|  |  |  |
| --- | --- | --- |
| Department of Labor and IndustriesClaimsPO Box 44291Olympia WA 98504-4291Fax completed application directly to claim file at 360-902-4567. | **state seal** | **Pre-Job Accommodation Assistance Application** |

|  |  |  |
| --- | --- | --- |
| Worker Name      | Job Goal      | Claim Number(s)      |

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

* You have a state fund claim.
* Your claim is open or is a statutory pension.
* The equipment accommodates restrictions imposed by the accepted condition(s) on your claim.
* The attending provider (AP) has verified the requested item(s) are medically necessary for the accepted condition(s).
* No employee-employer relationship exists.
* Request does not exceed benefit maximum of $10,000 (combined with prior approvals/job modification benefit).
* Items being requested are not above and beyond necessity or for convenience.
 **and**
* The items are needed for: (check which option applies)

|  |  |  |
| --- | --- | --- |
| [ ]  **Retraining Plan** | **OR** | [ ]  **Job Goal** |
| * Participate in a retraining plan, **and**
* The retraining site is not able to provide requested accommodations.
 |  | * Perform essential functions of a job consistent with recommendation of a vocational assessment or (nearly) completed plan, **and**
* The labor market is positive with modifications and does not already supply the requested item(s).
 |

**Required Attachments:**

1. AP’s statement of medical necessity for each requested item.
2. Consult report and/or 1 page narrative report.
3. Vendor bid (include a 2nd bid if a single item including tax, shipping, and delivery is over $2,500).
4. Signed *Pre-Job Accommodation Ownership Agreement* (2nd page of this form).

|  |
| --- |
| **List specific equipment, training, tools requested:**      |
| **Itemization of Costs:** |  | **Vendor Information (one per application)** |
| Equipment/Tools/Other: |       |  | Vendor Name      | L&I Provider Number      |
| Assembly, Installation, & Delivery: |       |  | Address       | Phone Number      |
| Tax: |       |  | 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/FormPub/Detail.asp?DocID=1617). Use procedure code **0385R.**Include your invoice and a copy of this approved application form. |

|  |  |
| --- | --- |
| Requested By      | Company Name      |
| L&I Provider Number (if present)      | Phone Number      | Fax Number      |
| Date      | Requestor’s Signature |
| **L&I Use Only** | [ ]  Approved | [ ]  Approved with Modifications:       | [ ]  Disapproved |
| Total Amount Approved      | Date      | Signature Authority      |

**Pre-Job Accommodation Ownership Agreement**

|  |  |
| --- | --- |
| Worker Name:      | Claim Number(s):      |
| Return-to-Work Job Goal:      |

**Required for Return-to-Work (RTW) Goal**

* This accommodation is related to my attending health care provider’s requirements for my release to work.
* I will own these items upon my release to work as determined by Labor & Industries (L&I).

**Required for Participation in a Retraining Plan**

|  |  |
| --- | --- |
| Plan Dates: |       |

* This accommodation is related to my attending health care provider’s requirements to participate in my retraining plan.
* These items remain the property of L&I during my retraining plan.
* Permission to use these items is based on cooperative participation in my retraining plan and may be withdrawn at any time while L&I remains the owner.
* I will make every effort to keep these items safe and free from damage.
* I will own these items upon my successful completion of the retraining plan as determined by L&I.

**Return Policy**

* If I do not use these items in my RTW goal, if my retraining plan fails, if I select Option 2, or if my counselor or L&I inform me for any reason that this equipment must be returned, I will do so immediately.
* I will contact L&I and make arrangements to return equipment to the nearest L&I service location.

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

|  |  |  |
| --- | --- | --- |
|  |  |       |
| Worker Signature |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |       |
| Witness Signature |  | Date |

**Inventory:**

|  |  |
| --- | --- |
| **Item** | **Brand/Manufacturer** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |