Alberta AlbertaWorks

Medical Information

Income Support

Alberta Human Services (HS) is collecting this personal information to determine and verify your eligibility for Income Support. The collection, use and disclosure of your personal information are done under the authority of the *Income and Employment Supports Act* and in compliance with the *Freedom of Information and Protection of Privacy Act*. If you have any questions about this, please contact your worker.

Section 1 - Name of Client - Please PRINT Clearly

Last Name | First Name | Birth date (year / month / day)

Mailing Address

Health problem(s): As reported by client or worker comments:

Section 2 - Authority to Release Information - Completed by Client

I, First Name | Last Name

of Address

in the Province of Alberta give permission to any physician/nurse practitioner to disclose my individually identifying health information to the HS Worker named below in Section 3. I am aware that the release of information about my health and the medical opinion of the physician/nurse practitioner will be used to determine my ability to participate in employment, pre-employment, training and/or rehabilitation services. I have been made aware of the risks and benefits of consenting or refusing to consent to this disclosure and understand that my consent can be revoked at any time.

X

Client Signature

Date (year / month / day)

Section 3 - Important Message to the Physician/Nurse Practitioner

1. The person named above authorizes disclosure of medical information to Alberta Human Services (HS). It will be used in connection with administration of Income Support benefits and may be provided to the client.
2. The physician/nurse practitioner may be contacted to provide additional medical information.
3. The information in this report is not the only factor determining the client's availability for employment, pre-employment, training and/or rehabilitation services.
4. Physicians can receive a basic fee for completing this report. If it is necessary to examine the client specifically for this report, the physician may also charge the Alberta Health (AH) rate for comprehensive examination (AH Schedule of Medical Benefits section 03.04A).
5. **Payment will be made to the physician upon receipt of the attached original invoice and satisfactory completion of the Medical Information. Mail the invoice and report to the HS Service Centre address below.**

Service Centre Address (stamp or print)
Ensure postal code is included.

HS Worker Name (please print)

Unit/Caseload

Date Medical Information Requested (year / month / day)

Phone Number

Office use only

Client PID | Spouse/Partner PID | Service Centre Location | File Number

Section 4 - Medical Assessment

Please attach additional sheets if you have more information to submit.

Diagnosis

Primary Health Problem (specify) ☐ Severe ☐ Moderate ☐ Mild Date of Onset year month day

Secondary Health Problem (specify) ☐ Severe ☐ Moderate ☐ Mild Date of Onset year month day

Additional Health Problems (specify) ☐ Severe ☐ Moderate ☐ Mild Date of Onset year month day

With treatment, will the condition(s) ☐ Worsen ☐ Remain the same ☐ Improve ☐ Unpredictable

Is substance abuse a factor in the patient's health problem? ☐ Yes ☐ No

If yes, describe the problem and type of treatments (e.g. medication, psychotherapy)

Special Diet, specify type:

Prognosis

Duration of medical condition(s)

☐ Permanent ☐ Temporary ➔ (estimate duration)

☐ Cannot predict/ uncertain ☐ Episodic ➔ (explain)

How often is this patient required to access medical services per month? (e.g. medical appointments, physiotherapy, testing, counselling, etc.)

Number of times per month | Number of months

Client will be released from the hospital on year month day

What type of treatment (e.g. medication, physiotherapy, psychotherapy) is being recommended?

Is this patient following the recommended treatment? ☐ Yes ☐ No

If no, explain

Abilities

Is the patient currently able to undertake:

Physically demanding work:	*(lifting up to 45.5 kg., carrying up to 23 kg., etc.)*	☐ full time	☐ part time	☐ not at all
Medium work:	*(lifting up to 23 kg., carrying up to 9 kg., etc.)*	☐ full time	☐ part time	☐ not at all
Sedentary/Light work:	*(lifting up to 4.5 - 9 kg., carrying up to 4.5 kg., etc.)*	☐ full time	☐ part time	☐ not at all

Limitations

Identify possible limitations to employment, pre-employment, training, and/or rehabilitation services caused by the medical condition or the treatment:

Vision	☐ None	☐ Mild	☐ Severe
Hearing	☐ None	☐ Mild	☐ Severe
Memory	☐ None	☐ Mild	☐ Severe
Comprehension	☐ None	☐ Mild	☐ Severe
Speech	☐ None	☐ Mild	☐ Severe
Walking	☐ None	☐ Mild	☐ Severe
Standing	☐ None	☐ Mild	☐ Severe

Bending (knees, wrists, elbows, fingers)	☐ None	☐ Mild	☐ Severe
Use of Stairs	☐ None	☐ Mild	☐ Severe
Sitting	☐ None	☐ Mild	☐ Severe

If limitations, explain

Please attach additional sheets if more room required

Diagnosis

Medically fit for employment now ☐ Yes ☐ No

If no, expected date to return to work or date of reassessment year month day

Permanently unable to work ☐ Yes ☐ No

Medically able to attend training or rehabilitative program (e.g pre-employment program) ☐ Yes ☐ No If, yes: ☐ Full Time ☐ Part Time

Section 5 - Certification of Examining Medical Professional

I,

(Print name)

Specialization

(e.g. General Practice, Internal Medicine, Nurse Practitioner)

I have examined the patient and this report contains my findings and opinions at this time. I have known this patient for:

☐ 6 months or less **OR** ☐ over 6 months

X

Signature

Date year month day

Address (stamp or print) *Ensure postal code is included.*

Phone Number

Medical Information and attached Physician's Invoice to be mailed within 30 days of medical appointment.

Alberta AlbertaWorks

Physician's Invoice

Income Support

Invoice Date (year / month / day)

Physician's Office Invoice Number

Section 1 - Client Services Provided

Client Name

Date of Service (year / month / day)

Please indicate services provided:

	Form completion fee $25	$
	Medical exam amount as per fee schedule 03.04A	$
	TOTAL	$

Section 2 - Payee Information

Physician's Name

Mailing Address

Mailing Address

Phone Number

IF SUBMITTING YOUR OWN INVOICE, PLEASE ENSURE ALL THE ABOVE INFORMATION IS INCLUDED AND ATTACHED TO THIS FORM

Section 3 - For HS Office Use Only

Client File Number

Period of Assistance: (year / month / day)

Amount Requested

Need Code **1909**

Client Type

Head of Household

X

Worker Signature

Date (year / month / day)

Upon completion of this section, detach from Medical Information and forward to the Expenditure Officer for signature

X

Expenditure Officer Signature

Date (year / month / day)