ACC2222

Remote Claims Unit referral

PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

Branch managers complete this form when referring a claim to the Remote Claims Unit.

This form is for internal information only. Do NOT upload this form to Eos.

1. CLAIM DETAILS

This form was completed on: [dd month yyy]

Client name: [Client full name]		Claim number: [Claim number]
Residential address: [Client residential address]		Date of birth: [Client DOB]
Postal address (if different from home address):		Gender:
Home phone:	Mobile phone:	Work phone:
Date of accident:		Date of first incapacity:
Present injury diagnosis:		Weekly compensation rate:
Claims management staff member:		

2. REASON FOR REFERRAL

Provide specific details regarding what the client has done to warrant the transfer to RCU.

3. THREATENING BEHAVIOUR

Outline why this person cannot be managed by another branch. Detail specific threats made in the past six months towards the following.
ACC staff:
Providers:
Others:
Reasons why person cannot be managed at another branch:
Has the client been trespassed from any ACC location? ☐ Yes ☐ No
If yes, what location? Date client was trespassed:
Reason for trespassing client:

4. RELEVANT HISTORY AND BACKGROUND

Provide relevant details about the client's police history and any background checks.
History:
Background checks:

5. SECURITY INTERVENTIONS

Detail any interventions that have taken place in the last six months.
Police:
ACC Health, Safety and Security team:
Fraud concerns (if any):

6. CASE MANAGEMENT PLAN OF INTERVENTIONS

Detail the last two assessments or services the client has received and any future interventions planned.
Case management plan of interventions that are currently in place:

7. SIGN OFF

Remote Claims Unit Manager		
Name:	Signature:	Date:
National Manager Health, Safety and Security		
Name:	Signature:	Date:

ACC6267

Wellington Central branch transfer

Complete this form to refer clients to the Wellington Central Branch (WCB).

1. Claim details			
Client name: [Client full name auto]		Claim number: [Claim number auto]	
Address: [Address Line 1 Auto], [Address Line 2 Auto], [Suburb Auto], [Town Or City Auto], [Post Code Auto]			
Gender: [Gender auto]	Date of birth: [DOB auto]	Date of injury: [Date of injury auto]	Date of first incapacity:
Home phone: [Client home ph auto]		Mobile: [Client mobile auto]	Work phone: [Client work ph auto]
Present injury diagnosis:			
Weekly compensation rate:		Claims management staff member:	

2. Reason for referral
Provide specific details as to the reason why the client has been transferred to WCB, ie how much time has been spent on the claim, what resources have been used and what departments have been contacted?

3. Case management plan of interventions
Detail the last two assessments or services the client received and current or future interventions planned.

4. Sign off	
Wellington Branch Central Manager name:	
Signature:	Date:
Head of Client Service Delivery name:	
Signature:	Date:

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ACC29

File summary and overview

Fill in this form if you're a case owner and you need to transfer a claim to another branch or the Overseas Claims Unit. Upload it to the client's claim in Eos when you've finished.

1. Client details			
Client name: [Client full name auto]	Claim number: [Claim number auto]		
Date of birth: [Client date of birth auto]	Do they have an advocate?	☐ Yes	☐ No

2. Injury, rehabilitation and entitlements			
Injury: [Injury auto]	Date of injury (DOI): [DOI auto]		
Occupation at date of injury: [Occupation at date of injury auto]			
Diagnosis at time of injury:	Current diagnosis:		
List the covered injuries:			
Are there any significant non-injury factors that may have an effect on this claim?		☐ Yes	☐ No
If yes, put the details here:			
Are there any other claims that may have an effect on this claim?		☐ Yes	☐ No
If yes, put the details here:			
Is there a signed Individual Rehabilitation Plan (IRP) on file?		☐ Yes	☐ No
If yes, does it need updating?		☐ Yes	☐ No
IRP expiry date:	Outcome date:	Date of next monitoring step:	

Tick the ongoing current entitlements that the client is receiving:		
☐ Abatement	☐ Attendant care	☐ Training for independent living (TIL)
☐ Child care	☐ Education support	☐ Transport for independence
☐ Sleepover	☐ Home help	☐ Vocational rehab, eg work trial etc:
☐ Weekly compensation at $ pw		☐ Other (specify):
If we're providing any social rehabilitation assistance, eg hours of care, education support etc, put the details here:		

