Family Investment Administration Medical Report Form 500

_____Department of Social Services

The Family Investment Administration is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 1-800-332-6347.

Local District Office: _____ Date: _____

Case Manager: _____ Phone Number: _____

Customer's Name: _____ Customer ID#: _____

The information provided on this form may be used to determine eligibility for federal and State programs and participation in employment or training programs.

A. Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

B. **Date/s of Examinations**: First Visit:_____ Last Visit: _____

Presenting Symptoms:_____

Health Provider: Our goal is to help families gain the skills and knowledge needed to become self sufficient and independent of cash assistance programs. In terms of your patient's ability to perform work, attend training or attend an educational activity with a reasonable accommodation for any impairment, during an 8-hour day the patient can:

Activity	Unknown	No Restrictions	Never	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 hrs
Sit											
Stand											
Walk											
Climb											
Bend											
Squat											
Reach											

Does this individual have a substance abuse issue? ☐ YES ☐ NO
If yes, do other medical conditions exist in addition to substance abuse? ☐ YES ☐ NO

Does this individual have a **visual impairment or disease** that limits or interferes with his or her ability? to function independently, appropriately and effectively on a continuous basis? ☐ YES ☐ NO

C. **Mental/Emotional Health Status:**

Does this individual suffer from a mental illness? ☐ YES ☐ NO Is the mental illness severe enough to prevent the patient from working, participating in a work, training or educational activity. ☐ YES ☐ NO

To the best of your knowledge does the individual have any learning disabilities? □YES □ NO

To the best of your knowledge, does the individual exhibit any violent behaviors? □YES □ NO
If **yes**, please provide additional information at the end of this form.

Is this patient disabled or impaired and unable to work? □YES □ NO

Can the individual's impairment be expected to last at least 12 months or more? □YES □ NO

Please give the length of time the patient's impairment is expected to last.

_____/_____/_____ to _____/_____/_____
Month Day Year Month Day Year

If less than a 12 month impairment, is the individual's medical condition expected to result in death?
□ YES □ NO

Parent with a disabled child: If this medical form is being completed for a child, does the child's condition require the parent to be in the home full time to provide care for the child? □ YES □ NO

Health Provider:

Please indicate below if this individual has other limitations not previously covered that would prevent the individual from working or participating in a work, training or educational activity

Please add comments or clarifications here.

Signature of a health care provider with independent diagnostic authority, who is authorized to evaluate, determine impairment, and independently treat medical, mental and/or emotional disorders and conditions, and who is providing services according to the requirements of the appropriate professional board.

Signature:_____ Print Name:_____

Title:_____ License #:_____

Health Care Practice Name and Address: _____

Date: _____Phone #_____