

**A Guide to**

**Requesting  
Early Intervention  
Services**

**and**

**Application for Early  
Intervention Services-  
Report of Absence**



**RWAM DISABILITY MANAGEMENT**  
A division of RWAM INSURANCE ADMINISTRATORS INC.



## A Guide to Early Intervention Services (Please keep this section for your reference)

*RWAM Disability Management has been contracted by your employer to provide early intervention services. Applying for early intervention services can be confusing. This guide is designed to assist you in this process and to provide answers to the most commonly asked questions.*

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### **What is Early Intervention?**

Prior to the date you are eligible to receive disability benefits (your elimination period), the RWAM Early Intervention Program will assist you if you are absent from work for medical reasons. The program will provide you with the individualized support necessary to help you with a safe and timely return to work.

### **Who is involved in the program?**

Involved with you in the program are your employer, your health care provider, and the RWAM Early Intervention case manager.

### **Why is the program available?**

Studies show that providing early support to an individual who is absent from work for medical reasons improves the work environment and employee morale.

Although the original reason for your absence may be medical, other factors may extend that absence. Therefore the earlier support services are made available, the sooner you will return to work.

### **What are the goals of the program?**

- Provide support services to employees on medical leave
- Help employees safely return to work through planning and communication
- Promote the employee's self worth, family stability and social ties.

### **How does the program benefit you?**

When you participate in the program, your employer and the RWAM Early Intervention Program case manager will work with you during your medical absence. A recovery and return to work plan will be developed to meet your specific needs.

### **How do I participate in the program?**

When your medical condition causes you to miss 10 consecutive days of work, your supervisor or human resource representative will ask you to complete the Early Intervention Report of Absence form. (Except where prohibited by law, you are responsible for paying any fees your doctor charges for completion of these forms or for providing medical reports.) This form will then be sent to the RWAM Early Intervention Department for their review and recommendation. You can expect a telephone contact from an Early Intervention Program case manager.

### **What information does the RWAM Early Intervention department require to adjudicate my medical leave, provide me with supportive intervention, and assist me with my return to work? What can I do to avoid delays?**

1. Make sure all forms are fully completed.
2. Provide additional details of all factors, both at work and at home, which affect your ability to be at work.
3. Ask your doctor to include reports from all specialists, results of all testing, hospital admission/discharge summaries, operative reports and any other medical information. If we do not receive sufficient, clear information, we may be required to write to your physician to obtain the information, resulting in a delay.
4. Provide copies of CPP/QPP, WCB/WSIB and auto insurance claim records if you have applied for or are receiving any of these benefits.

### **Will my personal information have privacy protection?**

The RWAM Early Intervention department is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business. RWAM will abide by all federal and provincial privacy legislation which governs the protection of all personal information in its custody. For further information regarding RWAM's privacy policies, please refer to your Employee Booklet.

### **Will my personal and medical information be kept confidential?**

Yes, all medical and personal information is kept strictly confidential. The only information shared with your employer is the information necessary to plan your return to work; i.e. what job tasks can you safely and successfully accomplish on a part-time or full-time basis.

### **Will my physician be contacted?**

Yes, the involvement of your physician or specialists is vital in developing your return to work plan.

### **Return to Work Program**

We will work with you, your physician and your employer to develop and facilitate a safe and timely return to work plan for you.

### **What if I have applied for Workers Compensation (WCB/WSIB) benefits?**

You must still submit your completed Early Intervention forms and any other supporting documents to our office at the same time as you would have, had you not applied to WCB/WSIB. This ensures your Early Intervention form is received by us within sufficient time, in the event your Workers Compensation application is denied or benefits are discontinued and you have to apply for disability benefits at a later date.

### **Can I contact RWAM directly if I have questions regarding the program?**

Yes, once you have been referred to the program, please feel free to contact RWAM – Toll free at 1-877-888-7926 and ask for a member of the RWAM Early Intervention team.

