

Mail or fax to:
 Department of Labor and Industry
 Worker's Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221
 (651) 284-5032 or 1-800-342-5354
 Fax: (651) 284-5731

R-8 Notice of Rehabilitation Plan Closure



DO NOT USE THIS SPACE

PRINT IN INK or TYPE
 ENTER DATES in MM/DD/YYYY FORMAT

1. DATE OF FIRST CONSULTATION IN-PERSON OR TELEPHONE MEETING: (#29 on R-2)						
2. WID or SSN		3. DATE OF INJURY		7. INSURER CLAIM NUMBER		
4. EMPLOYEE NAME			8. DATE-OF-INJURY EMPLOYER			
5. EMPLOYEE ADDRESS			9. QRC NAME			
CITY	STATE		ZIP CODE	10. QRC #	11. QRC FIRM #	12. QRC PHONE #
6. INSURER/SELF-INSURER/TPA			13. NAME OF LAST PLACEMENT VENDOR		14. VENDOR #	
15. EMPLOYMENT STATUS AT PLAN CLOSURE (check one) <input type="checkbox"/> a. Employee RTW with DOI employer <input type="checkbox"/> b. Employee RTW with different employer <input type="checkbox"/> c. Released without physical limitations/effects of work injury and is unemployed (Skip to item 21) <input type="checkbox"/> d. Employee not employed – Other (Skip to item 21)			21. REASON FOR REHABILITATION PLAN CLOSURE (check one) (see instructions) <input type="checkbox"/> a. Plan completed (employee returned to suitable gainful employment) <input type="checkbox"/> b. Award on Stipulation/Mediation <input type="checkbox"/> c. Commissioner or Compensation Judge <input type="checkbox"/> d. Employee and insurer have agreed to close the plan without a stipulation, mediation, or order <input type="checkbox"/> e. Unable to locate employee <input type="checkbox"/> f. Death of employee <input type="checkbox"/> g. QRC withdrawal			
COMPLETE #16-20 IF EMPLOYEE RETURNED TO WORK						
16. NAME OF EMPLOYER AT PLAN CLOSURE						
17. JOB TITLE AT PLAN CLOSURE			22. Did employee have an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			
18. GROSS AWW AT PLAN CLOSURE		19. RTW DATE		23. If plan suspended by R-3 or an order, indicate the number of weeks suspended.		
20a. RETURN TO WORK JOB <input type="checkbox"/> Same job <input type="checkbox"/> Modified job <input type="checkbox"/> Different job			24. TRAINING SERVICES (check all that apply) <input type="checkbox"/> Retraining Plan Submitted – DLI/OAH Did Not Approve <input type="checkbox"/> Retraining Plan Submitted, Award on Stipulation/Mediation <input type="checkbox"/> Retraining Commenced or Completed <input type="checkbox"/> Skills Enhancement (i.e., short term classes) <input type="checkbox"/> On-the-Job Training Commenced or Completed			
20b. Occupational Demands <input type="checkbox"/> Sed. <input type="checkbox"/> Light <input type="checkbox"/> Med <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy						

25. Total number of previous assigned QRCs involved in this Rehabilitation Plan: _____

26. COSTS BY SERVICE AREA AND REHABILITATION PROVIDER

	Prior Placement Firm Costs	Current Placement Firm Costs	Prior QRC Firm Costs	Current QRC Firm Costs
00-Rehab Consultation	N/A	N/A		
01-Medical Management	N/A	N/A		
02-On-Site Job Analysis				

03-Coordination of RTW/Same Employer	N/A	N/A		
04-Job Modification				
05-Functional Capacities Evaluation	N/A	N/A		
06-Transferable Skills Analysis				
07-Work Evaluation	N/A	N/A		
08-Work Hardening/Adjustment	N/A	N/A		
09-Job Seeking Skills Training				
10-Job Development/Placement				
11-Post Placement Activity/Follow-up				
12-Tech/Academic Skills Improvement	N/A	N/A		
13-Vocational Counseling/Guidance	N/A	N/A		
14-Vocational Testing				
15-On-the-Job Training				
16-Labor Market Survey				
17-Retraining	N/A	N/A		
18-Administrative				
19-Prep/Attend Legal Proceeding				
20-Expenses/Other				
TOTAL COSTS OF EACH COLUMN	\$	\$	\$	\$
SUM OF COLUMN TOTALS ABOVE				\$

By signing and dating this form, I certify that copies of this form and attachments are being sent to the employee, insurer, any attorney(s), the Department of Labor and Industry , and if required, to the department's Vocational Rehabilitation Unit (VRU).

