Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "B" – REQUIRED CONTENT
INITIAL ASSESSMENT REPORT

Client Name:	**Date of Referral:**
Client Identifier Number:	**Service Provider (SP):**
Client Address:	**SP – Consultant:**
Client Telephone #:	**SP – Consultant's direct telephone #:**
Date of interview with the client:	
Date of interview with the physician:	
Date of interview with employer (if appropriate):	
Service Canada VR Case Manager:	

Diagnosis:

Specific Reason for Referral:

Please ensure your report addresses the areas identified below:

1. Psychosocial Profile

Subjective:

- General impression of the client
- General attitude of the client
- Motivation: what are the incentives, disincentives to return to work (RTW)
- Cognitive status
- Emotional status

Objective:

- Client personal and vocational goals
- Client perceived level of disability/capacity
- Support available
- Family situation and obligations

2. Description of client's home environment

Note: If the client is not met in his/her own home, provide the client's reason(s) for not meeting there.

3. Medical and Rehabilitative Interventions (May be contained in physician report)

- Main and secondary diagnosis(es)
- Recent medical interventions including client's compliance and response
- Past and current rehabilitation including client's compliance and response
- Change in medical status since benefits granted
- Prognosis: potential for "medical instability"
- Signed letter by client's physician, or summary of consultant's meeting and/or telephone conversation with client's physician.
- Special considerations, restrictions to RTW
- List of current medications taken by client
- Need/use of assistive devices

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "B" – REQUIRED CONTENT
INITIAL ASSESSMENT REPORT

4. Education/Vocational Profile

- Previous testing (aptitude, interest, vocational, etc.) results and/or interpretation if available
- Previous VR activities and programs
- Formal and informal education, course, certificate, dates of completion
- All previous work experience (occupations, duration, salary, job descriptions)
- Transferable skills
- Client vocational goals, expectations of a return to work program
- Employer's willingness to accommodate the client, provide alternative work, proposed schedule and salary (if applicable)
- Employability profile: academic skills, personal management skills, teamwork skills
- Interests, hobbies and volunteer work
- Volunteer work

5. Financial situation

- Revenues and expenses from other sources
- Coverage under other Programs (Student Loan, EI Program, WCB, Long-Term Disability Insurers, Auto Insurer, Social Assistance, etc.)

6. Functional Status

- Provide a description of the client's past and current functional level based on the client, physician and employer (if applicable) interviews (report of employer interview to be attached if applicable) clarifying the type of impairment affecting the client and how it affects current activities: self-care work and leisure, transportation, childcare, etc.
- List those barriers to employment and identify those that can be decreased/ minimized
- Identify whether or not the client's goals are realistic and within the CPPD Vocational Rehabilitation Program mandate

7. Employer interview (if applicable)

- Brief description of the activities performed in the client's own job and whether it is still available
- Accommodations the employer is willing to make, if necessary
- Availability of alternate work
- Client's work attitude and attendance

8. Partner interview

- Overview of planning and/or assessments done to date
- Cost sharing opportunity
- Type of resource available
- Information sharing

Recommendations:

Prior to making any recommendations for further service or intervention, please state clearly your opinion regarding the client's rehabilitation potential. For example:

a. The client has rehabilitation potential and is likely to succeed with minimal intervention. (*Clarify if the client can return to work now with job placement assistance ;)*
b. The client has some rehabilitation potential but may require more extensive intervention due to identified barriers;
c. The client's potential is not clear and needs further exploration; or

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "B" – REQUIRED CONTENT
INITIAL ASSESSMENT REPORT

d. The client has no rehabilitation potential and should not participate in the program.

Provide an explanation for your recommendation and justify the need for CPPD investment in a Vocational Rehabilitation Program.

Provide your opinion regarding whether or not the client remains totally disabled from performing any substantially gainful occupation, and your impression of his/her abilities.

Provide recommendations, with rationale, for activities required for next reporting period with estimated costs.

