

MEDICAL EXAMINATION & CAPACITY

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

The provision of your Social Security Number (SSN) is mandatory under Wisconsin Statutes 49.145 (2)(k). Your SSN may be verified through computer matching programs and may be used to monitor compliance with program regulations and program management. Your SSN may be disclosed to other Federal and State Agencies for official examination. If you do not provide your social security number, your application for benefits will be denied.

Name	Date of Birth / /	Social Security Number	
Name of Professional Provider		Professional Title	
Office Address	City	State	Zip Code

The individual named above has applied for **Wisconsin Works (W-2)** and indicates that s/he has limitations that affect his/her ability to participate in certain Wisconsin Works (W-2) activities. Please evaluate this patient's capacity to participate in training activities, vocational and occupational assessment and work. **The information you provide on this form will not affect billing or reimbursement from Medicaid.**

W-2 is a work readiness program available to low-income families. The program philosophy is that most individuals can do something, even if activities are limited to a few hours per week. W-2 provides cash assistance and services in exchange for participation in activities. To assign appropriate activities, it is important for us to have an idea of tasks and assignments that are reasonable for this participant. Activities that can be a part of a W-2 placement include job readiness/life skills workshops, HSED/GED classes, work preparation activities, treatment recommendations, counseling and physical rehabilitation to create a healthier lifestyle and may lead to employment. Thank you for taking the time to complete this form. We look forward to providing the best individualized service to your patient.

Diagnosis/Condition: (include Physical, Mental Health, Learning Disabilities and AODA concerns)

Prognosis: (if the patient's condition is related to pregnancy, please enter the expected date of birth)

In what type of treatment plan is the patient involved for the symptoms mentioned? (Include the number of hours involved in a treatment program each week and/or treatment that needs to occur during a normal workday and the type of activities or treatment, examples: physical therapy, self-initiated or organized exercise program, smoking cessation program, weight loss program, counseling).

This individual may have his/her vocational capacity assessed. What, if any, accommodations should be provided for the assessment?

Physical Capacities

Maximum ability to lift and carry on an occasional basis (no more than 3 hours out of an 8 hour day).

No limitation 100 lbs. 50 lbs. 20 lbs. 10 lbs. Other _____

Maximum ability to lift and carry on a frequent basis (more than 3 hours out of an 8 hour day)

No limitation 100 lbs. 50 lbs. 20 lbs. 10 lbs. Other _____

Maximum ability to stand and walk (with normal breaks) during an 8 hour day.

No limitation at least 6 hours at least 2 hours Other _____

Maximum ability to sit (with normal breaks) during an 8 hour day.

No limitation at least 6 hours at least 2 hours Other _____

What is your assessment of this individual's ability to use hands, communicate and see?

What is your assessment of other capacities, such as need for assistive device for ambulation, need to alternate positions frequently, limits on pushing and pulling, operating hand or foot controls, bending and stooping?

Does this person's medication(s) cause side affects that impact his/her ability to participate in a work/education environment?

Yes No If "Yes" specify: _____

Does this person require any adaptive devices or other accommodations to help them function effectively in a work/education environment?

Yes No If "Yes" describe what is needed: _____

Cognitive Abilities

Does this person have any cognitive difficulties that cause the following to occur?

- Low tolerance for frustration
- Difficulty communicating his/her needs
- Difficulty following instructions
- Difficulty engaging in complex tasks that require judgement
- Difficulty with decision making
- Difficulty following through on agreed actions

Mental Health

Does this person have any mental health issues that cause the following to occur?

- Low tolerance for frustration
- Difficulty working around other people
- Difficulty controlling anger appropriately
- Socially inappropriate responses to situations
- Inability to work with children
- Difficulty with reality interpretation
- Difficulty being in unfamiliar environments
- Difficulty with decision-making
- Panic attacks
- Difficulty with impulse control

Other conditions:

Are there any more restrictions that exist?

Please recommend activities that may improve this individual's ability to live a healthier lifestyle or become employed:

- Work Site Activities
- Job Readiness/Life skills workshops
- Job Skills Training
- Assessment and treatment program
- Job Search
- Adult Basic Education Classes
- SSI or SS(D)I Advocacy
- Counseling or Physical Rehabilitation

Additional Recommendations: _____

Number of hours a day (5 days a week) this individual can participate in activities/work within these restrictions?	Date Examined	Date Restrictions Expire	Date of Next Appointment
	/ /	/ /	/ /

Additional Comments or Concerns:

Name of Professional Provider	Title	Telephone Number ()
Signature of Professional Provider		Date Signed

Return completed form to:

Name of Agency Representative		Address		Date Sent
City	State	Zip Code	Telephone Number ()	Fax Number ()