

Mail completed application form to:
 Department of Labor & Industries
 Claims Section
 PO Box 44291
 Olympia WA 98504-4291



JOB MODIFICATION ASSISTANCE APPLICATION

One vendor per application form		Date of injury	Claim number
Injured worker's name		Accepted diagnosis	
Vocational counselor/job modification consultant		Provider number	
Firm's name		Phone number	
Address		Fax number	
City	State	ZIP+4	

Worker's Job title	
Employer name	Phone number

RESTRICTIONS	DESCRIPTION OF JOB MODIFICATION

ITEMIZATION OF COSTS: Equipment _____ Tools _____ Other _____ Assembly, installation & delivery _____ Tax _____ Total \$ _____ Employer's portion of costs _____ State Fund or Self-Insured portion of costs _____	REQUIRED DOCUMENTATION <input type="checkbox"/> Job modification narrative or consultation report AND <input type="checkbox"/> Ownership agreement AND <input type="checkbox"/> Bids (2 bids if single item over \$2,500)	Labor and Industries (L&I) provider number required for payment. If equipment vendor does not have a L&I provider number – Call: Provider Accounts (360) 902-5140 For payment, submit bill on pink "Statement for Retraining and Job Modification Services" form (F245-030-000). Attach copy of approved application.
Vendor name _____		
Address _____		
City	State	ZIP+4
Provider number		Phone number

Date	Vocational counselor or consultant signature	Employer signature (if contributed to costs)
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For Dept Use Only	<input type="checkbox"/> Approve	<input type="checkbox"/> Authorization code (0380R) entered on AUTH	<input type="checkbox"/> Authorization amount entered on CLOG	<input type="checkbox"/> Disapprove
Date	Signature authority			

Ownership Agreement for Tools and Equipment Purchased as a Job Modification

Worker: _____ Claim #: _____

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 upon 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.

Maintenance Responsibility:

Safekeeping, proper maintenance and repair of the equipment (beyond the expiration of the manufacturer's warranty, if applicable) are the responsibility of the identified owner.

Return Policy:

I will return any items to L&I if not used by me or if I am not able to successfully return to work. I will contact L&I and make arrangements to return the equipment to the nearest service location.

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.

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

Worker Signature

Date

Employer Signature

Date

Inventory

Equipment/model #	Owner (upon successful completion)

**INSTRUCTIONS FOR COMPLETING THE JOB MODIFICATION ASSISTANCE APPLICATION FORM
(F245-346-000)**

NOTE: SUBMIT A SEPARATE APPLICATION FOR EACH VENDOR.

- 1) **DATE OF INJURY:** Record the date of injury.
- 2) **CLAIM NUMBER:** For the injured worker on whose behalf the application is being submitted.
- 3) **INJURED WORKER'S NAME:** Injured worker's full name.
- 4) **ACCEPTED DIAGNOSIS:** Record the accepted industrial condition(s).
- 5) **VOCATIONAL COUNSELOR/JOB MODIFICATION CONSULTANT:** Record the name of the individual submitting the application (must be vocational counselor, job modification consultant, or employer that has been trained in completing the applications.) May not be submitted by the worker.
 - a) **FIRM NAME:** Record the firm that the vocational counselor/job modification consultant represents.
 - b) **PROVIDER NO.:** Record the vocational counselor/job modification consultant's provider number.
 - c) **ADDRESS:** Record the vocational counselor/job modification consultant's address, phone, and fax number.
- 6) **JOB TITLE:** Record the actual or anticipated job title for which the application is being submitted.
- 7) **EMPLOYER NAME:** Record the employer's name and telephone number for the job title listed.
- 8) **DESCRIPTION OF WORK RESTRICTIONS:** List the restrictions or limitations in physical capacities that relate to the requested modification.
- 9) **DESCRIPTION OF JOB MODIFICATION:** Briefly list the equipment being requested and the reason for the request.
- 10) **ITEMIZATION OF COSTS:**
 - a) **EQUIPMENT:** Record the cost of equipment being requested.
 - b) **TOOLS:** Record the cost of any tools being requested.
 - c) **OTHER:** Record the cost of non-equipment, non-tool items, such as training time.
 - d) **ASSEMBLY:** Record the cost of assembly, installation and delivery.
 - e) **TOTAL:** Record total cost of modifications requested for this vendor.
 - f) **EMPLOYER'S PORTION:** Record the amount the employer will pay to the vendor.
 - g) **STATE FUND (SF) OR SELF-INSURED (SIE) PORTION:** Record the amount the SF or SIE is asked to pay.
- 11) **REQUIRED DOCUMENTATION**
 - a) **REPORT:** If the report has been previously submitted, please indicate that it is "on file".
 - b) **BIDS:** Submit two bids for any item over \$2,500.00. The price includes any tax, shipping, delivery, and training charges. If the item is only available from one vendor, please specify that it is a sole source item.
 - c) **OWNERSHIP AGREEMENT:** Submit completed form F245-346-000, page 2.
- 12) **VENDOR:** Enter the vendor's name, address, phone and provider number. Vendors must have a provider number in order to be reimbursed.