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "C" – REQUIRED CONTENT
Labour Market Analysis

Client Name:	Service Provide(SP):
Client Identifier Number:	SP Consultant:
Client Address:	SP Consultant's direct telephone #:
Client Phone #:	Date of Report:
Service Canada VR Case Manager:	

A Labour Market Survey for ___*(list type of occupation)*____ was completed by *(service provider's name)*. All labour market research was conducted on _____ (or) between _____ and _____.

JOB DESCRIPTION

Job title: NOC #:
Duties:
Skills, interests, values:
Environment/Physical Demands of the job:
Qualifications/Educational Requirements:

Researched Positions

(It is expected that three companies will be contacted by the service provider and three by the client)

Position:	Company:
Contact:	Location:
Qualifications & Responsibilities:	Physical Requirements:
Tools & Equipment Utilized:	Travel Requirements:
Security Clearance Required (yes or no):	Salary Range:
Company Benefits	Hours:
Available Positions (past, current, predicted)	Accessibility:

Repeat above group of headings for each company contacted.

Summary: (*Address whether the job market in the client's area of residence, as per the information gathered above, supports his/her career choice*)

Enclosures: Client's labour market research and job postings.

_____ _____
Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "D" – REQUIRED CONTENT
Individual Written Rehabilitation Plan (IWRP)

Original (Y/N)_____ Revised (Y/N)____If yes, revision #_____ Date:_____

Client Name:	Service Provider (SP):
Client Identifier Number:	SP Consultant:
Client Address:	SP Consultant's direct telephone #:
Client telephone#	Service Canada VRCM:
Previous Occupation:	
Education:	
Future Job Expectation:	

Employment Goal

RTW – Same Employer
____Same Occupation
____Alternate Job
____ Modified Work

RTW – New Employer
____Same Occupation
_____ Alternate Job
____ Modified Work

Self-Employment
____Same Occupation
____ Alternate Job
____ Modified Work

Vocational Rehabilitation Short & Long Term Goals:

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "D" – REQUIRED CONTENT
Individual Written Rehabilitation Plan (IWRP)

Original (Y/N)_____ Revised (Y/N)____If yes, revision #_____ Date:_____

Reference Guide for Numbering (refer to the Statement of Work):
Assessment Phase: 5.1
Planning Phase: 5.2
Intervention Phase: 5.3
Financial Services: 5.4
Client Disbursement and Travel Expenses: 8.1
Service Provider Disbursement and Travel Expenses: 8.2

#	Objective	Services/Goods/Strategies Required	Provider	Cost or Funding Source	Start Date	End Date

CPPD/Service Provider Costs:_____
Partner Costs: _____
Client Costs: _____
Total Projected IWRP Cost: _____

____ **I agree to comply and take responsibility for my own rehabilitation plan, including** maintaining contact as determined with the service provider and informing the service provider of any change(s) in my medical condition and/or life situation that will affect the progression of the rehabilitation plan. **I understand the plan may change as required throughout the rehabilitation process and will be subject to further review and signatures.**

____ **I do not accept this plan.**

Client Signature: _____ **Date:**_____

____I agree with the rehabilitation plan as outlined. There are no medical concerns re the client's active participation in this rehabilitation plan.

____ **I do not agree with the rehabilitation plan as outlined. Please see the rationale in the comment section.**

Physician Signature:_____ **Date:** _____

SP Consultant: _____ **Date:**_____

Partnering Agency:_____

Representative Signature:_____ **Date:**_____

SC VRCM Signature: _____ **Date:**_____

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "D" – REQUIRED CONTENT
Individual Written Rehabilitation Plan (IWRP)

Original (Y/N)_____ Revised (Y/N)____If yes, revision #_____ Date:_____

COMMENTS:_____
_____
_____

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "E" – REQUIRED CONTENT
PROGRESS REPORT

Client Name:	**Service Provider:**
Client Identifier Number :	**SP Consultant Name:**
Client Address:	**SP Consultant Direct Telephone #:**
Client Phone #:	**Date of Last Report:**
Current Phase: (Assessment, Planning, Intervention)	
SC Vocational Rehabilitation Case Manager:	

NOTE: Do not repeat or "copy and paste: information contained in previous reports or in the referral information.

