STATE OF ALASKA
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC ASSISTANCE

DPA Use Only
DPA Office: _____ Date: _____
Case #: _____

DISABILITY AND VOCATIONAL REPORT

Be sure the form is complete. If you need more space for any answer, use another piece of paper. Please print clearly.

NAME: _____ **SSN:** _____

ADDRESS: _____ **PHONE:** _____

_____

I. INFORMATION ABOUT YOUR CURRENT ABILITIES

(Please answer questions by checking Yes or No)

SEDENTARY WORK ACTIVITIES	**Yes**	**No**
Are you able to sit for a continuous period of not less than (30) minutes?	☐	☐
Are you able to walk a short distance?	☐	☐
Are you able to lift ten pounds on occasion?	☐	☐

BASIC WORK ACTIVITIES	**Yes**	**No**
Are you able to follow simple instruction?	☐	☐
Are you able to respond to expected changes in a work or home environment?	☐	☐
Are you able to see, hear, and speak?	☐	☐
Are you able to employ judgment to the degree of making safe choices?	☐	☐

ACTIVITIES OF DAILY LIVING	**Yes**	**No**
Are you able to tend to your own personal hygiene?	☐	☐
Are you able to prepare a simple meal and feed yourself?	☐	☐
Are you able to utilize basic community resources, like riding the bus or placing a telephone call?	☐	☐

II. INFORMATION ABOUT TREATING SOURCES

Give name, address, and telephone number of physician(s) and of the hospital or clinic where you have received treatment for the condition(s) that disabled you. For more than four providers, make a copy of the blank page and attach.

A. _____ _____ _____

Name of Physician or clinic /hospital | Telephone number | Date first treated

_____ _____

Address | Date last treated

DPA Use Only
DPA Office: _____ Date: _____
Case #: _____

B. _____ _____ _____
Name of Physician or clinic /hospital | Telephone number | Date first treated

_____ _____
Address | Date last treated

C. _____ _____ _____
Name of Physician or clinic /hospital | Telephone number | Date first treated

_____ _____
Address | Date last treated

D. _____ _____ _____
Name of Physician or clinic /hospital | Telephone number | Date first treated

_____ _____
Address | Date last treated

Reason for Hospitalization or Outpatient Visits

_____
_____
_____
_____

Type of Treatment Received

_____
_____

E. **Have you been seen by other agencies for your disability?** **Yes** ☐ **No** ☐
(VA, Workmen's Compensation, Vocational Rehabilitation, etc.)

Name of agency: _____

Address of agency: _____ Telephone: _____

Name of counselor, examiner, etc.: _____

Approximated dates of visits: _____ Type of treatment or examination: _____

DPA Use Only
DPA Office: _____ Date: _____
Case #: _____

III. INFORMATION ABOUT YOUR PAST WORK

A. List the jobs you had in the last 15 years before you stopped working. Please start with your most recent and work backwards.

JOB TITLE	TYPE OF BUSINESS	DATES WORKED	DAYS PER WEEK	RATE OF PAY
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

B. Provide the following information for the first 3 jobs listed above.

JOB #1

Job Title: _____

In this job did you: (check yes or no)	**Yes**	**No**
Use machines, tools, or equipment of any kind?	☐	☐
Use technical knowledge or skills?	☐	☐
Do any writing, complete reports, or perform similar duties?	☐	☐
Have supervisory responsibilities?	☐	☐

Describe the basic duties of this job. **Give a full description of types of machines, tools or equipment you used; the technical knowledge and skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:**

_____

_____

_____

_____

Describe the kind and amount of physical activity this job involved during a typical day. Circle how many hours you spent each day on each activity below:

How many hours each day did you spend walking?	1 2 3 4 5 6 7 8
How many hours each day did you spend standing?	1 2 3 4 5 6 7 8
How many hours each day did you spend sitting?	1 2 3 4 5 6 7 8

Circle how often you spent each day on each activity below:

Bending	NEVER OCCASIONALLY FREQUENTLY
Reaching	NEVER OCCASIONALLY FREQUENTLY

Lifting and carrying: Describe below what kind of objects or material was lifted, how many times a day you lifted this material, and how far you carried it: _____

_____

_____

JOB #2

Job Title: _____

In this job did you: (check yes or no)	**Yes**	**No**
Use machines, tools, or equipment of any kind?	☐	☐
Use technical knowledge or skills?	☐	☐
Do any writing, complete reports, or perform similar duties?	☐	☐
Have supervisory responsibilities?	☐	☐

Describe the basic duties of this job. **Give a full description of types of machines, tools or equipment you used; the technical knowledge and skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:**

_____

_____

_____

_____

Describe the kind and amount of physical activity this job involved during a typical day. Circle how many hours you spent each day on each activity below:

How many hours each day did you spend walking?	1 2 3 4 5 6 7 8
How many hours each day did you spend standing?	1 2 3 4 5 6 7 8
How many hours each day did you spend sitting?	1 2 3 4 5 6 7 8

Circle how often you spent each day on each activity below:

Bending	NEVER OCCASIONALLY FREQUENTLY
Reaching	NEVER OCCASIONALLY FREQUENTLY

Lifting and carrying: Describe below what kind of objects or material was lifted, how many times a day you lifted this material, and how far you carried it: _____

_____

_____

JOB #3

Job Title: _____

In this job did you: (check yes or no)	**Yes**	**No**
Use machines, tools, or equipment of any kind?	☐	☐
Use technical knowledge or skills?	☐	☐
Do any writing, complete reports, or perform similar duties?	☐	☐
Have supervisory responsibilities?	☐	☐

Describe the basic duties of this job. **Give a full description of types of machines, tools or equipment you used; the technical knowledge and skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:**

_____

_____

_____

Describe the kind and amount of physical activity this job involved during a typical day. Circle how many hours you spent each day on each activity below:

How many hours each day did you spend walking?	1	2	3	4	5	6	7	8
How many hours each day did you spend standing?	1	2	3	4	5	6	7	8
How many hours each day did you spend sitting?	1	2	3	4	5	6	7	8

Circle how often you spent each day on each activity below:

Bending	NEVER	OCCASIONALLY	FREQUENTLY
Reaching	NEVER	OCCASIONALLY	FREQUENTLY

Lifting and carrying: Describe below what kind of objects or material was lifted, how many times a day you lifted this material, and how far you carried it: _____

_____

_____

IV. EDUCATION AND TRAINING

What is the highest grade of school that you completed? _____

Have you gone to trade or vocational school or had any type of special training? If so, please give type of school or training, approximate dates you attended and how this school or training was used in any work you did. _____

_____

_____

_____

DPA Use Only
DPA Office: _____ Date: _____
Case #: _____

If you do not speak or write English, or would otherwise have difficulty completing disability forms, or you would have difficulty in traveling to a medical examination, please provide us with a name, address, and phone number of someone who can assist you.

Name: _____ Phone: _____
Address: _____
_____

REMARKS: Use this section for additional space to answer any previous questions and to provide any additional information that you think will be helpful in making a decision on your application.

_____
_____
_____
_____
_____
_____
_____
_____

Please read and sign below:

I understand that this report will be used in conjunction with documenting my claim for Adult Public Assistance. I understand the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of my claim.

Signature of Adult Applicant: _____
Signature **Date (month/day/year)**

Witness if signed with an "X": _____
Signature **Date (month/day/year)**

Signature of Authorized Representative: _____
Signature **Date (month/day/year)**