



## Documentation Request for Medical or Disability Condition

Dear Health Care Provider:

\_\_\_\_\_ (name of client) told us that a medical, mental or emotional condition prevents or limits participation in WorkFirst activities that could include job search, job preparation, education classes, training, or working.

Please complete the enclosed form to describe these limitations. In addition, if a condition is expected to last longer than 3 months, please also provide copies of current chart notes.

We will use this information to determine the level of participation up to 40 hours per week, in job search, job preparation, educational classes, training, or working.

**Please provide the information by \_\_\_\_\_ (deadline date). If we don't receive any information from you, we may require full-time participation, up to 40 hours a week, in the types of activities described above.**

If you have any questions or need more time to send us the information, please call me at \_\_\_\_\_ (number of worker).

Thank you,

\_\_\_\_\_  
Worker's Name



WORKFIRST

# Documentation Request for Medical or Disability Condition

CLIENT NAME	DATE OF BIRTH	CLIENT IDENTIFICATION NUMBER
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WORKFIRST STAFF NAME	TELEPHONE NUMBER
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COMMUNITY SERVICES OFFICE (CSO) ADDRESS

To help the department determine the limitation(s) of the above-named individual, please provide the following information:

1. Does this person have specific physical, mental, emotional, or developmental issues that require special accommodations or considerations?  Yes  No If yes, what is the type of condition(s) or diagnosis:

Is this supported by testing, lab reports, etc.?  Yes  No If yes, attach and send documents.

2. Does the condition(s) limit the person's ability to work (such as lift heavy objects, stand or sit for long periods of time, follow instructions, bend over, reach above, concentrate for extended periods of time, repetitive motions, interact with people, or exposure to chemicals, synthetic materials)?  Yes  No

If yes, describe any specific limitations:

If yes, this person should be limited to the following time limits per week:

0 hrs (unable to participate)  1 – 10 hrs  11 – 20 hrs  21 – 30 hrs  31 – 40 hrs.

3. Does the condition(s) limit the person's ability to participate in activities related to preparing for and looking for work (such as attend educational or vocational classes which may involve sitting for extended periods of time, complete job applications which may involve memory retention, reading or writing, and information gathering, making and keeping appointments, using transportation, standing in line, participating in interviews, following a written employability plan, or advocating for him/herself)?  Yes  No

If yes, describe how:

If yes, this person should be limited to the following time limits per week:

0 hrs (unable to participate)  1 – 10 hrs  11 – 20 hrs  21 – 30 hrs  31 – 40 hrs.

4. Does this person have any limitations with lifting and carrying?  Yes  No

If yes, this person has the following limitations:

Severely limited: Unable to lift at least 2 pounds or unable to stand or walk.

Sedentary work: Able to lift 10 pounds maximum and frequently\* lift or carry such articles as files and small tools. A sedentary job may require sitting, walking and standing for brief periods.

Light work: Able to lift 20 pounds maximum and frequently\* lift or carry up to 10 pounds. Even though the weight lifted may be negligible, light work may require walking or standing up to 6 out of 8 hours per day, or involve sitting most of the time with occasional pushing and pulling of arm or leg controls. Occasional means the person is able to perform the function from very little up to 2.5 hours in an 8-hour day. It isn't necessary that performance be continuous.

Medium work: Able to lift 50 pounds maximum and frequently\* lift or carry up to 25 pounds.

Heavy work: Able to lift 100 pounds maximum and frequently lift or carry up to 50 pounds.

\* Frequently means the person is able to perform the function for 2.5 to 6 hours in an 8-hour day. It isn't necessary that performance be continuous.

5. Does this person's condition(s) impact their ability to access services (such as using the telephone, receiving treatment, making and keeping appointments, using transportation services, or finding locations of services)?

Yes  No

If yes, describe:

6. How long will this person's condition likely limit their ability to work, look for work, or train to work?

\_\_\_\_\_ Number of weeks    \_\_\_\_\_ Number of months    \_\_\_\_\_ This is a permanent condition.

7. Is there a specific treatment plan you made to address this person's health-related condition or disability?

Yes  No

If yes, describe the treatment plan.

8. Are there specific issues that need further evaluation or assessment?  Yes  No

If yes, please describe what type of assessment or evaluation and to what type of specialist this person should be referred.

MEDICAL/MENTAL HEALTH CARE PROVIDER/OTHER PROFESSIONAL		
SIGNATURE	DATE	TELEPHONE NUMBER
PRINTED NAME		
MAILING ADDRESS	CITY	STATE ZIP CODE <b>WA</b>
AUTHORIZATION TO RELEASE INFORMATION		
<p>I authorize _____ to release to the Department of Social and Health Services the information on this form and any medical record information that substantiates the illness/injury condition that prevents me from working, solely to evaluate my capacity to participate in the WorkFirst Program. I understand that this release specifically includes diagnostic testing or treatment information concerning mental health, alcohol or drug abuse and the result of Sexually Transmitted Diseases (STD), including HIV/AIDS, when such information is part of the record. (Revised Code of Washington (RCW) 78.24.105)</p>		
PATIENT'S SIGNATURE		DATE

### INSTRUCTIONS

**DSHS WorkFirst Case Manager/Social Worker:** The purpose of this form is to assist you in developing an Individual Responsibility Plan when, as a result of a condition or disability, there is an impact on the person's ability to work, look for work, attend training and/or access services. **Use of this form is NOT mandatory if other documentation exists.** You may give this form to the applicant/recipient to take to the appropriate professional service provider for completion or you may mail this directly to the provider. If you choose to mail this form, obtain the client's signature on the last page, and enclose a self-addressed metered envelope including your name to ensure the form will be returned to the appropriate person.

**DSHS Customer:** The purpose of this form is to gather information from a medical provider that will assist your Case Manager or Social Worker in reviewing your health issues and creating an Individual Responsibility Plan that best fits your specific needs and limitations.

**Physician/Health Care Provider:** For adult clients to get public assistance (TANF), they are required to work, actively look for work, or get training to work for 32 to 40 hours per week. Some clients may not be able to meet this requirement because of health-related issues. These clients may need to be temporarily deferred from a work activity, may be able to participate but for a limited number of hours, or may need to avoid certain types of work activities. Please complete this form and give to client or send to the WorkFirst Case Manager or Social Worker, using the enclosed envelope. Send us any notes, letters or other documentation you already have in your records that address the person's limitations.