1. List of all activities performed since the last progress report and **date** for each activity (the date for billable activities should match the date on the invoice).

2. Summary of Contacts:
   - Client
   - Employer
   - Physician: all medical and disability related information provided by the treating physician should be confirmed in writing and should include a date and the signature of the physician.
   - Others

3. Job Development/Placement Activities:
   - List specific employers contacted
   - Job and salary information
   - Employer response/outcome

4. Community resources used during the reporting period.
5. Degree of client's follow through and cooperation comment on the interest, motivation and specific efforts initiated by the client.
6. Barriers emerging which may delay the rehabilitation process and actions taken/ recommendations.
7. Evidence of capacity or incapacity to work.
8. Next significant milestones for client.
9. Projected costs to complete the case.
10. Specific recommendations.
11. Justification for change in vocational rehabilitation cost and/or plan.
12. Assessment on successful outcome.
13. Outcome.
14. Service Canada Vocational Rehabilitation Case Manager action requested.

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "E" – REQUIRED CONTENT
PROGRESS REPORT

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "F" – REQUIRED CONTENT EMPLOYER CONTACT SHEET

Client Name _____ **Identification Number:** _____

Date	Contact Type (phone, email, fax, In-person)	Company (Name & Address)	Contact Person (phone #)	Call Back	Apply In-Person	Submit Resume or Application	Job Interview or Info Interview	Outcome
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "G" – REQUIRED CONTENT
JOB SEARCH AGREEMENT

Original _____Revised _____If Yes, Revision # _____Date: _____

Client Name:	**SC Vocational Rehabilitation Case Manager:**
Client Identifier Number:	**SP Consultant:**
Client Telephone #:	**SP Consultant Direct Telephone #:**

As a component of (*client's name*) active participation in Canada Pension Plan's (CPP) Disability Vocational Rehabilitation Program, CPP has agreed to sponsor (*client name*) in a _____ **month job search** facilitated by (*Service Provider's name*) from (*date*) to (*date*).

(*Client's name*) will be provided Employer Contact Sheets by (*Service Provider*) in order to document job search efforts on a bi-weekly basis. (*Client's name*) is expected to contact a **minimum of** _____ **employers per day (**_____ **employers per week)** and to submit these to (*Service Provider*) every two weeks.

(*Client's name*) agrees to focus job search efforts in the following occupations: (list occupation(s) here).

(*Service Provider's name*) agrees to ongoing regular weekly communication with (*client's name*) to assist with the Job Search process. This assistance may include the provision of additional copies of résumés and cover letters when required, the identification of potential employers and job opportunities (and/or sources where these can be obtained) as well as ongoing job search support throughout the job search period.

Should (*client's name*) be successful in his/her efforts to secure paid substantially gainful employment within the _____ month job search period his/her disability benefits will be extended during a work trial for a minimum of three months. (*Client's name*) agrees to inform (*Service Provider's*) of all employment and employment-related earnings obtained during the job search and work trial period and agrees to provide copies of paystubs if requested by the Service Provider or Service Canada.

I agree to comply with the conditions outlined above and to take responsibility for carrying out my own job search to the best of my ability.

