Reset Form

RAMSEY COUNTY
Workforce Solutions

Request for Medical Opinion:

Family Member Needing Care

This form is to be completed by a qualified medical professional

To the health care provider: This is a request for you to provide information to Ramsey County Workforce Solutions and their designated subcontractors, about any physical health and/or mental health conditions your patient ("Family Member Needing Care")may have that you believe, in your professional opinion as a health care provider, impact the availability of your patient's caregiver (the County's MFIP or DWP client) to work in another capacity. Your information will help an employment counselor working for Ramsey County, or a designated subcontracted agency, to provide or arrange appropriate support services for your patient's caregiver; assist your patient's caregiver in finding and securing employment that is appropriate given your patient's health status and caregiver needs; and determine what work expectations are not appropriate for the patient's caregiver. Please be advised that Minnesota Statutes §13.03, subd. 3 allow a client of a public entity access to private data maintained by that public entity. The information you provide on this form is classified as private data on your patient. Upon request by your patient or the patient's representative, the County or its designated agency, is required by law to provide access to the information contained on this form.
NOTE: This request does not represent an offer of payment on the part of Ramsey County or its designated agency.

Caregiver name (MFIP/DWP client):_____ Maxis #: _____
Former name (if any): _____ Date of Birth:_____ Gender:_____
Street Address: _____ City _____ Zip Code _____

Name of person needing care (patient):_____
Date of Birth: _____ Gender: _____ Relationship to client/caregiver: _____

Authorization for Release of Information: I give permission to _____ to release the requested health care information by completing and sending this form to Ramsey County Workforce Solutions and/or contracted MFIP-ES provider staff_____. I understand this information about me is protected under state and /or federal privacy laws and cannot be disclosed without my written authorization unless otherwise provided for by state or federal law. I voluntarily and knowingly waive those protections of this information and consent to its release to the agency listed above. This information will be used, in part, to qualify me for public assistance and/or services. I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested. This authorization will end one year from the date I sign it, unless the law allows for a longer period.

Patient's signature(age 18 and older must sign)_____ **Date**: _____
Client signature: _____ Date: _____
(or authorized representative)

Please answer all questions regarding the above-identified patient.

1. For what type(s) of conditions have you treated or evaluated the patient? (Check all that apply)
Mental health _____ Physical health _____

2. Date of last visit: _____ Date of next scheduled visit: _____
Date of next appointment for **re-evaluation** of the condition: _____

3. Please state the diagnosis(es) regarding a physical and/or mental health condition of the patient that is expected to last more than **30 days**, and that could affect the patient's caregiver's **availability to maintain employment other than as the patient's caregiver**:
Diagnosis _____ Date of on-set_____
Employment restriction(s) on caregiver: _____
_____

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Diagnosis _____ Date of on-set_____

Employment restriction(s) on caregiver: _____

_____

4. Does your patient need someone in the home to care for him or her (caregiver)? Yes _____ No _____

If yes, describe what assistance is needed as well as the amount of time required of the caregiver (e.g. after school, all day)

_____

_____

5. Have you prescribed a treatment plan(s) for your patient? Yes _____ No _____

If yes, describe the treatment plan: _____

_____

6. If there is a treatment plan, are you recommending that the caregiver participate in the treatment plan?

Yes _____ No _____

If yes, please explain the caregiver expectations: _____

_____

7. Check if applicable:

- ☐ I have **no or little recent knowledge** about this patient and have not diagnosed any physical or mental health conditions within the last three years.
- ☐ I would support this patient in applying for Supplemental Security Income (SSI)

It is important that you sign and date this form below. Thank you for your cooperation. Please mail or FAX this form to the agency named at the bottom of this page as soon as possible. You may call that agency with any questions.

_____

Qualified Professional (name): _____ Credentials: _____

(Please print or type)

Clinic Name/Address _____

City/State _____ Zip _____ Clinic phone _____

Signature _____ **Date**_____

Please mail or FAX to: _____ Agency/Dept.: _____

Address: _____ City/State: _____ Zip: _____

Fax number: _____ Phone number: _____