Notice to Physical/Mental Health Care Provider

Attached you will find the Weld County Work Status Report (also known as a Med 9 Form). The purpose of this form is to determine if a TANF (Temporary Assistance for Needy Families) client is able to participate in a work program administrated by the Department of Social Services and contracted by Employment Services of Weld County. According to TANF law, anyone requesting cash assistance from the government with children over the age of three months is required to participate in a work program to help them to become self-supporting as part of welfare reform. Activities we assign our clients vary on a case by case basis and can range from job search to GED remediation to placement in a community service activity. All activities are designed to give our clients the tools they need for success. In addition we have a limited time to provide services to these individuals; twenty-four months to help them become work ready or obtain SSI/SSDI benefits and total of sixty months in their ***lifetime.***

The client who has provided this form to you is a participant in the TANF program. We would like to help this individual become successful in attaining the employment/life skills and work maturity they need to seek, obtain, and maintain employment. Some of our clients have physical and/or mental barriers that legitimately keep them from entering the workforce, and the Social Security process can be lengthy and difficult. We also have individuals who are temporarily unable to participate with our program because of an injury or other trauma. But many also manipulate the medical/mental health system in an attempt to keep from participating in assigned work activities. Unfortunately this only hinders them and hurts their families by preventing them from achieving something more than simply making ends meet and not taking the opportunity to transcend poverty.

As the work program is a requirement of this client receiving monetary benefits we would appreciate your cooperation in filling out this form with the aforementioned information in mind.

Thank you and have a wonderful day.

Physician/Therapist Name (*please print*):_____

Physician/Therapist Signature:_____

Contact Phone:_____ Type of Practice:_____

Address:_____

_____

Greeley Office
P. O. Box 1805
Greeley, CO 80632
FAX: 970-346-7981

Ft. Lupton Office
PO Box 1069
Ft. Lupton, CO 80621
FAX: 303-637-2436

WELD COUNTY COLORADO WORK STATUS REPORT (MED 9)

Please fill out all fields in their entirety so we have a clear picture of the client's medical/mental health

Requested by: _____ _____ _____**Phone:** _____

Client's Name: _____ _____ **Date:** _____
Patient's Name (*If different from above*): _____
Is the Client needed in the home to take care of Patient? Yes ☐ No ☐

PART ONE: DIAGNOSIS & TREATMENT

1. What is your diagnosis of the Patient (*please be detailed*)?_____
   _____
   _____
   _____

2. Does Patient require medication for the treatment/cure? Yes ☐ No ☐ (If yes, list below.)
   Med:_____ Mg: _____ QD:☐ BID:☐ TID:☐ QID:☐
   Indications: _____
   Med:_____ Mg: _____ QD:☐ BID:☐ TID:☐ QID:☐
   Indications: _____
   Med:_____ Mg: _____ QD:☐ BID:☐ TID:☐ QID:☐
   Indications: _____
   Med:_____ Mg: _____ QD:☐ BID:☐ TID:☐ QID:☐
   Indications: _____
   Med:_____ Mg: _____ QD:☐ BID:☐ TID:☐ QID:☐
   Indications: _____

3. Does Patient require regular visits to treat/manage/cure diagnosis? Yes ☐ No ☐ (If yes, continue.)
   a.) How often will you need to see this patient? _____
   b.) Please list appointments you have pre-scheduled with this patient:
      1.) Date: _____ Time: _____
      2.) Date: _____ Time: _____
      3.) Date: _____ Time: _____

4. Does Patient require hospitalization for his/her illness? Yes ☐ No ☐ (*If 'No' Please go to Part Two*)
   a.) What is the approximate duration of the hospitalization? _____
   b.) Do you expect additional instances of inpatient care for this diagnosis? Yes ☐ No ☐
   c.) If '***Yes***', please explain approximate frequency and reasoning. _____
   _____
   _____
   _____

—

5. Do you feel this individual has an alcoholism or controlled substance abuse problem? Yes ☐ No ☐
   a.) If '***Yes***' please explain: _____
   _____

PART TWO: RESTRICTIONS & PROGNOSIS

1. Is patient able to participate in employment and/or work activities? Yes ☐ No ☐

a.) If '***No***' please indicate the duration of the disability below.

☐ PERMANENT

☐ TEMPORARY with recovery expected in: _____

b.) Please explain the specific symptoms preventing participation in employment or work activities:

_____

_____

_____

c.) If '***Yes***' please indicate any restrictions in place for this patient below (check all that apply).

☐ CAN PARTICIPATE IN A CLASSROOM SETTING

☐ SHELTERED WORK ONLY (U*nable to engage in competitive employment*)

☐ SEDINTARY (*Lift no more than 10 pounds. Sitting with occasional walking or standing*)

☐ LIGHT (*Lift no more than 20 pounds at one time. Frequently can lift 10 pounds*)

☐ MEDIUM (*Lift no more than 25 pounds at one time. Frequently can lift 25 pounds*)

☐ HEAVY (*Lift more than 100 pounds at one time. Frequently can lift 50 pounds*)

☐ NO WORK LIMITATION

☐ OTHER (*Please explain.*) _____

_____

_____

d.) Please describe your prognosis for this patient below:

_____

_____

_____

PART THREE: TREATMENT HISTORY(*Please briefly describe as to the patient's ability to work*)

1. Chronology of Treatment History:

_____

_____

_____

_____

2. Components of Treatment:

_____

_____

_____

_____

DOCTOR'S NAME (*Please Print*)	DOCTOR'S SIGNATURE		DATE
ADDRESS	PHONE NUMBER	TYPE OF PRACTICE	
PATIENT'S NAME (*Please Print*)	PATIENT'S SIGNATURE		DATE

Release of Information

I, _____, hereby authorize former and current employers, public agencies, non-profit agencies, legal/judicial representatives or systems, financial institutions, and educational facilitates to supply information concerning me, as requested by Weld County Department of Human Services, and to allow inspection and reproduction of records pertaining to me by a duly authorized representative of the Weld County Department of Human Services.

I also authorize the Weld County Department of Human Services to supply information to public agencies, non-profit agencies, legal/judicial representatives or systems, financial institutions, and educational facilities, and allow inspection and reproduction of records pertaining to me by a duly authorized representative of the public agencies, non-profit agencies, legal/judicial representatives or systems, financial institutions, and educational facilities.

I hereby release all above mentioned parties from any or all liability for supplying such information and waive any and all rights I may have to non disclosure of such records by governmental agencies pursuant to the Colorado Governmental Records Act, Sections 24-72-201, et. Seq., C.R.S.

_____ _____/_____/_____

Signature of Applicant/Participant Month Day Year

_____ _____/_____/_____

Signature of Applicant/Participant Month Day Year

_____ _____/_____/_____

Signature of Applicant/Participant Month Day Year