DEAR HEALTH CARE PROVIDER:

The California Work Opportunity and Responsibility to Kids (CalWORKs) program requires that non-exempt individuals participate in work, training, or educational activities for 32 or 35 hours (for one or two-parent households, respectively) per week. CalWORKs participants must make "satisfactory progress" in their activities.

We ask your help in evaluating this individual by providing us with information regarding how his/her mental or physical condition will affect the ability to participate in a work/training program. With this information, we can better assign the participant to an appropriate activity. It will also help us to determine if the participant's condition will enable him/her to participate or successfully complete 32 or 35 hours per week of work and/or training requirements.

Please complete Section 2 of the attached form and sign (or have your authorized representative sign) the Certification in Section 3. Please also complete the Physical Capacities and/or Mental Capacities form(s), as appropriate.

Thank you for your assistance.

WORKER NAME	
WORKER PHONE NUMBER	FAX NUMBER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

COUNTY USE ONLY	
CASE NAME:	CASE NUMBER:
WORKER NAME:	WORKER NUMBER:

Section I must be completed by the patient/client. Sections 2 and 3 are to be completed by the type of provider *(or his/her authorized representative)* checked below: *(County worker to check appropriate box below.)*

☐ Licensed physician or certified psychologist.

☐ Health care professional licensed or certified by a state to diagnose/treat physical or mental impairments affecting the ability to work or participate in education/training activities including, but not limited to, medical doctors, osteopaths, chiropractors, and licensed/certified psychologists.

SECTION 1. PATIENT/CLIENT INFORMATION AND AUTHORIZATION TO RELEASE INFORMATION

NAME OF PATIENT/CLIENT *(LAST, FIRST, MIDDLE)*	SEX *(CIRCLE)*	BIRTH DATE	SOCIAL SECURITY NUMBER	AGE(S) OF CHILD(REN) IN HOME
	M F	- -	- -	

I authorize_____ of _____

NAME OF PROVIDER — CLINIC OR MEDICAL GROUP

to release information to the county welfare department from my records on the conditions checked below:

☐ Physical Condition ☐ Mental Condition ☐ Other *(Describe)*_____

I know this authorization may be used by the county welfare department for up to one year to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the welfare department. This information is needed by the county welfare department to determine eligibility for cash aid or food stamps. It is also needed to decide the type of work or training activities that I can take part (participate) in, and the CalWORKs services that I need. This information will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had this form read to me) after it was completed. I know I can get a copy of this form if I ask for it.

PATIENT/CLIENT SIGNATURE	RELATIONSHIP TO PATIENT, IF NOT SELF	DATE SIGNED
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR PATIENT/CLIENT		DATE SIGNED

SECTION 2. STATEMENT OF PROVIDER

The information requested is needed to evaluate eligibility for public assistance for the person named above and to determine his/her work assignment. Please answer the following questions as indicated by check mark:

☐ Questions 1 through 5 ☐ Question 6 ☐ Question 7

1. Does the patient have a medically verifiable condition that would limit or prevent him/her from performing certain tasks? . . . . . ☐ **YES** ☐ **NO**

   If YES, complete the rest of this form, and the Physical Capacities and/or Mental Capacities form *(if attached)*, as appropriate.
   If NO, just complete the Health Care Provider Certification Section below.

2. Onset Date of Condition _____. The condition is ☐ Chronic ☐ Acute, expected to last until_____

3. Is the patient actively seeking treatment? ☐ **YES** ☐ **NO** Next appointment date _____

4. Is this person able to work? . . . . . ☐ **YES** ☐ **NO**
   If YES, how many hours per day?_____

5. Does this person have any limitations that affect his/her ability to work or participate in education or training? . ☐ **YES** ☐ **NO**

6. It is necessary to determine whether child care needs to be provided to enable the other parent to work. Does the patient's condition prevent him/her from providing care for the child(ren) in the home? . . . . . ☐ **YES** ☐ **NO**

7. Does the patient's condition require someone to be in the home to care for him/her? . . . . . ☐ **YES** ☐ **NO**

SECTION 3. PROVIDER CERTIFICATION

SIGNATURE OF PROVIDER OR PROVIDER'S AUTHORIZED REPRESENTATIVE			DATE SIGNED	
PRINT NAME AND TITLE/SPECIALTY			PHONE NUMBER	
			( )	
STREET ADDRESS	*(MAILING ADDRESS, IF DIFFERENT)*	CITY	STATE	ZIP CODE