3. Work capacity			
Date of incapacity:	Date of subsequent incapacity:		
Has the client worked at all since the injury?		☐ Yes	☐ No
If yes, what type of work have they been doing?			
Has capacity to return to their pre-injury employment been assessed?	☐ Yes - Date:		☐ No

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If yes, list the recommendations:		
What is the current ACC18 expiry date?		
What is their current capacity for work shown on the ACC18? ☐ FUF (fully unfit for work) ☐ FFSW (fit for some work) ☐ Fully fit		
Is the client currently working?	☐ Yes	☐ No
Fill in this section if the client is currently working.		
What is their role?	How many hours do they work?	
Are they self-employed?	☐ Yes	☐ No
If no, who is their current employer?		
Are they receiving abatement?	☐ Yes	☐ No
How do we find out what they earn? ☐ payslips ☐ ACC38s ☐ other (specify):		
Fill in this section if the client is FFSW.		
Have we approached the current employer about light or alternative duties or Return to Work (RTW) on a work trial basis?	☐ Yes	☐ No
If yes, what was the employer's response?		
If work is available, has a current workplace assessment been carried out?	☐ Yes	☐ No
Is active or monitored job search happening?	☐ Yes	☐ No
Fill in this section if the client is not currently working.		
List the barriers that are preventing them from returning to either part-time or full time work, eg medical, motivation, psychosocial factors:		
What skills, experience and strengths does the client have that will help them return to work?		
Does any outstanding vocational rehabilitation need to be offered or completed?	☐ Yes	☐ No
If yes, put the details here:		

4. Medical status		
Has a Medical Case Review (MCR) been completed?	☐ Yes - Date:	☐ No
Has there been a specialist medical review or assessment in the last 2 years?	☐ Yes	☐ No
What were the recommendations for future treatment and/or interventions from the medical report?		
Have all the recommendations been completed?	☐ Yes	☐ No
If no, why not?		

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Have both an Initial Occupational and Initial Medical Assessment (IOA and IMA) been completed?	☐ Yes - Date	☐ No
Are the work type options included in the Individual Rehabilitation Plan (IRP)?	☐ Yes	☐ No
Are any of the IMA job options medically sustainable?	☐ Yes	☐ No
If yes, list here:		
Has the client had any surgery?	☐ Yes	☐ No
If yes, put the details here, eg type of surgery and date(s):		
Is any surgery pending?	☐ Yes	☐ No
If yes, put the details here, eg type of surgery and date scheduled:		
Are any assessment reports or diagnostic tests pending?	☐ Yes	☐ No
If yes, put the details here:		
Are there any barriers to rehabilitation, eg pain, drugs and alcohol, literacy, other psycho/social impairment, other?	☐ Yes	☐ No
If yes, put the details here:		
If pain is a barrier to returning to work, has a pain programme been:		
• offered or discussed with the GP?	☐ Yes	☐ No
• completed?	☐ Yes	☐ No
Are there other injury related issues that need to be addressed before or at the same time as vocational rehabilitation?	☐ Yes	☐ No
If yes, put the details here:		
Please note anything that the new case manager should be aware of if it's not mentioned above, eg known information on the client's rehabilitation or other useful comments about the client:		

5. Overseas claims

Fill in this section if you're transferring the claim to the Overseas Claims Unit (OCU).

Is the client: ☐ living overseas already ☐ intending to move overseas?

Address: [Client address line 1 auto], [Client address line 2 auto], [Client address line 3 auto], [Client address postcode auto]

Mailing address (if different from above):

Home phone number:	Cell phone number:

What are the best times to contact the client by phone?

When did they leave or when do they plan to leave New Zealand?

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Have they been or will they be out of New Zealand for more than 3 months?	☐ Yes	☐ No
Has the client's tax code been confirmed, eg 'DTA' if moving to Australia?	☐ Yes	☐ No
Has the overseas case manager confirmed and explained the client's tax obligations?	☐ Yes	☐ No

Tick the forms that are on the client's claim file:

- ☐ ACC165 Declaration of rights and responsibilities
- ☐ ACC167 Authority for the collection and disclosure of information
- ☐ ACC6300 Authority to collect medical and other records
- ☐ ACC174 Declaration of responsibilities
- ☐ ACC210 Change of bank account or address
- ☐ ACC1584 Client identification register
- ☐ ACC2132 Bank tax declaration

6. Summary

What are the next steps needed for the client's rehabilitation?

1:

2:

3:

4:

5:

6:

7. Your name and signature

Case manager/team manager name: [Staff member auto]

Signature:	Date:

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