

Voc. Rehab Plan

QuickStart Guide



The Vocational Rehabilitation Plan can be submitted directly through CompHub by a Practitioner. Using the Voc Rehab Plan Form you will complete the Plan using the space provided, acquire signature(s), and upload the approved VR Plan. **Find this process under Start New Action>Voc. Rehab>Voc. Rehab Plan.**

1 Review the Claim Information section for accuracy.

Claim Information

First Name: John Middle Name: M Last Name: Smith
Email: John.Smith@wcc.invalid Address: 3235 KAISER DR ELLICOTT CITY MD 21043 Date Of Injury: 08/01/2023
Phone: 234-567-8899 DOB: 01/01/1970
Pre-Injury Wage: \$996.00
Pre-Injury Occupation:

Claimant Attorneys: No records

Targeted Jobs

Duration of the plan
Plan Start Date: MM/dd/yyyy Plan End Date: MM/dd/yyyy Plan Cost:
Please click the + sign to add targeted jobs

List Targeted Jobs: No records

Targeted Jobs Tab

Certification

I, John Smith the undersigned disabled covered employee, do hereby certify that I have read the attached Vocational Rehabilitation plan and that I understand the following:

- 1) This plan is an agreement that outlines each party's responsibilities with regard to my vocational rehabilitation.
- 2) The Insurer will pay rehabilitation benefits equal to weekly temporary total disability benefits as well as the expenses of the rehabilitation services.
- 3) The time frame(s) agreed to by the parties may be extended if necessary. If the Insurer refuses to agree to an extension and I believe I am entitled to additional rehabilitation services, I have the right to request a hearing before the Commission and to have a Commissioner determine whether services should be continued.
- 4) I am not required to accept any employment offered to me unless I agree that it is suitable employment. I am aware that if the Insurer believes the employment is stable and I have declined to accept it, the Insurer may discontinue payment of rehabilitation benefits and expenses and assert my non-cooperation. I understand that I may request a hearing to have a Commissioner determine whether the employment offer was suitable employment.
- 5) The Insurer may stop benefit/expense payments if the Insurer determines that rehabilitation services are no longer necessary or if they determine that I am not cooperating in the rehabilitation effort.
- 6) If benefit/expense payments are stopped for any reason with which I do not agree, I have the right to request a hearing and have a Commissioner decide the issue.
- 7) I have a right to be an active participant in my rehabilitation and have both the right and the responsibility to express my desires and expectations.
- 8) I have a right to confer with an attorney regarding the terms of the rehabilitation plan.

I HAVE READ THIS CERTIFICATION AND/OR HAVE HAD IT EXPLAINED TO ME, AND I UNDERSTAND ITS PROVISIONS

Claimant Name: John Smith Claimant Signature:
WCC Claim No: W401786 Date Signed: MM/dd/yyyy

2 Complete the form by entering the respective data into the Targeted Jobs, Claimant's Diagnosis, Hierarchy of Services, Voc. Assessment, and Goals tabs.

3 Once the Certification tab is reached, the Claimant must review the proposed plan and enter the Claimant Name and Date Signed.

Voc. Rehab Plan

Plan Submission

The final tab of the form allows you to generate the VR Plan, acquire signatures, upload any supporting documentation, and sign your submission. Once the plan has been received by the Commission you will receive electronic notification.



1 *Electronic Signatures: Enter the names of the parties and click the Generate Document button. Print/Download the document and obtain physical signatures on the plan. Remember, you can save this task and come back later!*

Plan Specifications

Services Proposed | Targeted Jobs | Claimant's Diagnosis | Hierarchy of Services | Vocational Assessment/Rationale/Supporting Documentation | Goals/Responsibilities | Certification | Upload and Submission Process

Claimant must review and sign the certification (Page 3) prior to signing this Approval. The Certification must not be detached from the plan.

Claimant's acknowledgment:

I Have I have not reviewed and signed the Claimant's Certification.

Do not submit until you have gotten all of the required signatures.

Please type the full names below and then generate the proposed VOC rehab plan

Claimant Signature _____

Claimant Attorney Signature _____

Insurer/Employer Representative Signature _____

Insurer/Employer Attorney (if Applicable) Signature _____

Rehabilitation Counselor Signature _____

Training Representative Signature _____

DORS Counselor (if Applicable) Signature _____

Generate Document

Please save the form. Click on the generate proposed VOC rehab plan button below to print the form for signatures.

Generate Proposed Vocational Rehabilitation Plan

Upload Signed Document

Once all necessary signatures are ready, please use below upload options to upload signed Vocational Rehabilitation Plan.

No files uploaded

Upload Supporting Documents

Please click on upload icon below to upload supporting documents.

No files uploaded

Upload Document: _____

CERTIFICATIONS AND SIGNATURE

I HEREBY CERTIFY that on November 8, 2023, that service of the foregoing was made in accordance with COMAR 14.09.01.03.

By checking this box, I affirm this is the electronic signature of the submitter for all purposes under the Maryland Workers' Compensation Law, Title 9 of the Labor & Employment Article of the Annotated Code of Maryland and the Maryland Uniform Electronic Transactions Act, Title 21 of the Commercial Law Article of the Annotated Code of Maryland.

Electronically Signed By

Trisha Sam
Voc Rehab Practitioner
11/08/2023

CLAIM INFORMATION				
WCC Claim #: W401786	Date of Injury: 06/07/2022	DOB: 01/01/1970	Insurer Name: CHESAPEAKE EMPLOYERS' INSURANCE COMPANY	Contact Number:
TT Benefits \$664.00	SSI/SSDI Benefits	Other Benefits	InsurerAttorney: s Alice Baker	Contact Number: 4105551111 Fss
Claimant Name: John Smith		Phone Number : 234-567-8899	Insurer Rep/ Adjuster	Phone Number
Address: ELLICOTT CITY MARYLAND 21043-			EmployerName: 101 EATON LIQUORS LLC	Contact Number: 64112345678
Claimant Attorney:	Contact Number:	VR Counselor's Name:	WCC Reg#:	
Educational Level Attained :	Pre Injury Wage: \$996.00	Company/DORS Information :	Work Phone Number :	
Pre Injury Occupation:	Anticipated Wages :	Optional: VR counselor's email address :		

SECTION I – VOCATIONAL REHABILITATION PLAN INFORMATION

Type of Plan Submission

Informational

**Please note that only Section I of the plan is required when extending the duration of VR services

3 *Don't forget to Sign and Certify!*

2 *Once signatures have been acquired, click the Upload Document icon to upload the signed VR Plan.*