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| **Itemization of Costs** | |  | **Vendor Information (one per application)** | | |
| Equipment/tools/other: | $0.00 |  | Vendor Name | | L&I Provider Number |
| Assembly, installation, & delivery: | $0.00 |  | Address | | Phone Number |
| Tax: | $0.00 |  | City | State | Zip Code |
| **Total:** | $0.00 |  | An L&I Provider Number is required for payment. Contact Provider Credentialing 360-902-5140 for more information.  Submit your bill on the [Statement for Retraining and Job Modification Services (F245-030-000)](http://www.Lni.wa.gov/go/F245-030-000). Use procedure code **0380R.** Include your invoice and a copy of this approved application form.  Self-Insured employers refer to L&I’s website for billing process. | | |
| Employer’s portion of costs | $0.00 |  |
| State Fund or Self-Insured portion of cost | $0.00 |  |

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| Requested By | | | | Company Name | |
| Phone Number Extension | | | | Fax Number | |
| Date | | | | Requestor’s Signature | |
| Employer’s Signature (if contributing to cost) | | | | | |
| **L&I Use Only** | Approved | | Approved with modification: | | Disapproved |
| Total Amount Approved  $ | | Date | | Signature Authority | |

**Job Modification Ownership Agreement**

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| Worker Name | Claim Number(s) |
| Employer | |

This modification is being provided to accommodate my work restrictions so I may perform my job duties and return to work.

My employer and I will need to agree who will own the equipment and note it below. Typically a worker would be listed as the owner for any portable items.

The designated party will own these items when I successfully return to work. Any equipment owned by the employer must remain available to me during my shift.

The identified owner will make every effort to keep these items safe and free from damage.

If the employer paid for any cost of the modification or the equipment is affixed to the work site, the employer may retain the equipment regardless of the outcome of the modification or return to work.

**Return policy for workers covered under State Fund**

I will return any items I do not use in my return to work goal or if I am not able to successfully return to work. I will contact L&I and make arrangements to return equipment to the nearest L&I service location.

I understand the agreement above and I am willing to comply with the terms.

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| Worker Signature |  | Date |

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| Employer Signature\* |  | Date |

\*Signature required if job is with the employer of injury regardless of who is listed as the owner.

**Inventory:**

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| **Item** | **Owner (on successful return to work)** |
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