PLEASE READ INSTRUCTIONS BEFORE COMPLETING FORM

COMPLETION INSTRUCTIONS - EMPLOYABILITY ASSESSMENT FORM (PA 1663)

An individual with a physical or mental disability which temporarily or permanently precludes him or her from any gainful employment may be eligible for General Assistance, GA. This form must be completed to document the disability.

To implement these requirements, we are asking you to complete this form for an applicant for public assistance.

Who may complete assessment: The assessment may be performed only by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist.

Who signs the form: Only the individual who performed the employability assessment may sign the form. The signature must be original or the form will be invalidated. Signature or clinic stamps, labels, and other facsimilies ***are not*** acceptable.

General form completion requirements: The information on the form and attachments must be complete and legible. The inability of county staff to read your material will result in the client's application being delayed and the form being returned to you for clarification. If possible, the form and any attachments should be typed.

If all questions are not answered fully, the client's application will be delayed and the form returned to you for completion.

EMPLOYABILITY SECTION

Permanently Disabled: Check this block if the client should be considered permanently disabled and, therefore, unable to work. When making this determination, you must consider whether the client is unable to engage in ***any gainful employment*** by reason of any medically determinable physical or mental impairments. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, ***not*** only by the individual's statement of symptoms.

Temporarily Disabled: There are two blocks for use in evaluating a client who is ***temporarily disabled*** - one for a client whose disability is expected to last 12 months or more, and one for a client whose disability is expected to last less than 12 months. Check the appropriate block if the client has an injury or condition that temporarily prevents the client from working in any gainful employment. Once the injury or ailment is resolved, the client can work. The date shown is when the temporary disability is expected to end. A client whose disability is expected to last 12 or more months may be a candidate for Social Security Disability or SSI benefits.

Employable: Check this block if, based on your examination, it is not appropriate to check either the Permanently or Temporarily Disabled blocks.

EXAMINATION RESULTS SECTION

This section must be fully completed so that it clearly establishes the basis for your decision that the client is either temporarily or permanently disabled. Simply providing a diagnosis is not sufficient. You must provide information about the ***basis*** for your diagnosis and assessment. Further, documentation sufficient to support your decision, for example medical records, X-rays, and lab reports, must be available for further review if required.

Questions: Contact your local county assistance office

ឈ្មោះ និងអាសយដ្ឋាន CAO

ការកំណត់អត្តសញ្ញាណសំណុំរឿង				
ខោនធី	លេខកំណត់ត្រា	CAT	CSLD	DIST
ឈ្មោះកំណត់ត្រា				លបរិច្ឆេទ

RESET

ក្រសួងសេវាកម្មពលរដ្ឋនៅរដ្ឋផេនស៊ីលវ៉ានៀ PENNSYLVANIA

សំណុំបែបបទវាយតម្លៃសមត្ថភាពការងារ

កម្មករ ៖

ផ្នែក I (ត្រូវបំពេញដោយអ្នកដាក់ពាក្យសុំ/អ្នកទទួលជំនួយរដ្ឋ ។)

សូមសរសេរជាអក្សរពុម្ព ឬសរសេរយ៉ាងច្បាស់ ។ សូមប្រាកដថា ត្រូវចុះហត្ថលេខាឈ្មោះរបស់អ្នក និងកាលបរិច្ឆេទលើសំណុំបែបបទនេះ នៅកន្លែងបម្រុងទុកខាងក្រោម ។

ឈ្មោះ ៖	ថ្ងៃខែឆ្នាំកំណើត ៖	លេខឧបត្ថម្ភសង្គមកិច្ច ៖
អាសយដ្ឋាន ៖	លេខទូរស័ព្ទ ៖	
ទីក្រុង ៖	រដ្ឋ ៖	លេខប្រៃបណីយ៍ ៖

សូមពន្យល់ដោយសង្ខេបថាហេតុអ្វីលោកអ្នកគិតថា លោកអ្នកមិនអាចធ្វើការ ៖

តាមន័យនេះខ្ញុំអនុញ្ញាតឱ្យអ្នកផ្តល់សេវាកម្មវេជ្ជសាស្ត្រទាំងអស់ ដើម្បីបញ្ចេញឱ្យដឹងព័ត៌មានវេជ្ជសាស្ត្រណាមួយ ដែលពាក់ព័ន្ធនឹងសមត្ថភាពការងាររបស់ខ្ញុំ ជូនទៅក្រសួងសេវាកម្មពលរដ្ឋនៅរដ្ឋផេនស៊ីលវ៉ានៀ PENNSYLVANIA ។ ព័ត៌មានដែលទទួលបាននឹងត្រូវប្រើប្រាស់សម្រាប់គោលបំណងទាក់ទងនឹងការវាយតម្លៃសមត្ថភាពខ្ញុំចំពោះកិច្ចការ និងភាពមានសិទ្ធិស្របច្បាប់របស់ខ្ញុំចំពោះជំនួយរដ្ឋ ។

