RAMSEY COUNTY
Workforce Solutions

Reset Form

# Request for Medical Opinion:

## MFIP or DWP Participant

*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 may have that you believe, in your professional opinion as a health care provider, impact your patient's (the County's MFIP or DWP client) ability to work. Work is an important part of adult life and, when appropriate expectations and supports are in place, can assist in recovery from illness. Your information will help an employment counselor working for Ramsey County, or a designated subcontracted agency, to provide or arrange appropriate support services and assist your patient in finding and securing employment that is appropriate given the patient's health status. This is not a certification of disability. 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.

**Client Information (MFIP/DWP client)**

Name: _____ Maxis #: _____
Former name (if any): _____ Date of Birth: _____ Gender: _____
Street Address _____ City: _____ Zip Code: _____

***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 employment counselor 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.

**Client signature: _____ Date: _____**
(or authorized representative)

**Please answer all questions regarding the above-identified person.**

**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 DIAGNOSIS(es) regarding a physical and/or mental health condition that is expected to last more than **30 days**, and that affect your patient's **ability to obtain or maintain employment**:
Diagnosis _____ Date of on-set_____
Employment restriction(s): _____
_____
Diagnosis _____ Date of on-set_____
Employment restriction(s): _____
_____

**4**. If a restriction is due to pregnancy, when is the patient's due date? _____

**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, has your patient followed the treatment plan? Yes _____ No _____
If yes, please explain the change in the condition as a result of the treatment: _____
_____
If no, please explain how the patient has failed to follow the treatment plan and what the consequences have been for your client. _____

**7**. a. Based on your assessment, how many hours <u>per week</u> can s/he currently perform employment activities?
1-10 hours _____ 11-19 hours _____ 20-29 hours _____ 30 + hours _____
b. What supports, accommodations, or assistive technologies are needed in the work environment, if any?
_____

**8.** If s/he is UNABLE TO WORK at this time:
a. Please explain the restrictions and reasons: _____
_____
b. When will s/he be able to return to employment? Date of anticipated return: _____

**9.** How many hours <u>per week</u> can s/he participate in *other employment-related activities* (e.g. Adult Basic Education, training, job search, volunteering, etc.)?
1-10 hours _____ 11-19 hours _____ 20-29 hours _____ 30 + hours _____

**10.** If your patient has a <u>MENTAL HEALTH condition</u>:
a. Is ongoing case management or community support services advised? Yes _____ No _____
b. If yes, describe the services you recommend: _____
_____

**11.** Does your patient need someone in the home to care for him or her? Yes _____ No _____
If yes, Please describe what assistance is needed. _____
_____

**12**. <u>Check if applicable:</u>
☐ 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) benefits.

**It is important that you <u>sign and date</u> 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.**

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Name of **Qualified Professional**: _____ Credentials: _____

Clinic Name/Address _____

City/State _____ Zip _____ Clinic phone _____

**Signature** _____ **Date**_____

**Please mail or FAX to:** _____ Agency: _____

Address: _____ City/State: _____ Zip: _____

Fax number: _____ Phone number: _____