Commonwealth of Virginia
Department of Social Services
Temporary Assistance for Needy Families (TANF)
Virginia Initiative for Employment not Welfare (VIEW)
SNAP Employment and Training (SNAPET)

Case Name

Case Number

MEDICAL EVALUATION

It is our goal to assist the individual named below in becoming economically self-sufficient. This person states that he/she is unable to participate in employment and training activities. Please give careful consideration in completing this medical evaluation. The information that you provide will be used to determine program activities that this individual may be able to perform, even if there are some limitations.

Patient's Name

Address

Phone # **Birthdate / /**

Agency Name

Address

Agency Contact

Phone #

ABILITY TO PARTICIPATE IN EMPLOYMENT AND TRAINING ACTIVITIES:

1. Date of examination on which this medical evaluation is based: / / (Examination must have been conducted within the last 90 days).

2. In terms of participating in employment and training activities and the patient's current health issue(s), check that which is *MOST* applicable at this time.

A. ☐ Able to participate in employment and training activities without limitations or modifications

↓

Skip the remaining questions and sign at the bottom of page 2.

B. ☐ Able to participate in employment and training activities at least **10** hours per week with limitations and/or modifications as needed

↓

Anticipated duration of limitation or need for modification (Check one)

↓

☐ Less than 30 days
☐ 31 – 60 days
☐ More than 60 days. Specify duration:_____

☐ Do you recommend that this patient apply for SSI or SSA disability at this time?
Yes ☐ No ☐

↓

Skip to question 3 and continue through the signature section on page 2

C. ☐ Unable to participate in employment and training activities in any capacity at this time

↓

Anticipated duration of incapacity. (Check one)

↓

☐ Less than 30 days
☐ 31 – 60 days
☐ More than 60 days. Specify duration:_____

☐ Do you recommend that this patient apply for SSI or SSA disability at this time?
Yes ☐ No ☐

↓

Skip to question 4 and continue through the signature section on page 2

(OVER) →

3. Please check the total number of hours per week that the patient can participate in employment and training activities.
   Circle one: ☐10 ☐15 ☐20 ☐25 ☐30 ☐35

4. In your professional opinion, and based on your medical knowledge of the patient's condition, list any limitations that would affect the patient's ability to participate in employment and training activities.

   ☐ Physical Limitations:

   ☐ Psychiatric Limitations:

   ☐ Other Limitations Not Listed Above:

DIAGNOSIS AND TREATMENT:

5. Please indicate the primary medical reason for the patient's inability to participate, or to participate with modifications and/or limitations, in employment and training activities in the "primary diagnosis" space below.

   Primary Diagnosis:

   If other medical issues contribute to the patient's inability to participate, or to participate with modifications and/or limitations, in employment and training activities, please record those in "secondary diagnosis" space below.

   Secondary Diagnosis:

6. Would reviewing this form jeopardize the patient's health or well-being? ☐ Yes ☐ No

COMPLIANCE:

7. If physical therapy, counseling, medication or other treatments were prescribed, is the patient complying? ☐ Yes ☐ No ☐ Don't know
8. If patient is not complying with recommendations, are you aware of the reason for not complying? ☐ Yes ☐ No ☐ Don't know
9. Does the patient's condition hinder his/her ability to care for his/her children? ☐ Yes ☐ No

REFERRALS:

10. Does the patient require additional evaluation and/or assessment to determine current and/or future functioning?
    ☐ Yes ☐ No

    If yes, by whom:

    Field or area of expertise

    Date Referred:

SIGNATURE:

This form may be signed **only** by a medical doctor, including a psychiatrist, a doctor of osteopathy, or by a physician's assistant or nurse practitioner working in the practice of a medical doctor or doctor of osteopathy.

Signature _____ Office telephone number: _____
(Physician or Nurse Practitioner or, Physician's Assistant)

Name _____ Date form was completed: _____
(Please print)

Office Address_____