

### 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

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