X _____ _____ _____

(ហត្ថលេខា) អ្នកដាក់ពាក្យសុំ/អ្នកទទួលជំនួយរដ្ឋ | សរសេរឈ្មោះជាអក្សរពុម្ព | កាលបរិច្ឆេទ

បន្ទាប់ពីលោកអ្នកបានបំពេញផ្នែកនេះ ត្រូវរៀបចំការណាត់ជួបមួយគ្រូពេទ្យដែលមានអាជ្ញាប័ណ្ណ (វេជ្ជបណ្ឌិតវេជ្ជសាស្ត្រ វេជ្ជបណ្ឌិតព្យាបាលជំងឺឆ្អឹងដោយចលនា អ្នកជំនួយការគ្រូពេទ្យ អ្នកហ្វឹកហាត់អនុវត្តការងារគិលានុបដ្ឋាយិកាដែលបានចុះបញ្ជីឈ្មោះបញ្ជាក់ត្រឹមត្រូវ ឬអ្នកចិត្តសាស្ត្រ ។ អត្ថប្រយោជន៍ជំនួយទូទៅ មិនអាចផ្តល់សិទ្ធិអនុញ្ញាតជូនលោកអ្នកបានទេ រហូតដល់សំណុំបែបបទបានបំពេញហើយនេះ ត្រូវបានបញ្ជូនទៅបុគ្គលិកការិយាល័យជំនួយខោនធី ។

ត្រឡប់ទៅ ៖

SECTION II (To be completed by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist)
ផ្នែក II (ត្រូវបំពេញដោយគ្រូពេទ្យដែលមានអាជ្ញាប័ណ្ណ អ្នកជំនួយការគ្រូពេទ្យ អ្នកហ្វឹកហាត់អនុវត្តការងារគិលានុបដ្ឋាយិកាដែលបានចុះបញ្ជីឈ្មោះបញ្ជាក់ត្រឹមត្រូវ ឬអ្នកចិត្តសាស្ត្រ។)

The information on this form will be used by Department of Human Services, DHS, to make an assessment of your patient's qualification for GA benefits based on his or her inability to work. Please complete this section based on your evaluation of the patient's statement in Section I, your examination of the patient, and your use of other medical procedures.

EMPLOYABILITY (Check only one)

1. ☐ **PERMANENTLY DISABLED -** Has a physical or mental disability which **permanently** precludes any gainful employment. The patient is a candidate for Social Security Disability or SSI.

2. ☐ **TEMPORARILY DISABLED - 12 MONTHS OR MORE -** Is currently disabled due to a temporary condition as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment.

   The temporary disability began _____ (DATE) and is expected to last until _____ . (DATE)

   The patient may be a candidate for Social Security Disability or SSI benefits.

3. ☐ **TEMPORARILY DISABLED - LESS THAN 12 MONTHS -** Is currently disabled due to a temporary condition as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment.

   The temporary disability began _____ (DATE) and is expected to last until _____ . (DATE)

4. ☐ **EMPLOYABLE -** The patient's physical and/or mental condition is such that he or she can work.

EXAMINATION RESULTS: (Both parts of this section must be completed if **#1, #2** or **#3** above is checked. If not completed, the client will be ineligible for GA.)

1. DIAGNOSIS (Primary and Secondary):

PRIMARY:

SECONDARY:

2. ASSESSMENT BASED UPON: (Check all that apply)

- ☐ A. PHYSICAL EXAMINATION
- ☐ B. REVIEW OF MEDICAL RECORDS
- ☐ C. CLINICAL HISTORY
- ☐ D. APPROPRIATE TESTS AND DIAGNOSTIC PROCEDURES
- ☐ E. OTHER (Specify) _____

AS A LICENSED MEDICAL PROVIDER, I CERTIFY THAT I HAVE READ AND COMPLIED WITH THE ATTACHED INSTRUCTIONS AND THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE. I FURTHER CERTIFY THAT MY DIAGNOSIS AND ASSESSMENT ARE BASED SOLELY ON THE PATIENT'S CONDITION AS DETERMINED BY MY EXAMINATION. I UNDERSTAND AND AGREE THAT MY DIAGNOSIS AND SUPPORTING DOCUMENTATION MAY BE SUBJECT TO REVIEW BY THE DEPARTMENT OF HUMAN SERVICES.

MEDICAL PROVIDER (PRINT NAME):	TELEPHONE NO.:
ADDRESS:	

SIGNATURE | MEDICAL ASSISTANCE PROVIDER NO. | DATE