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 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 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

RESET

NOMBRE Y DIRECCIÓN DE LA CAO

IDENTIFICACIÓN DEL CASO				
CO	NÚM. CASO	CAT	CSLD	DIST
NOMBRE CASO:				FECHA

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES
EMPLOYABILITY RE-ASSESSMENT FORM

EMPLEADO:

SECCIÓN I (el solicitante/beneficiario de asistencia social deberá llenar esta sección)

REVISE CUALQUIER INFORMACIÓN IMPRESA A CONTINUACIÓN. SI ESTA INFORMACIÓN ES INCORRECTA, TÁCHELA Y ESCRIBA LA INFORMACIÓN CORRECTA. ESCRIBA CON LETRA DE IMPRENTA O LEGIBLE. FIRME Y FECHE ESTE FORMULARIO EN EL ESPACIO CORRESPONDIENTE ABAJO.

NOMBRE:	FECHA NACIM:	NÚM. SEGURO SOCIAL:
DIRECCIÓN:	TELÉFONO:	
CUIDAD:	ESTADO:	CÓDIGO POSTAL

USTED PROPORCIONÓ ANTERIORMENTE UN FORMULARIO DE EVALUACIÓN DE CAPACIDAD PARA TRABAJAR EN EL CUAL INDICÓ QUE TENÍA UNA DISCAPACIDAD TEMPORAL. EXPLIQUE BREVEMENTE POR QUÉ AÚN NO PUEDE TRABAJAR, AUNQUE SU PROVEEDOR MÉDICO INDICÓ EN EL FORMULARIO ORIGINAL DE EVALUACIÓN DE CAPACIDAD PARA TRABAJAR QUE TENÍA PREVISTO QUE SU DISCAPACIDAD TEMPORAL SE TERMINARÁ ANTES DEL _____ .

¿EL PROVEEDOR MÉDICO LE RECETÓ UN PLAN DE TRATAMIENTO?

☐ SÍ ☐ NO

SI LA RESPUESTA ES SÍ, ¿LO SIGUIÓ? ☐ SÍ ☐ NO

SI LA RESPUESTA ES NO, EXPLIQUE POR QUÉ NO.

POR MEDIO DEL PRESENTE AUTORIZO A TODOS LOS PROVEEDORES MÉDICOS QUE REVELEN AL DEPARTAMENTO DE SERVICIOS HUMANOS DE PENNSYLVANIA CUALQUIER INFORMACIÓN MÉDICA QUE ESTÉ RELACIONADA CON MI CAPACIDAD PARA TRABAJAR. LA INFORMACIÓN OBTENIDA SE USARÁ ÚNICAMENTE PARA LOS FINES RELACIONADOS CON LA EVALUACIÓN DE MI CAPACIDAD PARA TRABAJAR Y MI ELEGIBILIDAD PARA RECIBIR ASISTENCIA SOCIAL.

X _____ _____ _____

(FIRMA) SOLICITANTE/BENEFICIARIO DE ASISTENCIA SOCIAL | NOMBRE (CON LETRA DE IMPRENTA) | FECHA

DESPUÉS DE COMPLETAR ESTA SECCIÓN, HAGA UNA CITA CON UN MÉDICO AUTORIZADO PARA EJERCER (MD, DO), ASISTENTE DE MÉDICO, ENFERMERA REGISTRADA O PSICÓLOGO. NO PODEMOS AUTORIZAR SUS BENEFICIOS DE ASISTENCIA GENERAL HASTA QUE DEVUELVA EL FORMULARIO COMPLETADO AL REPRESENTANTE DE LA OFICINA DE ASISTENCIA DEL CONDADO.

DEVOLVER A:

SECTION II (To be completed by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist)

SECCIÓN II (Esta sección la deberá llenar un médico autorizado para ejercer, un asistente de médico, enfermera registrada o psicólogo)

Previously, the patient provided an Employability Assessment Form documenting that he or she could not work due to a temporary disability. The patient is requesting a continuation of assistance or an exemption from work requirements or has reapplied for assistance. For eligibility (or exemption from work requirements) to continue or be re-established, 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 -** Based on my assessment, I find that the patient now has a physical or mental condition which **permanently** precludes any gainful employment. The patient is a candidate for Social Security Disability or SSI.

2. ☐ **TEMPORARILY DISABLED - 12 MONTHS OR MORE -** Based on my assessment, I find that the patient remains 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 continues to be temporarily disabled because _____

   _____

   Did the patient pursue the prescribed treatment for the disability?

   ☐ Yes ☐ No ☐ Don't know

   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 _____ (DATE) and is expected to last until _____ (DATE) .

   The patient continues to be temporarily disabled because _____

   _____

   Did the patient pursue the prescribed treatment for the disability? ☐ Yes ☐ No ☐ Don't know

4. ☐ **EMPLOYABLE -** Based on my assessment, I found that 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