Medical Examination for Employability and ABAWD Determination

Department of Social Services

Division of Family Independence| TA and CED

B-5724TA (4/2020)

Worker Name	Address	Phone Number	Fax Number

All changes in medical status affecting employability must be reported and documented timely.

CLIENT IDENTIFICATION

Client Name		Veteran ☐ Yes ☐ No
Address	City	Zip Code
Case Number	CIN	DOB
Reason(s) for Referral		

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining health care practitioner to disclose to the Department of Social Services any information provided, any diagnoses made, conditions revealed, functional limitations and any prognoses identified, as a result of the examination given. I understand that this information will be treated as confidential.

Client Signature	Date

MEDICAL INFORMATION

List all medical conditions. Include psychiatric and alcohol/drug addiction diagnosis using DSM-IV format. (List all medical diagnoses and specify medical/clinical findings, including prognoses and how long each condition is expected to last.)

Medical Condition	Prognosis and Treatment Recommendations including prescribed medications	Date of original diagnosis/diagnosis type	Expected Duration From Present (Months)
		☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐ 1-3 ☐ 4-6 ☐ 7-11 ☐ 12+ ☐ Permanent
		☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐ 1-3 ☐ 4-6 ☐ 7-11 ☐ 12+ ☐ Permanent
		☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐ 1-3 ☐ 4-6 ☐ 7-11 ☐ 12+ ☐ Permanent
		☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐ 1-3 ☐ 4-6 ☐ 7-11 ☐ 12+ ☐ Permanent

FUNCTIONAL LIMITATIONS (related to medical findings previously noted)

Physical Functioning	No Evidence of Limitations	Moderately Limited	Very Limited
Walking	☐	☐	☐
Standing	☐	☐	☐
Lifting, Carrying	☐	☐	☐
Pushing, Pulling, Bending	☐	☐	☐
Seeing, Hearing, Speaking	☐	☐	☐
Using Hands	☐	☐	☐
Stairs or other climbing	☐	☐	☐
Other: ____________________	☐	☐	☐

Mental Functioning	No Evidence of Limitations	Moderately Limited	Very Limited
Understands and remembers instructions	☐	☐	☐
Carries out instructions	☐	☐	☐
Maintains attention/concentration	☐	☐	☐
Makes simple decisions	☐	☐	☐
Interacts appropriately with others	☐	☐	☐
Maintains socially appropriate behavior without exhibiting behavior extremes	☐	☐	☐
Maintains basic standards of personal hygiene and grooming	☐	☐	☐
Other: _____	☐	☐	☐

TREATMENT HISTORY (list for medical, psychiatric, alcoholism and drug treatment for the past two years)

Name of Program/Provider	Type of Program/Provider i.e. Outpatient, Residential, Methadone (for addiction specify modality)	Length of Treatment (# of Months)

CURRENT TREATMENT PROGRAM IDENTIFICATION (include medical, psychiatric, alcoholism and drug treatment as applicable)

Program Name

Address of Client's Treatment Site

Mailing Address (if different than above)

Treatment Program Contact	Title
Telephone Number	Fax Number

LIMITATIONS ON WORK ACTIVITIES

Taking into consideration physical, mental and addiction limitation(s), describe any working conditions, environments, or work activities which are contraindicated: _____

If the individual has limitations due to a physical or mental health condition, do these limitations preclude the individual from working in competitive employment for at least 80 hours per month? _____

Are these restrictions expected to last:

☐ 1-3 months ☐ 4-6 months ☐ 7-11 months ☐ 12+ months ☐ permanent

Do you recommend referral to rehabilitation, including but not limited to, a mental health or alcohol/substance abuse, or a physical rehabilitation program? ☐ Yes ☐ No If yes, please specify _____

SCREENING FOR POSSIBLE SSI REFERRAL

Based on the evidence available to you, does this individual have severe impairment(s) which has lasted, or is expected to last at least 12 months? ☐ Yes ☐ No If yes, please explain: _____

If substance abuse is also found, would such impairment be expected to continue if use of drugs and/or alcohol were to cease? ☐ Yes ☐ No

HEALTH CARE PRACTITIONER'S INFORMATION

Health Care Practitioner's Name (please print)	Medical Position

Address

If a physician, Board eligible or Board-certified specialty	Telephone #	Fax #

Is this patient of the examining health care practitioner? ☐ Yes ☐ No If yes, how long?

Last date of Examination	Signature pf health care practitioner	Date