Workers Compensation
independent review office

Application for ILARS Grant

TO APPLY FOR AN ILARS GRANT, PLEASE COMPLETE THIS FORM AND EMAIL TO WIRO AT ilarscontact@wiro.nsw.gov.au AS A PDF.
PLEASE DO NOT SEND HARD COPY MATERIAL TO WIRO.

Please print and fill out or type the details onto the application
To select a response, double click on a check box and select "Checked" under "Default value" then click "OK"

APPLICANT INFORMATION

1. Worker Details			
Title			
Given name(s)			
Surname			
Address line 1			
Address line 2			
Gender	Male ☐ Female ☐	Date of Birth	
Occupation at time of injury			
To your knowledge has the worker had a previous ILARS grant?	Y ☐ - Please provide Reference N ☐ - Continue with Application	Previous ILARS Reference:	

2. Solicitor Details		
Solicitor Name		
ILARS no.		
Firm		
Email		

RESPONDENT INFORMATION

3. Employer Details	
Employer name	
Industry	

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4. Insurer Details		
Insurer name		
Email		Phone:
Case Manager		

CLAIM INFORMATION

1. Details of claim		
(a) Date of injury:	(b) Date of claim:[1]	(c) Claim number

2. Details of the injury – What is the injury and how was it sustained?

3. Has liability been denied for this claim?
☐ Y - If so please provide a copy of the Section 74 Notice. ☐ N

ABOUT YOUR APPLICATION

1. What is the nature of the claim or dispute (tick any or all that apply):	
(a) ☐ Permanent impairment (Questions 5 and 6)	
(b) ☐ Weekly payments (Question 7)	
(c) ☐ Medical treatment / Home modifications / Domestic assistance (Question 8)	
(d) ☐ Commutation	
(e) ☐ Death Benefit	Beneficiary Name:

[1] For hearing loss the date of injury is the last day worked at the last noisy employer **OR** the date that the claim is made.

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(f) ☐ Other

2. Why do you say there is an arguable case? **If you wish to challenge a Section 74 notice, what is the basis of this challenge?** **OR** **If you wish to investigate a claim not yet put to the insurer, what is the potential claim?**

3. Provide details of the specific items or disbursements for which you are seeking funding. If you are seeking reports or clinical notes from treatment providers, please name each provider and his or her specialty.

Disbursement	**Number and type**
Medical Report(s) (Please indicate complexity)	
Clinical Notes	
Interpreter(s)	
Other - please provide details:	

4. For hearing loss claims please provide work history and details of noisy employment. If your client is not presently in noisy employment, please provide details of their activities since ceasing noisy employment.[2]

Period	**Occupation**	**Type of noise exposure and frequency**	**Employer**

[2] For hearing loss matters with a deemed date of injury prior to 1 January 2002, please attach proof of employment eg) pay-slip, group certificate/payment summary. Where no documentation is available please attach a statement from the worker.

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5. Please provide details of any previous lump sum claims for permanent impairment.			
Date	**Type of Injury**	**Insurer and claim number if known**	**Details of Claim (including previous percentage of impairment)**

6. Permanent Impairment (Complete only if you are proposing to investigate/claim this type of benefit)

(a) Please indicate the last date of treatment and the nature of the treatment:

Date	Nature of Treatment

(b) Please provide dates and brief details of surgical procedures relevant to this claim:

Date	Details

(c) Please attach the following documents: ***(please ensure that only the documents referred to in your submissions are attached to this application)***

☐ Evidence of whether liability is accepted or declined i.e. an email, Section 74 notice, statement from the solicitor

☐ Any documentation received from the insurer organising a medical

7. Weekly payments (Complete only if you are proposing to investigate/claim this type of benefit)

(a) Was the worker an existing recipient of weekly benefits immediately prior to 1 October 2012 AND has been given notice of a work capacity decision.

Yes ☐ - Please provide a copy of the Work Capacity Decision

No ☐ - Continue with your application

(b) Was the worker in receipt of weekly compensation as at 1 September 2015?

Yes ☐

No ☐

(c) At the time of this application, how many weeks of weekly benefits has the worker received since payments

commenced?

(d) Please set out the amount and period of weekly benefits in dispute in the table below:

Period from	Period to	Pre-injury average weekly earnings	Ability to earn and/or current earnings

8. Medical treatment / Home modifications / Domestic assistance (Complete only if you are proposing to investigate/claim this type of benefit)

(a) Please provide details of the nature of medical treatment, or proposed treatment, and/or domestic assistance:

(b) Please indicate the estimated cost of treatment:

(c) Please attach a copy of the treatment recommendation or referral from the worker's GP or specialist

(d) Please advise if your client is receiving weekly payments or when they last received weekly payments.

(e) Has your client ever been precluded by Section 59A of the Workers Compensation Act 1987 from claiming medical treatment expenses?

(f) Has your client's permanent impairment for this injury ever been assessed by an Approved Medical Specialist resulting in a Medical Assessment Certificate? If so please provide a copy of the Certificate.

9. If you are applying for funding to proceed directly to the WCC, please provide details of:

a) Preliminary investigations and attempted dispute resolution undertaken on behalf of your client to date. NOTE – funding may not be granted to proceed to the Commission where informal dispute resolution has not been attempted; and
b) A statement about why you believe your client has an arguable case before the Commission
c) An estimate of the value of the claim should it succeed at the Commission.

a)

b)

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c)

The following should be provided if they are available:

☐ Claim form

☐ Insurer Investigation (IME)

☐ S74 Notice

☐ S54 Notice

☐ Work Capacity Decision (S43)

☐ Certificate of Capacity

☐ If this is a psychological injury - statement from the worker addressing the issues involved in the claim

☐ Medical Assessment Certificate(s)

☐ For hearing loss matters – a copy of a recent audiogram

☐ For hearing loss matters with a deemed date of injury prior to 1 January 2002 – proof of employment (eg – payslip, tax return or statement from worker)

The following may be provided:

☐ Relevant medical reports

☐ Relevant correspondence (For psychological injuries please provide a brief history from the worker

10. Please attach any documentation you have in support of your application for funding
a)
b)
c)

CONSENT AND DECLARATION

I certify that:

1. I have advised my client of the purpose of providing information to WIRO and that WIRO may use this information to attempt to resolve the dispute;
2. My client has consented to the release of this information; and
3. The contents of this document are true and correct and I am not aware of any other relevant material in relation to this application for an ILARS Grant.
4. I certify that I have advised the applicant worker that this is the only claim for lump sum compensation for any permanent impairment arising from the work injury that he or she will ever be able to make and no further claim may be made if the current condition deteriorates in the future.

ALSP Signature Name Date

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Please note that unsigned applications **will not** be processed.