PLEASE READ INSTRUCTIONS BEFORE COMPLETING FORM COMPLETION INSTRUCTIONS -EMPLOYABILITY RE-ASSESSMENT FORM (PA 1664)

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/recipient for public assistance whose initial eligibility for GA or whose exemption from work requirements was based on a temporary disability. The client has indicated that he/she continues to be temporarily disabled. Your assessment is necessary to help the Department of Human Services, DHS, make the decision to continue or reauthorize GA.

- **Who may complete** 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 <u>any gainful employment</u> 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, <u>not</u> only by the individual's statement of symptoms.
- **Temporarily Disabled:** There are two blocks for use in evaluating a client who is **temporarily** <u>disabled</u> - 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 begin date shown is when the disability began. The end date shown is when the temporary disability is now 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. In the space provided, indicate why the temporary disability did not end when originally expected. Also, check the appropriate block regarding whether the client followed a prescribed treatment plan.

If you are not the physician or psychologist who made the original diagnosis, the client should provide you with that person's name and telephone number. You are asked to contact him/her if you deem it appropriate for a consultation to obtain information concerning the original diagnosis.

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 និងអាសយដ្ឋានការិយាល័យជំនួយខោនធី CAO

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ឈ្មោះកំណត់ហេតុ

ខោនធិ៍

អេ**ព្តសញ្ញាណេសណុង្សាង** ប្រភេទ ចំនួនបណ្តឹង មណ្ឌល

កាលបរិច្ឆេទ

ក្រសួងសេវាកម្មពលរដ្ឋនៅរដ្ឋផេនស៊ីលវ៉ាននៀ សំណុំបែបបទវាយតម្លៃឡើងវិញលើសមត្ថភាពការងារ

កម្មករ ៖

ផ្នែក I (ត្រូវបំពេញដោយអ្នកដាក់ពាក្យសុំ/អ្នកទទួល ឬអ្នកទទួលជំនួយរដ្ឋ ។)

សូមសរសេរជាអក្សពុម្ភ ឬសរសេរយ៉ាងច្បាស់ ។ សូមប្រាកដថា ត្រូវចុះហត្ថលេខាឈ្មោះរបស់អ្នក និងកាលបរិច្ឆេទលើសំណុំបែបបទនេះ នៅកន្លែងបម្រុងទុកខាងក្រោម ។

ឈ្មោះ ៖	ថ្ងៃខែឆ្នាំកំណើត ៖	លេខឧបត្ថម្ភសង្គមកិច្ច ៖		
អាសយដ្ឋាន ៖	លេខទូរស័ព្ទ ៖			
ទីក្រុង ៖	រពី ៖	លេខហ្ស៊ីបកូដ ៖		

លោកអ្នកបានផ្តល់ជូនសំណុំបែបបទវាយតម្លៃសមត្ថភាពការងារ សង្ខេបអំពីមូលហេតុដែលលោកអ្នកនៅតែមិនអាចធ្វើការ បើទេ វាយតម្លៃសមត្ថភាពការងារសំណៅដើមថាពិការភាពមួយរយៈពេលរប	<u></u> ។ះជាអ្នកផ្តល់សេវាវេជ្ជសាស្ត្ររបស់អ្នកបាន	បង្ហាញនៅក្នុងសំណុំបែបបទ			
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បន្ទាប់ពីលោកអ្នកបានបំពេញផ្នែកនេះ ត្រូវរៀបចំការណាត់ជួបជាមួយគ្រូពេទ្យដែលមានអាជ្ញាប័ណ្ណ (វេជ្ជបណ្ឌិតវេជ្ជសាស្ត្រ វេជ្ជបណ្ឌិតព្យាបាលជំងឺឆ្អឹងដោយចលនា) អ្នកជំនួយការគ្រូពេទ្យ អ្នកហ្វឹកហាត់អនុវត្តការងារគិលានុបដ្ឋាយិកាដែលបាន ចុះបញ្ជីឈ្មោះបញ្ជាក់ត្រឹមត្រូវ ឬអ្នកចិត្តសាស្ត្រ ។ ការធានារ៉ាប់រងជំនួយទូទៅ មិនអាចផ្តល់សិទ្ធិអនុញ្ញាតជូនលោកអ្នក បានទេរហូតដល់សំណុំបែបបទបានបំពេញហើយនេះ ត្រូវបានបញ្ជូនទៅបុគ្គលិកការិយាល័យជំនួយខោនធី ។

បញ្ចូនទៅ ៖

SECTION II (To be completed by a licensed physician, physician's assistant, certified registered nurse practitioner, or ផ្នែក II (ត្រូវបំពេញដោយត្រូវពទ្យដែលមានអាជ្ញាប័ណ្ណ អ្នកជំនួយការត្រូវពទ្យ អ្នកហ្វីកហាត់អនុវត្តការងារពិលានុបដ្ឋាយិកាដែលបានចុះបញ្ជីឈ្មោះបញ្ជាក់ត្រឹមត្រូវ ឬអ្នកចិត្តសាស្ត្រ ។)	r psychologist)			
Previously, the patient provided an Employability Assessment Form documenting that he or she could not work due to disability. The patient is requesting a continuation of assistance or an exemption from work requirements or has reapp assistance. For eligibility (or exemption from work requirements) to continue or be re-established, please complete this on your evaluation of the patient's statement in Section I, your examination of the patient, and your use of other medic	blied for s section based			
EMPLOYABILITY (Check only one)				
1. PERMANENTLY DISABLED - Based on my assessment, I find that the patient no mental condition which <u>permanently</u> precludes any gainful employment. The patier Social Security Disability or SSI.				
2. TEMPORARILY DISABLED - 12 MONTHS OR MORE - Based on my assessmer remains disabled due to a temporary condition as a result of an injury or an acute contemporarily precludes any gainful employment.				
The temporary disability began and is expected to last until				
Did the patient pursue the prescribed treatment for the disability?				
The patient may be a candidate for Social Security Disability or SSI benefits.				
3. TEMPORARILY DISABLED - LESS THAN 12 MONTHS - Based on my assessment, I find that the patient remains disabled due to a temporary condition or as a result of an injury or an acute condition and the disability temporarily precludes any gainful employment.				
The temporary disability began and is expected to last until				
The patient continues to be temporarily disabled because				
Did the patient pursue the prescribed treatment for the disability?	on't know			
4. EMPLOYABLE - Based on my assessment, I found that the patient's physic condition is such that he or she can work.	cal and/or mental			
EXAMINATION RESULTS: (Both parts of this Section must be completed if #1, checked. If not completed, the client will be ineligible for GA.)	#2 or #3 above is			
1. DIAGNOSIS (Primary and Secondary):				
PRIMARY:				
SECONDARY:				
2. ASSESSMENT BASED UPON: (Check all that apply)				
A. PHYSICAL EXAMINATION E. OTHER (Specify)				
B. REVIEW OF MEDICAL RECORDS				
D. APPROPRIATE TESTS AND DIAGNOSTIC PROCEDURES				
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):	HONE NO.:			
ADDRESS:				