DHS C1(b)
Rev: 5/18

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Dear Medical Professional,

Your patient, _____, has requested an exemption (or extension of a previous exemption) from required work-related activities associated with his/her application for/receipt of cash assistance, Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) and/or Child Care benefits.

While our goal is to assist our clients to achieve economic security, there may be reason to delay the start of, reduce the hours of, or exempt the individual from work activity at this time.

Please complete the form on the reverse side of this letter and return within 10 days to:

RI DHS _____ Phone: _____
_____
_____

Thank you for your assistance today.

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

I. My information is to be disclosed by:

_____
(Name of Person/Organization)

_____
(Address)

_____
(City, State, Zip)

And is to be provided to:

_____
(Name of Person/Organization)

_____
(Address)

_____
(City, State, Zip)

The information to be disclosed: (*to be filled out by client- check the applicable box(es)*)

Physical Diagnosis(es)	Medical Treatment Information	Functional Abilities/Limitations
Mental Health Diagnosis(es)	Mental Health Treatment Information	HIV/AIDS-related Treatment
Alcohol/Drug Abuse Treatment	Other *(specify)*: _____	

II. Specific Information I do <u>NOT</u> want disclosed: *(to be filled out by client- check the applicable box(es)):*

Physical Diagnosis(es)	Medical Treatment Information	Functional Abilities/Limitations
Mental Health Diagnosis(es)	Mental Health Treatment Information	HIV/AIDS-related Treatment
Alcohol/Drug Abuse Treatment	Other *(specify)*: _____	

III. I hereby authorize the release of the medical information requested in this medical verification form to the Rhode Island Department of Human Services, which is subject to the confidentiality provisions of Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR part 164], and the Privacy Act of 1974 [5 USC 552a]. I also understand that I may revoke this authorization in writing at any time to the Department of Human Services and that, if I do, DHS may condition my eligibility and access to services on my decision to revoke. In addition, any information disclosed to DHS before I revoked this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

*(If you want the release to expire on a date other than one year, please write that date here)*_____

_____ _____ _____
Signature of Patient or Guardian Relationship to Above Date

Medical Verification Form

This form is to be completed by one of the following medical professionals: Doctor of Medicine (M.D.), Psychiatrist (M.D.), Psychologist (PhD), Doctor Of Osteopathy (D.O.), Licensed Clinical Social Worker (LICSW), Physician's Assistant (PA) or Certified Registered Nurse Practitioner (RNP), on behalf of the patient/individual named herein.

Name of Individual _____ DOB _____

Primary Diagnosis _____ Secondary Diagnosis _____

Date of Most Recent Office Visit/Examination _____ Next Visit _____

What is the treatment, and frequency of treatment, for the above diagnosis(es)/limitations? _____
_____

Is the individual following prescribed treatment/therapy? Yes or No

This individual requires further assessment: Yes or No
If yes, please state what additional assessments/tests are recommended: _____

Please indicate functional limitations associated with this individual's diagnosis(es) by placing a check mark in the applicable boxes below:

	Not Limited	Mildly Limited	Significantly Limited
Standing			
Walking			
Sitting			
Climbing or Crawling (circle one or both)			
Pushing/Pulling (circle one or both)			
Bending			
Handling/Feeling/Manipulating			
Lifting			
Seeing, with glasses			
Hearing, with aids			
Speaking/Communicating			
Tolerance for environmental conditions (circle or cite limitations) wet, cold, dust, noise, machinery _____			
Ability to maintain concentration			
Age-appropriate ability to understand, remember, carry out instructions			
Age-appropriate ability to respond to authority-like figures, co-workers, etc.			
Age-appropriate ability to cope with changes in school or work setting			
Ability to perform at a consistent pace			
Ability to perform activities within a schedule and maintain regular attendance			

For how many hours <u>per week</u> could this individual engage in employment, education, or skills training? _____

For how many hours <u>per day</u> could this individual engage in employment, education, or skills training? _____

What is the expected <u>duration of the above limitations</u> (# of weeks, months, or years)? _____

What is the expected <u>duration of the condition itself</u> (# of weeks, months, or years)? _____

Is an application for Social Security disability benefits or Supplemental Security Income recommended? _____

Does the individual require accommodations in order to participate in an activity? Please circle: Yes No Don't know

If yes, please describe what accommodations he/she may need:

_____

_____

Additional Comments: _____

_____

Signature of Medical Professional_____ (print name) _____

Date_____ Address_____ Phone_____