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### Employer Statement (Please Print)

Please complete this form in full as incomplete information may result in delays.

## RWAM EARLY INTERVENTION PROGRAM REPORT OF ABSENCE/EMPLOYER

### EMPLOYEE INFORMATION

Employee name \_\_\_\_\_  
Last name First name

RWAM Group # \_\_\_\_\_ Certificate # \_\_\_\_\_ Company name \_\_\_\_\_

Date of birth 

dd	mm	yyyy							

 Gender:  Male  Female

Employee home address \_\_\_\_\_  
Street name & number City/Town Province Postal code

Employee work address \_\_\_\_\_  
Street name & number City/Town Province Postal code

Home telephone # \_\_\_\_\_ Work telephone # \_\_\_\_\_  
Area code Area code

Occupation/Job title (occupation held just before absence from work) \_\_\_\_\_

**Please provide a copy of your most recent job description**

Immediate supervisor's name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Area code

Is condition due to injury or illness arising out of employment?

No  Yes – If 'Yes' has the employee applied for Workers' Compensation Benefits (WCB/WSIB)  No  Yes

### COVERAGE INFORMATION

Date of employment 

dd	mm	yyyy							

 Date last worked 

dd	mm	yyyy							

Date expected to return to work 

dd	mm	yyyy							

 Date returned to work 

dd	mm	yyyy							

State current rate of gross earned income \$ \_\_\_\_\_  Hourly  Weekly  Bi-weekly  Monthly  Annually

Date rate of gross earned income became effective 

dd	mm	yyyy							

 Regular hours worked per week (excluding overtime) \_\_\_\_\_

If employment is now terminated, please indicate date & reason \_\_\_\_\_  
\_\_\_\_\_

Employer name \_\_\_\_\_

Employer address \_\_\_\_\_  
Street name & number City/Town Province Postal code

Contact person (please print) \_\_\_\_\_ Title of contact person \_\_\_\_\_

Signature of contact person \_\_\_\_\_ Date \_\_\_\_\_

Telephone # \_\_\_\_\_ Email address \_\_\_\_\_  
Area code

Fax # \_\_\_\_\_ Is Fax confidential?  No  Yes  
Area code



**Employee Statement** (Please Print)

Please complete this form in full as incomplete information may result in delays.

**RWAM EARLY INTERVENTION PROGRAM  
REPORT OF ABSENCE/EMPLOYEE**

**EMPLOYEE INFORMATION**

Name \_\_\_\_\_  
Last name First name

Employee home address \_\_\_\_\_  
Street name & number City/Town Province Postal code

Home telephone # \_\_\_\_\_ Date of birth \_\_\_\_\_  
Area code dd mm yyyy

RWAM Group # \_\_\_\_\_ Certificate # \_\_\_\_\_ Employer name \_\_\_\_\_

Briefly describe your job duties \_\_\_\_\_

Describe your present medical condition, its cause and history \_\_\_\_\_

Have you ever had a similar injury or illness in the past?  No  Yes If 'Yes', describe your condition and the original date of illness or injury \_\_\_\_\_

Date of first treatment for this illness/injury \_\_\_\_\_ Date medical condition has prevented you from working \_\_\_\_\_  
dd mm yyyy dd mm yyyy

Have you, or did you attempt to return to work?  No  Yes

If 'Yes', from \_\_\_\_\_ to \_\_\_\_\_ Indicate:  full-time  part-time  usual job  new job or modified duties  
dd mm yyyy dd mm yyyy

If 'No', when do you expect to return to your own occupation? \_\_\_\_\_  
dd mm yyyy

Are you claiming or receiving any other disability or wage loss benefits?  No  Yes

If 'Yes', check the applicable benefit:  WCB/WSIB  Auto Insurance  Employment Insurance (EI)  Other \_\_\_\_\_

**ACCIDENT INFORMATION – complete only if absence is the result of an accident**

Date of accident \_\_\_\_\_ Time of accident \_\_\_\_\_ : \_\_\_\_\_  a.m.  p.m.  
dd mm yyyy

