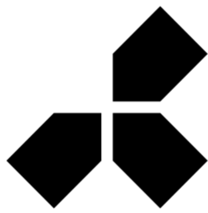
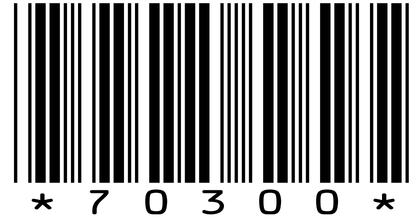




Name of Physician ______________________ Date ______________________

Dear Physician,

I, _____________, am requesting that the attached Medical Verification form be completed.

In order to receive temporary cash assistance and prepare individuals and families for self-sufficiency, individuals receiving cash assistance are required to participate in countable work activities. Additionally, Florida limits such families to receive cash assistance for a total of 48 months. Some participants may receive a medical deferral as a result of an injury, a temporary medical condition, or other good cause reason. However, if a participant is in deferred status, he/she continues to be subject to the cash assistance time limits.

- I am requesting that my medical information be released to the Welfare Transition Program provider to help me develop my self-sufficiency plan. To become self-sufficient, I will work with my Career Specialist to overcome barriers to employment and/or seek medical/disability services.
- My self-sufficiency plan may include participation in medical treatment, counseling, therapy, etc.
- My plan may include employment, attending classes, studying at home, or volunteering at a worksite designed to meet my physical/mental health limitations.
- Each time a new form is needed, *I will sign a request for medical information authorizing the licensed physician to complete the form.*
- The participant or legal guardians for participants under the age of 18 are the only representatives allowed to provide consent/request for information on the medical verification form.
- **The release of medical information portion of the medical verification form is located on the next page.** The release of medical information verifies that I have reviewed my rights and responsibilities regarding the release of my confidential health information with my Career Specialist. **The release includes my rights and responsibilities as stated in the Health Insurance Portability and Accountability Act (HIPAA).**

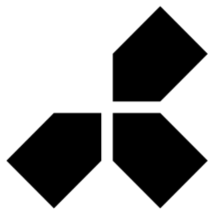
Thank you for taking the time to complete the medical verification form. Please forward the completed form to my Career Specialist at the below address/fax number. If you prefer, you can release the paperwork back to me, and I can deliver the paperwork myself.

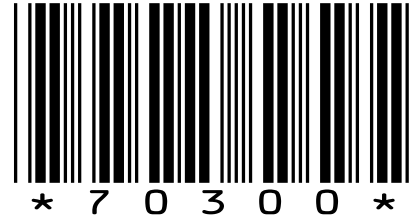
Name: **Phone Number:**

Address: **Fax Number:**

DEO-WTP 2288(a), December 2006 (Replaces AWI-WTP 2288(a), 12/2005)
INCLUDES HIPAA LANGUAGE AND REQUIREMENTS

An equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. All voice telephone numbers on this document may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711.





Release of Medical Information

Participant's Name: ______________________________ **Social Security Number:** ___________________________

Birth date: _______________________________________

I understand that I have given the physician permission to complete the medical verification form.

- I understand that the information will state my current diagnosis and possible limitations to engage in countable work activities. By completing the medical form, I am requesting that my physician provide the information to the Welfare Transition Program (WTP) provider.
- The information on the form will be used to develop a personalized self-sufficiency plan that takes my limitations, medical needs and treatment into consideration. The completed form may also be used when considering an extension to my cash assistance time limits.

<u>Rights</u>

- I have the right to refuse to sign the Release of Medical Information Form. Refusing to sign the form (**alone**) will not affect my benefits.
- The authorization of the Medical Verification Form may not condition medical treatment, payment, or enrollment.
- I understand that I have the right to revoke the authorization of this form. To revoke the authorization, **I must submit a request in writing to both the physician and the WTP provider. I will have to provide the written request to both parties by the close of business (5 p.m.) on ________/________/________.**
- Once the form is completed, the form will be included in my case file, but the information may not be used to determine limitations or medical inability after six months from the physician's signature date.
- I have the right to privacy. The medical verification form and information that is given in the form is confidential health information. The WTP provider is the sole recipient of the information. The information may be disclosed only in the course of official business and the verification of continued eligibility/compliance.

<u>Responsibilities</u>

- I have agreed to have the form completed and return the completed form to my Career Specialist by (*date*)__________________________ at (*time*)____________________________.
- **If I refuse to sign the form or fail to supply the required information by the above date**, I **must** participate in the Welfare Transition Program's (WTP) countable activities for the minimum required hours unless another good cause reason is documented.
- I **must** complete the activities as indicated on my self-sufficiency plan. **Refusal to sign the form and failure to participate in countable activities may result in the reduction or cancellation of my cash assistance and food stamp benefits.**
- **If I refuse to participate in the program and fail to complete the agreed upon activities listed in my self-sufficiency plan, my benefits may be reduced or cancelled.**
- If the form is revoked, I am still responsible for completing the activities I agreed to complete on my self-sufficiency plan.

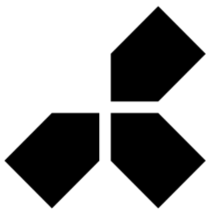
I have reviewed my rights and responsibilities with my Career Specialist.

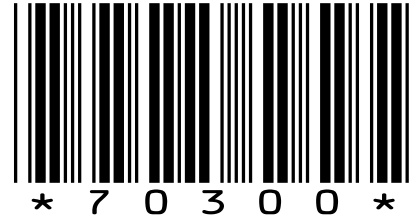
______________________________ ____________________ Expiration of Request is 60 days from signature date.

Signature of Participant Date of Signature

________________________________ ______________________ ____________________________

Signature of Guardian if under 18 years of age Printed Name of Guardian Date





1. What is the specific diagnosis of illness/injury of the participant? ____

2. A participant **may still be able to work** with limitations **or be assigned to an activity** that requires little physical strain or demand (attending classes, volunteer, home study, answering telephones, filing while seated).

WORK

a) Can (s)he "work" sitting down? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted ____________________

b) Can (s)he "work" standing up? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted ____________________

c) Are there other restrictions to him/her working? ☐ Yes ☐ No

Restrictions: ____

d) Are the number of hours (s)he can "work" limited? ☐ Yes ☐ No

☐ 1-10 hours ☐ 11-20 hours ☐ 21-30 hours ☐ 31-40 hours a week **or** ☐ Unable to "work" at all

VOLUNTEER

e) Can the (s)he volunteer hours? ☐ Yes ☐ No ☐ Only if frequent breaks are permitted ____________________

Other limitations: ____

SCHOOL

f) Can the (s)he go to school or go to classes? ☐ Yes ☐ No Comments:____________________________________

Are there limitations? ____

3. Is this condition ☐ permanent or ☐ temporary? If temporary, indicate estimated duration ______# Months. If this individual is pregnant, what is the expected date of delivery? _____/_____/_____.

4. Is (s)he required to attend physical therapy? ☐ Yes ☐ No If yes, how often? __________________________________

5. Is (s)he required to attend counseling appointments? ☐ Yes ☐ No If yes, how often? ____________________________

6. Is (s)he required to attend any other type of therapy or regular appointments? ☐ Yes ☐ No If yes, how often? _______

7. Date of patient's most recent office visit: _____/_____/_____

________________________________ ____ (____) ____-_______

Name of Licensed Physician **Signature of Physician: this form must be signed by a *Licensed* Physician.** **Telephone Number**

____

Mailing Address (include city and zip code)

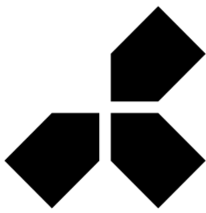
____ ________/________/_________

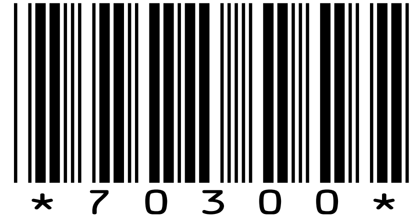
Physician's License Number (per Chapter 458 or Chapter 459, F.S.) **Date Form Completed**

Refrain from using white out or correction fluid.

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.





MEDICAL VERIFICATION FORM TO BE COMPLETED BY LISCENSED PHYSICIAN

Name of Participant: **Social Security Number:**

*****If your diagnosis indicates the above customer cannot participate (or participation must be limited) in activities mandated by Federal and State law, a detailed explanation is required below to justify the deferral process and to provide adequate information to facilitate an independent verification of the diagnosis. Please note that if the above customer is approved to be placed in deferred status, a new medical verification form will be required as deemed necessary based upon the length of the deferral.**

____

____

____

____

____

____

____

________________________________ ____ (____) ____-________
Name of Licensed Physician **Signature of Physician: this form must be signed by a *Licensed* Physician.** **Telephone Number**

____
Mailing Address (include city and zip code)

____ _________/________/__________
Physician's License Number (per Chapter 458 or Chapter 459, F.S.) **Date Form Completed**

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

INCLUDES HIPAA LANGUAGE AND REQUIREMENTS