Client Signature:	**Date:**
Service Provider's Signature:	**Date:**

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "H" – REQUIRED CONTENT
RTW Follow-Up Report

Date of Report:	
Client Name:	**Service Provider(SP):**
Client Identifier Number:	**SP Consultant:**
Client Address:	**SP Consultant's Direct Telephone #:**
Client Phone #:	
Date(s) of contact(s) with the client:	
Date (s) of contact (s) with the employer:	
Service Canada VR Case Manager:	

EMPLOYMENT INFORMATION

Employer Name:	**Type of Work and Start Date:**
Employer Telephone # and Address:	**Nature of Employment:** ▪ **Continuing/Permanent (full or part-time)** ▪ **Temporary (end date)** ▪ **Seasonal (end date)** ▪ **Self-Employment**
Hour of Work (per day – week):	**Reason for Part-Time Employment (if applicable):** ▪ **Client's Choice** ▪ **Labour Market Conditions** ▪ **Client's Work Capacity**
Rate of Pay (per hour – week- month):	**Date & Reason Work Ceased (if applicable):**
Total Monthly Earnings:	

Supervisor Evaluation of Performance (complete only upon direction of Service Canada Vocational Rehabilitation Case Manager)

- Employer Accommodation
- Time loss due to illness (reasons)
- Job demand tolerance

Client Evaluation of Performance

- Employer Accommodation
- Time loss due to illness (reasons)
- Job demand tolerance

Service Provider Supports/Services: *(narrative of your support/services provided to the client during this time)*

Issues Identified:

Recommendations:

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "H" – REQUIRED CONTENT
RTW Follow-Up Report

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "I" – REQUIRED CONTENT
CLOSURE REPORT

Client Name:	**Service Provider (SP):**
Client Identifier Number:	**SP Consultant:**
Client Address:	**SP Consultant Direct Phone #:**
Client Phone #:	**Date of Report:**
Service Canada VR Case Manager:	

1. **Overview of Vocational Rehabilitation Activities and Outcomes:**

2. **Evidence of Client's Capacity or Incapacity to Return to Substantially Gainful Employment:**

3. **Where Substantially Gainful Employment is not achievable, provide any additional recommendation:**

4. **Total Invoiced Costs:**

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "J" – REQUESTED CONTENT
General Invoice Template

Invoice number	Invoice Date	Service Canada VRCM

Payment Information (please ensure that you have completed your Direct Deposit Information)

Service Provider Name:	Service Provider Branch Address:
Service Provider File Number:	Telephone Number (include area code)

Client Information

Client's Last Name	Client's First Name
Client Identification Number:	Procurement or Requisition Number:

Service Information

Date of service	Rehab Phase	Description	Number of hours	Cost per hour	Subtotal (not including taxes)	GST (if charged)	HST (if charged)	Total (including taxes)
								A:

Disbursement Information (at cost, no mark-up)

Date of service	Description	GST (if applicable)	HST (if applicable)	Total (including taxes – if applicable)
				B:
			Invoice Total A + B	

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "K" – REQUESTED CONTENT
TRAVEL EXPENSE CLAIM

To Be Completed by the Traveller (Service Provider)

Organization: **Invoice #:**

Name: **Telephone:**

Address:

City: **Postal Code:**

START DATE OF TRAVEL: _____ **END DATE OF TRAVEL:** _____
DESTINATION: _____
TIME OF DEPARTURE: _____ **TIME OF RETURN:** _____
TOTAL DAYS TRAVELED FOR THIS INVOICE: _____

TRANSPORTATION		
Air fare as per ticket		$
Taxi, Bus, Train		$
Car: Rate/Km $_____x Km travelled _____ =		$
Other (specify)		$
	Subtotal	$
MEALS AND INCIDENTALS		
Breakfast (Leave residence before 6:30 a.m.)	$_____ X _____days	$
Lunch	$_____ X _____days	$
Dinner (Arrival at residence after 7:30 p.m.)	$_____ X _____days	$
Incidentals (For overnight stay only)	$_____ X _____days	$
	Subtotal	$
ACCOMMODATIONS		
Hotel / Motel	$_____ X _____days	$
Other (specify)_	$_____ X _____days	$
	Subtotal	$
EXPENDITURES	**TOTAL**	$

Traveller's Signature:_____ Date:_____

This form must accompany the invoice and is subject to the Treasury Board Travel Policy. Receipts and Itemized invoice required for all travel except meals and incidentals.