NEW JERSEY WORK FIRST

THE DIGNITY OF WORK; THE PRIDE OF INDEPENDENCE

The individual named on the reverse side of this form has requested a medical deferral from the work participation requirement of the Work First New Jersey (WFNJ) program (New Jersey's public financial assistance program) due to a reported medical condition. Recipients of WFNJ assistance are required to participate in a "work activity."

Completion of the Examination Report (WFNJ-MED-1 form) is required in order to determine whether the individual is able to participate in a work activity or meets the criteria for a medical deferral from the WFNJ work requirement due to his/her medical condition. The information supplied in the Examination Report must be based on an actual in-person evaluation of the patient by the examining healthcare professional.

Instructions for Completing the WFNJ-MED-1

The WFNJ-MED-1 form must be completed by a licensed physician, psychologist, midwife or advanced practice nurse, as appropriate.

Section 1: In completing this section, the examining healthcare professional must supply his/her name, signature, professional credential, license number, office address, and phone number.

Section 2: In completing this section, the healthcare professional must supply all clinical information requested and indicate whether the patient is able to participate in a work activity.

The WFNJ program offers a diverse set of work activities in which individuals can participate. Work activities require varying levels of physical and psychological capability and include full-time employment, volunteer activities, vocational training, and educational activities, among others. Therefore, please consider the range of work activities available when assessing the level to which an individual may be able to participate, as opposed to simply stating that the individual is able/unable to participate in work activities in general.

Lastly, if it is determined that the individual is not currently able to participate in a work activity, please indicate, relative to prognosis and treatment regimen, when the individual will be well enough to participate.

*If the **fully completed** form is not returned to our office within 30 days, the individual will be expected to participate in a work activity, and is subject to loss of his/her public assistance benefits if he/she does not participate in the work activity. Please send the completed form directly to the office indicated below. Please do not return the completed form to the client.*

Agency:	Special Instructions:

EXAMINATION REPORT

Patient's Name:	WFNJ Case Number:

Section 1	
Examining Healthcare Professional Name (Print):	Date:
Examining Healthcare Professional Name (Signature):	
Professional Credential & License Number:	
Office Address:	
Office Phone Number:	

Section 2	
Date of Patient's Last Exam:	Patient's Date of Birth:
Patient Diagnoses/Date of Onset:	
ICD-9-CM/DSM-5 Codes:	
Current Treatment Regimen:	
Treatment Recommendations/Frequency:	
Does the patient require behavioral health/substance abuse treatment? Yes ☐ No ☐	
Do any of the above diagnoses *limit* the patient's ability to participate in gainful employment and/or occupational training? Yes ☐ No ☐	
If yes, please specifically explain how the diagnoses limits the patient's ability to participate in gainful employment and/or occupational training (ex. unable to stand for long periods of time, unable to lift objects, etc.):	
Is the patient able to engage in any gainful employment and/or occupational training *of any kind*? Yes ☐ No ☐	
If No – Please specify the date when you expect that the patient will be able to engage in any gainful employment and/or occupational training. _____ /_____ /_____	
Do you expect the patient's barriers to employment/training to last longer than 6 months ☐ 12 months ☐ ?	

County/Municipal Welfare Agency Use		
☐ Approved Deferral start date: _____ / _____ /_____ Deferral end date: _____ / _____ / _____		
☐ Incomplete-Requested additional information from provider on _____ /_____ /_____		
☐ Refer to One-Stop	☐ Refer to SAI/BHI	☐ Refer to SSI Project
☐ Refer to Medicaid Fraud Division		
CWA/MWA Representative Name: _____ Date:_____		