Was work being done for an employer at time of accident?  No  Yes Was this a motor vehicle accident?  No  Yes

Give details of accident \_\_\_\_\_

**EDUCATION / TRAINING – please print**

Highest grade level of education completed \_\_\_\_\_ Number of years in post secondary education \_\_\_\_\_

Name of post secondary degree or diploma obtained \_\_\_\_\_

Other training, special or vocational courses \_\_\_\_\_



REPORT OF ABSENCE/EMPLOYEE cont'd
Employee Statement

Employee Name (print) \_\_\_\_\_

EMPLOYEE INFORMATION continued

EMPLOYMENT HISTORY

Please complete the following, providing details of your previous 3 positions.

Table with 3 columns: Name of Employer, Job Title and Duties, Duration of Employment (From, To). Includes three rows of blank lines for data entry.

What skills have you acquired in your current and previous jobs? (e.g. keyboarding, operation of equipment, supervisory skills, etc.). Where appropriate, give level of proficiency.

Three horizontal lines for writing skills acquired in previous jobs.

COMMUNITY INTERESTS/HOBBIES

Outline your past or present involvement with any community/church/volunteer organization(s).

Three horizontal lines for writing community interests and hobbies.

PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS

RWAM DISABILITY PRIVACY STATEMENT

RWAM Disability Management is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

AUTHORIZATION

I acknowledge that RWAM Disability Management, a division of RWAM Insurance Administrators Inc. ("RWAM") may provide supportive early intervention services to me prior to the date upon which I may, if at all, become eligible to receive monthly disability benefits and that these services provided by RWAM will not in any way be construed as an admission of liability by the insurer or acceptance of a claim for the payment of monthly disability benefits.

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, the group plan administrator or its representatives, any insurance company, government agency or my employer to release to the insurer or its representatives or agents, any and all medical, employment or vocational information or records regarding me for the following purposes: to provide early intervention services that may include the evaluation, administration and management of my medical absence from work and to assess and facilitate my return to work. I further authorize RWAM or the insurer or its representatives or agents to disclose any such information obtained during the course of my early intervention file to any physician, clinic or any other medical or health care provider or facility for such purposes.

I understand that my refusal or withdrawal of consent may delay the provision of, or result in the denial of such services. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to this early intervention Report of Absence to be true, complete and accurate.

In the event I do not return to work and I submit an application for monthly disability benefits, I understand and authorize that my entire early intervention file will form part of my claim file.

This authorization shall remain valid for the duration of the provision of early intervention services unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Signature of Employee

Date



**Physician Statement** (Please Print)

**RWAM EARLY INTERVENTION PROGRAM  
REPORT OF ABSENCE/PHYSICIAN**

**AUTHORIZATION**

I authorize the release of any medical information requested for this medical absence to RWAM Disability Management and the insurer.

Name of Patient \_\_\_\_\_

Date of birth 

dd	mm	yyyy							

RWAM Group # \_\_\_\_\_ Certificate # \_\_\_\_\_

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Signature of Employee

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Date

**DIAGNOSIS**

Primary \_\_\_\_\_ Secondary \_\_\_\_\_

Other contributing factors/complications \_\_\_\_\_

If condition is due to pregnancy, please give exact dates of confinement 

dd	mm	yyyy							

DSM IV Diagnosis (if applicable)

AXIS I \_\_\_\_\_ AXIS II \_\_\_\_\_ GAF (highest in last year) \_\_\_\_\_

AXIS III \_\_\_\_\_ AXIS IV \_\_\_\_\_ Current GAF \_\_\_\_\_

**PRESENT CONDITION**

Date symptoms first appeared or accident happened 

dd	mm	yyyy							

 Date patient ceased work because of present condition 

dd	mm	yyyy							

Date of first visit for present condition 

dd	mm	yyyy							

 Has patient ever had the same or a similar condition?  No  Yes  Unknown

If 'Yes', state original date of illness/injury and provide details \_\_\_\_\_  
\_\_\_\_\_

