Washington State
Department of Social
& Health Services

Documentation Request for Medical or Disability Condition

Dear Health Care Provider:

_____ (name of client) told us that they or a family member they care for has a medical, mental or emotional condition which prevents or limits the client's 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 three 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 bill DSHS, not the client, for any costs related to providing this information.

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). You may send this completed document and any chart notes to our statewide fax number at 1-888-338-7410 or mail it to DSHS, CSD – Customer Service Center, PO Box 11699, Tacoma WA 98411-6699.

Thank you,

_____
Worker's Name

Washington State Department of Social & Health Services

WORKFIRST

Documentation Request for Medical or Disability Condition

CLIENT NAME	DATE OF BIRTH	CLIENT IDENTIFICATION NUMBER
NAME OF PATIENT EVALUATED IF DIFFERENT THAN THE CLIENT NAMED ABOVE		
WORKFIRST STAFF NAME		TELEPHONE NUMBER
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 (please check the box) ☐ physical, ☐ mental, ☐ emotional, or ☐ developmental issues that require special accommodations or considerations?
   ☐ Yes ☐ No

2. If yes, what is the type of condition(s) and the diagnosis?

   Is this supported by testing, lab reports, etc.? ☐ Yes ☐ No

3. Does the physical, mental emotional, or developmental condition(s) listed above limit the person's ability to work, look for work, or prepare for work? ☐ Yes ☐ No

   Examples of limits include the ability to lift heavy objects, stand or sit for long periods of time, follow instructions, bend over, reach above, concentrate for extended periods of time, make repetitive motions, interact with people, or tolerate exposure to chemicals, synthetic materials)? Other examples include a limited ability to attend educational or vocational classes which may involve sitting for extended periods of time, completing 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.

   If yes, describe any specific limitations:

   If yes, this person should be limited to the following participation limits per week:
   ☐ 0 hrs (unable to participate) ☐ 1 – 10 hrs ☐ 11 – 20 hrs ☐ 21 – 30 hrs ☐ 31 – 40 hrs.

Barcode label

10353

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. Is this person's condition permanent and likely limit their ability to work, look for work, or train to work?
☐ Yes ☐ No; if the condition isn't permanent, how long will this person's condition likely limit their ability to work, look for work, or train to work. Please use the space below to indicate the number of weeks or months:

_____ Number of weeks, or

_____ Number of months.

7. a. 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.

b. Who will be providing and monitoring the person's ongoing 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.

9. If the patient being evaluated is different than the client named because of the impact the patient's condition has on the client's ability to participate, please complete the following.

Given the child's / adult relative's condition, check the appropriate box:

☐ The parent / caretaker can participate 0 – 10 hours per week.
☐ The parent / caretaker can participate 11 - 20 hours per week.
☐ The parent / caretaker can participate 21 - 30 hours per week.
☐ The parent / caretaker can participate more than 30 hours per week.
☐ Please contact me for further information.

How long do you expect the parent will need to provide this level of care:

Medical / Mental Health Care Provider / Other Professional

SIGNATURE	DATE	TELEPHONE NUMBER
PRINTED NAME AND TITLE		
MAILING ADDRESS	CITY	STATE ZIP CODE **WA**

ការផ្តល់សិទ្ធិអនុញ្ញាតឲ្យបើកបញ្ចេញព័ត៌មាន (Authorization to Release Information)

ខ្ញុំសូមផ្តល់សិទ្ធិអនុញ្ញាតដល់ _____ ដើម្បីបើកបញ្ចេញ ជូនក្រសួងសេវាសង្គមកិច្ច និងសុខាភិបាល (Department of Social and Health Services) នូវព័ត៌មានលើទម្រង់នេះ ព្រមទាំងព័ត៌មានក្នុងបញ្ជីសំណុំរឿងផ្សេងៗទៀតរបស់ខ្ញុំ ដែលចង្អុលបង្ហាញ ភ័ស្តុតាងស្តីអំពីស្ថានភាពនៃជម្ងឺ/រុគ្រាះថ្នាក់របួសស្នាម ដែលកំពុងរារាំងរូបខ្ញុំពីការប្រកបការងារ ដើម្បីឲ្យគេវាយតម្លៃមើលសមត្ថភាពរបស់ខ្ញុំក្នុងការចូលរួមក្នុង កម្មវិធី WorkFirst Program នេះទាំងស្រុង។ ខ្ញុំយល់ថា ការបើកបញ្ចេញព័ត៌មាននេះគឺសរុបមានទូវព័ត៌មានស្តីអំពីការធ្វើតេស្តរោគវិនិច្ឆ័យ ឬការព្យាបាល ជម្ងឺផ្លូវសតិ, ជម្ងឺញៀនគ្រឿងស្រវឹង ឬថ្នាំញៀន ហើយនិងលទ្ធផលនៃការរកឃើញជម្ងឺឆ្លងតាមផ្លូវភេទ (Sexually Transmitted Diseases – STD), ដោយសរុបមានដូចជាជម្ងឺ HIV/AIDS ជាដើម, នៅពេលណាព័ត៌មានប្រភេទនេះមានផ្ទុកនៅក្នុងបញ្ជីសំណុំរឿងរបស់ខ្ញុំ។ (ក្រមកំណែនៃរដ្ឋវ៉ាស៊ីនតោន (RCW) 78.24.105)

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)

ហត្ថលេខារបស់អ្នកជម្ងឺ (PATIENT'S SIGNATURE)	日期 (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, send it to our statewide fax number 1-888-338-7410, or send to the WorkFirst Case Manager or Social Worker at DSHS, CSD – Customer Service Center, PO Box 11699, Tacoma WA 98411-6699. Send us any notes, letters or other documentation you already have in your records that address the person's limitations.