Alaska Department of Health
Division of Public Assistance

Health Status Report Form

Patient Name:	Patient Social Security Number or EIS case number
Last First Middle	

Dear Health Care Professional: The Alaska Temporary Assistance Program (ATAP) provides temporary financial assistance and other supports that help adults find employment so their family can be self-sufficient. One principle of ATAP is that most people can work, if only for a few hours a week.

The person named above reports having health conditions that interfere with their ability to work. Please evaluate this person's capacity to work or to participate in other activities such as attending job readiness and job skills workshops, General Education Development (GED) classes, wellness planning, treatment, physical rehabilitation, counseling or therapy. We need this information from you to determine the extent this person's health has on their ability to work. Thank you for taking the time to complete this form.

Date of examination: _____

Medical Diagnosis/Condition _____

_____

1. Does the patient's physical or mental condition limit the patient's ability to work? ☐ Yes ☐ No

If no, stop here. If yes, please complete the following questions describing the patient's ability to work:

2. Can the patient work in some capacity full-time? ☐ Yes ☐ No **OR** part-time? ☐ Yes ☐ No

If the patient can only work part-time, please circle how many hours per day they can work?
1 2 3 4 5 6

3. Please circle how many months you expect the condition to limit the patient's ability to work?
Less than 1 1 2 3 4 5 6 7 8 9 10 11 12 12+

4. Are any accommodations needed to help this patient function effectively in a work or training environment? ☐ Yes ☐ No

If yes, what is needed:_____

5. If the patient can work, are there any limitations on what they can do, such as lifting, standing, walking, sitting, or performing repetitive activities? Please list any specific limitations below. ☐ Yes ☐ No

_____

_____

6. Can the patient participate in activities such as GED or high school completion classes, adult resume preparation workshops or other activities in classroom settings? ☐ Yes ☐ No

Patient Name_____

7. Do any of the patient's medications cause side effects that may impact their ability to participate in a work or training environment? ☐ Yes ☐ No
   If yes, please specify: _____

8. If the condition will respond to treatment, we want to support your patient's well-being by including your treatment recommendations as part of their self-sufficiency plan. Please summarize the recommended hours of treatment per week and the type of recommended activity or treatment.

_____

_____

_____

_____

9. Is the condition persistent or chronic enough that you would recommend a referral for additional diagnosis or treatment? Please check all that apply.

☐ Physical Therapy ☐ Surgical consultation ☐ Pain Management Consultation

☐ Mental Health Evaluation ☐ Functional Assessment ☐ Alcohol/Substance Assessment

☐ Anger Management ☐ Weight Loss Program ☐ Home Exercise Program

☐ Other Consultation (Please specify) _____

Name & Title of Licensed Health Care Professional Professional	Address
Signature Date	Phone

You may send a fax copy of the completed form to me at the number indicated below. If you have any questions, please call me. Thank you for your help.

_____
Division of Public Assistance Representative
Print Name

_____
Job Title

_____
Telephone

_____
Fax