**OBJECTIVE FINDINGS / INVESTIGATIONS**

Date you most recently examined this patient 

dd	mm	yyyy							

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Cardiac Status (if applicable):  Class 1 (no limitation)  Class 2 (slight limitation)  Class 3 (marked limitation)  Class 4 (complete limitation)

Physical Limitations (e.g. range of motion, restrictions on lifting, walking, etc.) \_\_\_\_\_  
\_\_\_\_\_

Other Limitations (e.g. vision, psychological, etc.) \_\_\_\_\_  
\_\_\_\_\_

*Investigations (e.g. EKG, x-rays, lab tests, MMPI, etc.)* \_\_\_\_\_ *Date Carried Out* \_\_\_\_\_ *Summary of Results - Attach copies of all available reports* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are any further investigations planned?  No  Yes If 'Yes', state type and when \_\_\_\_\_  
\_\_\_\_\_

Has your patient been referred to any other physician / specialist(s)?  No  Yes If 'Yes', complete the following:  
*Physician's / Specialist's Name* \_\_\_\_\_ *Specialty* \_\_\_\_\_ *Dates of Examinations* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Summarize findings (including copies of consultation reports) \_\_\_\_\_  
\_\_\_\_\_

**PLEASE ASSIST YOUR PATIENT BY PROVIDING COPIES OF CHART NOTES, TESTS & CONSULTATION REPORTS**



# REPORT OF ABSENCE/PHYSICIAN cont'd Physician Statement

Employee Name (print) \_\_\_\_\_

RWAM Group # \_\_\_\_\_

Certificate # \_\_\_\_\_

## TREATMENT

Since first visit, how often have you seen this patient?  Weekly  Bi-Weekly  Monthly  Other (specify) \_\_\_\_\_

Medications (if applicable)

Name of Medication	Dosage	Dates Initiated	Reason for Change in Medication (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date(s) of hospital admission(s) *From* \_\_\_\_\_ *To* \_\_\_\_\_ *Reason(s)* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Surgery?  No  Yes If 'Yes', type of surgery \_\_\_\_\_ Date  Performed  Planned  
 \_\_\_\_\_

dd	mm	yyyy
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Physiotherapy?  No  Yes If 'Yes', frequency:  Daily  3x per Week  Weekly  Other (specify) \_\_\_\_\_  
 Type  Outpatient/physiotherapy Dept.  Independent home exercises

Any other treatment or future plans for treatment? (specify dates) \_\_\_\_\_

## LIMITATIONS

Are you aware of what your patient's job duties are? \_\_\_\_\_

What major tasks of your patient's occupation is he/she:

Able to perform \_\_\_\_\_

Unable to perform - **Please list specifics that impair functional activity** \_\_\_\_\_

What daily living activities are impaired due to this illness and how? \_\_\_\_\_

What is being done to return your patient to work? \_\_\_\_\_

Is patient:  Ambulatory  House confined  Bed confined

## PROGNOSIS

Progress - Has patient:  Recovered  Improved  Not Improved  Plateaued  Regressed

**Based on limitations outlined above, the return to work plan is as follows:**

Own occupation  Full-time 

dd	mm	yyyy
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 Part-time 

dd	mm	yyyy
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 Other \_\_\_\_\_

Estimated number of weeks before possible return to work \_\_\_\_\_

Would you support a graduated return to work program?  No  Yes Explain \_\_\_\_\_

## PHYSICIAN INFORMATION - please print

Name \_\_\_\_\_ Telephone No. \_\_\_\_\_  
Last Name First Name Area code

Family Physician  No  Yes Specialist \_\_\_\_\_ Fax No. \_\_\_\_\_  
Indicate specialty Area code

Address \_\_\_\_\_  
Street name & number City/Town Province Postal code

Signature of Physician \_\_\_\_\_ Date 

dd	mm	yyyy
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