



Pre-Job Accommodation Assistance Application

Fax completed application directly to claim file at
 360-902-4567.

Worker Name	Job Goal	Claim Number(s)
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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 \$5,000 (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

- Participate in a retraining plan, **and**
- The retraining site is not able to provide requested accommodations.

OR **Job Goal**

- 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) . 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