COUNTY ASSISTANCE OFFICE NAME AND ADDRESS	
Return To CAO By:	CAO Fax Number:

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

Commonwealth of Pennsylvania Department of Public Welfare

MEDICAL ASSESSMENT FORM

This Medical Assessment Form (PA 635) is needed to determine whether this individual is pregnant, is able to participate in employment and training activities, what treatment plan(s) could help the individual move towards employment, or determine if the individual is a good candidate for disability benefits.

COMPLETED BY COUNTY ASSISTANCE OFFICE

Client's Name	Client's Date of Birth	Client's Phone Number
Client's Address *(Street, City, Zip Code)*		

Instructions to Medical Provider

This form may be completed by a counselor, social worker, or mental health therapist, but must be agreed upon and signed by a Physician, Psychologist, Physician Assistant or Certified Registered Nurse Practitioner.

Please complete the appropriate section(s) of this form and return (fax or mail) to the County Assistance Office (above) by _____.

Confirmation of Pregnancy

If this individual is pregnant, give expected delivery date. _____/_____/_____
Date

NOTE: IF PREGNANCY DOES NOT AFFECT THIS INDIVIDUAL'S ABILITY TO WORK, ONLY COMPLETE SECTION I OF THIS FORM.

SECTION I MEDICAL PROVIDER INFORMATION *Please complete this entire section.*

Printed Name of Medical Provider _____

Medical License Number _____ NPI Number _____
(If Applicable)

Phone Number ( ) _____

Address: _____

_____

_____

I certify that all of the information provided on this form is true, correct and complete to the best of my professional knowledge. I further certify that, the diagnosis and assessment related to this client's health condition are based on his/her medical condition as determined by examination and knowledge of this client's medical history.

I understand and agree that the diagnosis and supporting documentation may be subject to review by the Department of Public Welfare's Medical Review Team.

Signature of medical provider must be original or the form is invalid. Rubber stamps, labels or other reproductions are not acceptable.

_____ _____
Prepared By ***Date***

_____ _____
Signature of Medical Provider ***Date***

County/Record Number | Client's Name | Date of Birth

SECTION II EMPLOYABILITY

IF CHECKBOX 1 IS SELECTED FOR THIS INDIVIDUAL, DO NOT COMPLETE SECTION III.

IF EMPLOYABLE, THIS INDIVIDUAL WILL HAVE THE REQUIREMENT TO WORK OR PARTICIPATE IN TRAINING FOR _____ HOURS PER WEEK. PLEASE SELECT ONE OF THE FOLLOWING BASED ON YOUR BEST ESTIMATE OF THE INDIVIDUAL'S CURRENT CAPABILITIES:

1. ☐ **EMPLOYABLE –**

This individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above).

☐ with the following reasonable accommodations: _____

_____

2. ☐ **LIMITED EMPLOYABILITY – *Please check all that apply. Please also complete Section III.***

This individual is able to work or participate in training, on a sustained basis, **for fewer than the hours that are required per week** (see above). Approximately how many hours can the individual participate per week? _____

☐ with the following reasonable accommodations

_____

_____

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

☐ Prescribed Medication

☐ Therapy: _____ hours per week Type: _____

☐ Follow-up with specialist: Specialty _____ Name of Physician_____

Referral Made for Patient? _____

☐ Other *(describe)*: _____

This individual is expected to be limited from being able to work or participate in training for the number of hours indicated above on a sustained basis, until ____ / ____ / _____.
Date

3. ☐ **TEMPORARY INCAPACITY – *Please also complete Section III.***

This individual's physical or mental condition precludes him/her from participating in **ANY FORM** of employment or training activity, on a sustained basis, at this time, but the condition is expected to improve within 12 months.

This individual's temporary incapacity is expected to prevent working or participation in training until ____/____/_____.
Date

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

☐ Prescribed Medication

☐ Therapy: _____ hours per week Type: _____

☐ Follow-up with specialist: Specialty _____ Name of Physician_____

Referral Made for Patient? _____

☐ Other *(describe)*: _____

4. ☐ **DISABLED – *Please also complete Section III.***

This individual has a physical or mental condition that is expected to last for 12 months or more, and precludes **ANY FORM** of employment, on a sustained basis, of at least 30 hours per week. The individual is a candidate for Social Security Disability or Supplemental Security Income.

The disability begin date _____/_____/_____.
Date

County/Record Number | Client's Name | Date of Birth

SECTION III DIAGNOSIS (ES)

Include name of each Diagnosis with ICD-9 code and description. Please explain how each diagnosis affects the client's ability to work.

Primary Diagnosis:

Secondary Diagnosis:

Tertiary Diagnosis:

Other Diagnosis:

The individual is following the prescribed treatment plan.

_____ Yes _____ No _____Don't Know If No, indicate:

☐ Not taking medication as prescribed

☐ Not following up with specialist

☐ Not eligible or appropriate for needed medication or treatment. Explain: _____

_____

_____

☐ Other (describe): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____