CAO NAME AND ADDRESS

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

RESET

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

HEALTH-SUSTAINING MEDICATION ASSESSMENT FORM

إدارة الخدمات الإنسانية بولاية بنسلفانيا

نموذج تقييم علاج للمحافظة على الصحة

APPLICANT/RECIPIENT NAME:	WORKER:

This form is to be completed for the applicant/recipient who requires medication that allows the person to be employable or continue with employment. All items in this section must be completed by a licensed prescriber and signed by both the physician and applicant/recipient.

يجب إكمال هذه النموذج لمقدم الطلب/المستفيد والذي يطلب دواءً يسمح للشخص بأن يصبح مؤهلا للوظيفة أو الاستمرار في الوظيفة.
كافة البنود في هذا القسم يجب استكمالها بمعرفة واصف علاج مُعتمد مع توقيعها بواسطة كل من الطبيب ومُقدم الطلب/المستفيد.

Does the applicant/recipient need health-sustaining medication? ☐ Yes ☐ No If no, you do not need to enter any further information. Just sign and date. If Yes, complete the following information.
Diagnosis:
Medication(s) needed for the APPLICANT/RECIPIENT to sustain employment based on the above diagnosis:
Explain why the APPLICANT/RECIPIENT cannot work in any capacity without this medication. (*Please be specific*)

MEDICAL PROVIDER:	TELEPHONE NUMBER:
ADDRESS:	

_____ _____

SIGNATURE *DATE*

I HEREBY AUTHORIZE ALL MEDICAL PROVIDERS, INDIVIDUAL OR FACILITY OF WHATEVER TYPE, INCLUDING MENTAL HEALTH AND DRUG OR ALCOHOL TREATMENT TO RELEASE ALL MEDICAL/CLINICAL INFORMATION TO THE PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES (DHS) WHICH RELATES TO MY ABILITY TO WORK.

أنا أرخص بموجبه جميع مزودي الخدمات الطبية، أو أي فرد أو منشأة أيا كان نوعها، بما في ذلك الأفراد أو المنشآت المتصلة بالصحة العقلية والأدوية أو معالجة إدمان الكحول بالإفصاح عن كافة المعلومات الطبية/السريرية إلى إدارة الخدمات الإنسانية (DHS) بولاية بنسلفانيا، والتي تتعلق بقدرتي على العمل.

X _____ _____ _____

(توقيع) مُقدم الطلب/المستفيد من المساعدات العامة اكتب الاسم التاريخ

See Reverse Side For Instructions

COMPLETION INSTRUCTIONS

HEALTH–SUSTAINING MEDICATION ASSESSMENT FORM

READ INSTRUCTIONS CONTAINING SPECIFIC DEFINITIONS AND REQUIREMENTS BEFORE COMPLETING THE FORM

Medical information is required by the Department of Human Services (DHS) in determining whether an applicant qualifies for a certain category of public assistance benefits as well as his or her employability. Your medical assessment and documentation are necessary to help the CAO make these decisions.

Who may complete the assessment: The assessment may only be completed by the following licensed medical providers: physician, physician-assistant, certified registered nurse practitioner, or psychologist.

Who signs the form: Only the individual who completed the employability assessment may complete and sign the form. Signature or clinic stamps, labels, and other facsimiles **<u>are not</u>** acceptable. The signature must be original or the form will be invalidated.

General form completion requirements: The information on the form and attachments must be 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 at all 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.

Diagnosis: Record your diagnosis of the applicant/recipient's condition. The explanation should indicate whether or not the condition is chronic or temporary. Attach documentation sufficient to support your decision such as medical records, X-rays, and lab reports that support your conclusion must be attached. Simply providing a diagnosis is not sufficient. Without this documentation, the client will be determined ineligible for benefits.

Medication Needed: List the medication(s) needed by the applicant/recipient that address his medical condition thus enabling him/her to be able to work.

Explanation: Explain in detail what the consequences to the applicant/recipient would be if the medication(s) listed above were not available to him/her. Document in this section whether the medication is for a chronic condition such as diabetes that the person will be required to take for life. Also indicate if the medication will be needed for a limited time period. If that is the case, show the date the person is expected to no longer need the medication.

Questions: Contact your local county assistance office at: