MEDICAL EXAMINATION AND CAPACITY FORM

Cook Inlet Tribal Council, Inc.

Last First M.I.	**SSN # or EIS Case Number:**

Dear Medical or Mental Health Professional,

Please read the following information and answer the questions below. We will use your responses to determine the capacity of this individual to participate in work and self-sufficiency activities. The information you provide on this form will help us to decide the level of activity that is appropriate for this individual. It will also be used by the family's case manager to help the family develop their plans for supporting themselves without relying on assistance. The questions are opinion based on your years of education and experience in the health profession. It is not intended to be a legal document.

Thank you for taking the time to complete this form. We look forward to providing the best possible services to your patient.

1. Date of last examination: _____

2. Diagnosis/Condition(s): _____

3. In your opinion, is the patient's condition severe enough to prevent them from working full-time? ❒ Yes ❒ No

4. In your opinion, can the patient work part-time? ❒ Yes ❒ No
If "yes," Please circle how many hours per day? **1 2 3 4 5 6 7 8**

5. How long will the medical condition affect the patient's ability to work? (Please circle)
Less than one month 1 2 3 4 5 6

6. Does the patient's medication(s) cause side effects that may impact their ability to work or train? ❒ Yes ❒ No
If "yes" please specify: _____

What is the patient's treatment plan? (Please include type of activity & recommended hours of treatment per week)

_____

_____

Mental Health / Cognitive Abilities

Does this person have any mental health / cognitive difficulties that will cause the following to occur?

❒ Low tolerance for frustration	❒ Panic attacks	❒ Socially inappropriate response
❒ Difficulty communicating needs	❒ Difficulty with decision-making	❒ Difficulty in unfamiliar environment
❒ Difficulty following instructions	❒ Difficulty controlling anger	❒ Difficulty with impulse control
❒ Inability to work with children	❒ Difficulty working around people	❒ Difficulty with reality perception
❒ Difficulty engaging in complex tasks that require judgment		❒ Difficulty following through

Other Condition(s)

Are there any other restrictions? _____

_____

Name & Title of Licensed Health Professional (please Print):		Address:
Signature:	Date:	Contact Number:

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