QRC SIGNATURE	DATE	QRC INTERN SUPERVISOR SIGNATURE	DATE
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EMPLOYEE: IF YOU HAVE QUESTIONS ABOUT THE CLOSURE OF THIS REHABILITATION PLAN, CALL THE DEPARTMENT OF LABOR AND INDUSTRY AT 651-284-5032 OR 1-800-342-5354.

This form is located at www.dli.mn.gov/WC/Wcforms.asp and can be made available in different formats, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/Voice or TDD (651) 297-4198.

R-8 NOTICE OF REHABILITATION PLAN CLOSURE INFORMATION

Purpose: The Notice of Rehabilitation Plan Closure (R-8) form and the summary report document the closure of the Plan. The R-8 is used to document the reason the plan is being closed or suspended, the employee's employment status at Plan closure, and the cost of all rehabilitation services that were provided under the Plan. The narrative summary report describes the services that were provided from the beginning to the end of the Plan. Both of these documents must be filed within 30 calendar days of notice of any of the events listed in Minn. Rules 5220.0510, Subp. 7, or when the QRC withdraws under Minn. Rules 5220.0510, Subp. 7a.

Item 15: Employment Status at Plan Closure: Check Box C only if the employee is unemployed and has been released to return to any job, without any physical limitations/effects of work injury. Identify the documents (i.e. Work Ability form, etc.) that provides the basis for this selection within the R-8 summary report. Then skip to item 21.

Item 20a: RETURN TO WORK. Enter information about the job where the employee returned to work.

Item 20b: Occupational Demands. For DOT physical demands and strength rating description, see the R-2 Rehabilitation Plan Information sheet.

Item 21: Reason For Rehabilitation Plan Closure:

- a. the employee has been steadily working at suitable gainful employment for 30 days or more, or the time period provided for in the plan
- b. the employee's rehabilitation benefits have been closed out by an award on stipulation or award on mediation
- c. the commissioner or a compensation judge has ordered that the rehabilitation plan be closed and there has been no timely appeal of that order
- d. the employee and insurer have agreed to close the rehabilitation plan
- e. the QRC has been unable to locate the employee following a good faith effort to do so
- f. the employee has died
- g. the QRC decides to withdraw after the insurer has provided written notice to the employee, the employee's attorney, the commissioner, and the QRC that the insurer is denying further liability for the injury for which rehabilitation services are being provided. **(For 21 g, the QRC must file the R-8 and attach a copy of the insurer's notice of denial, copying appropriate parties, including a separate copy to the Department's Vocational Rehabilitation Unit.)**

NOTE: Item 21g does not apply if a claim petition, objection to discontinuance, request for an administrative conference, or other document initiating litigation has been filed on the liability issue. If one of these documents has been filed and the QRC decides to withdraw, the QRC shall document the withdrawal by filing a Rehabilitation Plan Amendment (R-3).

Item 23: If the rehabilitation plan was temporarily interrupted by an R-3 (i.e. agreement of the parties) or an order of the department, then indicate the cumulative number of weeks the plan was suspended.

Item 25: Total number of previously assigned QRCs involved in this Rehabilitation Plan: Include any other QRCs from your firm or another firm who provided services under the plan closed by this R-8 form.

Item 26: Costs By Service Area And Rehabilitation Provider: List the total costs for the individual services provided by rehabilitation provider firms in the applicable spaces. No information is to be listed in the spaces marked "N/A. After this is completed, total each of the four columns and enter the final amounts in "TOTAL COSTS OF EACH COLUMN."

Sum of Column Totals Above: Add the dollar amounts of the four "Total Costs" columns, and place it in the space provided.

ATTACH A CLOSURE REPORT SUMMARIZING SERVICES PROVIDED. Minn. Rule 5220.0510, subp. 7 F (4).

Send copies of the R-8 to the employee, insurer, and attorney(s). If the insurer is denying further liability, send a separate copy addressed to the Department's Vocational Rehabilitation Unit (VRU).