ONEIDA COUNTY
HUMAN SERVICES
Better Together

MEDICAL STATUS & ABILITY TO WORK REPORT

Patient Name: _________________________________ Date of Birth: _________________

To Medical Provider: *This report is part of an on-going child support case and is being used to assess the patient's ability to work and to contribute to the financial support of his/her child(ren).*

1. Patient occupation and essential work duties affected by patient's health:
____

2. What is/are the diagnosed condition(s) which affects the patient's ability to work?
____
Is this condition likely to be: ☐ temporary (lasting less than 12 months) or ☐ permanent?

3. What are the symptoms of the diagnosed condition(s) which affects the patient's ability to work?
____
____
____
Are these symptoms likely to be: ☐ temporary (lasting less than 12 months) or ☐ permanent?

4. What are the physical or mental impairments for this condition and symptoms which affect the patient's ability to work?
____
____

5. What is the medical prognosis for the patient?
____
____

6. What is the treatment the patient is to follow?
____
____

7. Is the patient complying with recommended treatment?

☐ YES ☐ NO If "No", what is the patient failing to do?

____

____

8. In your medical opinion, is the patient currently able to work?

☐ YES (no limitations) ☐ YES, but with limitations ☐ NO

If the answer is "Yes, but with limitations" or "No", please:

A. Describe any work restrictions: including but not limited to: duties, hours, physical/psychological limitations, impact of medications, treatment, recovery or rehabilitation.

____

____

B. Specify the expected duration of the limitation or inability to work:

_________ weeks _________ months OR ☐ unknown OR ☐ permanent

9. State the most recent date of examination or treatment:

____

10. State the next scheduled appointment date or follow–up period:

____

11. Specify the next step in treatment:

____

____

____

REPORT COMPLETED BY:

Provider Name: _______________________________

Facility: ______________________________________

Provider Signature: _______________________________ Date: _____________________

Telephone number for confirmation and contact: __________________________________

This request for information is being made in accordance with 42 U.S.C. 654, which requires that each state use all available sources of information to locate absent parents or alleged absent parents. This information will be used solely to enforce Wisconsin child support laws. The information will not be used for commercial purposes or private gain. You are authorized to release the information by s. 49.22(2m) Wis. Stats. Please give the most recent information you have and date it was valid. Return the completed form to the Agency address above. A covered entity under the Health Insurance Portability and Accountability Act (HIPPA) may disclose protected health

information to the extent that disclosure is required by law or to an agency performing a government regulatory program [45 C.F.R. s. 164.512(a) & (d)(1)(iii)].

Authorization: I hereby authorize and direct my Provider to complete this report regarding my medical condition(s) and agree that my Provider may discuss the content of this form with the Oneida County Child Support Agency. This authorization is valid for one year or until revoked by me.

Patient's Signature: ________________________________ Date: ______________________

I, Patient, understand that the information disclosed in this document will be used by the Oneida County Child Support Agency in connection with case management activity and legal action and may be shared with the Court and other parties to the action.