WorkCoverWA

SERVICE DELIVERY PLAN
Form 311

Provider name

Provider number

1. Worker's details

Title

Surname

Other name(s)

Date of Birth:

Claim Number

Workers Status

☐ Off Work ☐ At Work **Hrs working/per week**

2. ACKNOWLEDGEMENT OF WORKER'S INVOLVEMENT (Worker to complete)

- I acknowledge I have been involved in the development of the service delivery plan
- I agree with the content of the service delivery plan
- I agree to participate in the service delivery plan

Worker's Signature

Date

3. MEDICAL DETAILS

Treating Doctor

☐ Approval Obtained **Date**

4. EMPLOYER DETAILS

Business Name

☐ Approval Obtained **Date**

Contact Name

☐ Insurer nominated to act on employer's behalf

Copy of Service Delivery Plan provided to: ☐ Worker ☐ Treating Doctor ☐ Employer ☐ Insurer

5. ASSESSMENT SERVICES (Please complete this section only if first service delivery plan)

Commencement date

Completion date

Please indicate those prescribed services undertaken to complete assessment.

Item	Code	Prescribed Services	Cost ($)	Item	Code	Prescribed Service	Cost ($)
2	020	Vocational Counselling		10 (a)	081	Functional Capacity	
4	040	Case Management		10 (b)	082	Vocational Assessment	
11	090	Travel		10 (c)	083	Ergonomic Assessment	
12	100	Medical		10 (d)	084	Job Demands Assessment	
13	110	Report		10 (e)	085	Workplace Assessment	

Total Assessment Cost ($)

On completion of section 5 'Assessment Services' proceed to section 7 'Proposed Rehabilitation Goal'.

6. SERVICE DELIVERY PLAN MODIFICATION

Modification to service delivery plan required due to change in:

☐ Medical restrictions ☐ Employment status ☐ Other circumstances

On completion of section 6 'Service Delivery Plan Variation', proceed to sections 7-9

7. PROPOSED REHABILTIATION GOAL

☐ Same employer ☐ Original duties

☐ New employer ☐ New duties

8. PROPOSED SERVICE DELIVERY

Commencement date: **Review date(s):** **Completion date:**

Item	Code	Prescribed Services	Estimate of No. hours required	Estimated Completion Dated	Estimated Cost
1	010	Support Counselling			
2	020	Vocational Counselling			
3	087	Purchase of Aids & Appliances			
4	040	Case Management			
5	120	Retraining Criteria Assistance			
6	130	Specialised Retraining Prog Assistance			
7	050	Training & Education			
8	060	Workplace Activities			
9	070	Placement Activities			
		Assessments:			
10(a)	081	- Functional Capacity			
10(b)	082	- Vocational			
10(c)	083	- Ergonomic			
10(d)	084	- Job Demands			
10(e)	085	- Workplace			
10(f)	086	- Aids & appliances			
11	090	Travel			
12	100	Medical			
13	110	General reports			
				Plan Cost	
				Total Cost, including Assessment Costs	

9. PROVIDER DETAILS

☐ Original SDP, no alterations required

☐ Alterations requested and incorporated

By Whom: ☐ Worker ☐ Medical Practitioner ☐ Employer ☐ Insurer (on behalf of Employer)

I have developed the above service delivery plan in consultation with key parties (worker, employer, medical practitioner)

Case Manager

Provider

Signed

Date