ONEIDA COUNTY CHILD SUPPORT AGENCY

P.O. Box 400, 1 S. Oneida Ave., Rhinelander, WI 54501

PHONE - (715) 362-5695; FAX - (715)362-7910

MEDICAL STATUS & ABILITY TO WORK REPORT

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the **diagnosis** which affects the patient’s ability to work?

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2. What are the **physical or mental impairments** which affects the patient’s ability to work?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this: temporary (lasting less than 12 months) or permanent?

3. If this is not a new patient, is the patient **complying with recommended treatment**?

YES NO If “No,” what is the patient failing to do?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(The Child Support Agency may ask the Court to order compliance.)*

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

YES: no limitations YES: with limitations NO

If the answer is “Yes: with limitations” or “No,” please:

1. Please describe any work restrictions (including but not limited to: duties, hours, physical/psychological limitations, impact of medications, treatment, recovery or rehabilitation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Specify the expected duration of the limitation or inability to work:

\_\_\_\_\_\_\_\_\_ weeks; \_\_\_\_\_\_\_\_\_ months OR unknown permanent

1. State the next scheduled appointment date or follow–up period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Specify the next step in treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To Medical Provider*: *This request is made as part of an on-going child support case to assess ability to work and to contribute to the financial support of his/her child(ren).*

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of treatment: \_\_\_\_\_\_\_\_\_\_\_

Telephone number for confirmation and contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Provider Signature Date*

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 agree that my medical 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_