MONROE COUNTY CHILD SUPPORT AGENCY
112 S COURT ST, ROOM 2100, SPARTA, WI 54656
PHONE - (608) 269-8733; FAX - (608)269-8970

MEDICAL STATUS & ABILITY TO WORK REPORT

Patient Name: _____ Date of Birth: _____

1. What is the **diagnosis** which affects the patient's ability to work?

_____

2. What are the **physical or mental impairments** which affects the patient's ability to work?

_____

_____

Is this: ☐ temporary (lasting less than 12 months) or ☐ permanent?

3. If this is not a new patient, is the patient **complying with recommended treatment**?

☐ YES ☐ NO If "No," what is the patient failing to do?

_____

(The Child Support Agency may ask the Court to order compliance.)

4. In your medical opinion, is the patient **currently able to work**?

☐ YES: no limitations ☐ YES: with limitations ☐ NO

If the answer is "Yes: with limitations" or "No," please:

1. Please describe any work restrictions (including but not limited to: duties, hours, physical/psychological limitations, impact of medications, treatment, recovery or rehabilitation)

   _____

   _____

2. Specify the expected duration of the limitation or inability to work:

   _____ weeks; _____ months OR ☐ unknown ☐ permanent

3. State the next scheduled appointment date or follow–up period: _____

4. Specify the next step in treatment: _____

To Medical Provider: *This request is made as part of an on-going child support case to assess ability to work and to contribute to the financial support of his/her child(ren).*

Facility: _____

Treatment Provider Name: _____ Date of treatment: _____

Telephone number for confirmation and contact: _____

_____ _____

Provider Signature *Date*

This request for information is being made in accordance with 42 U.S.C. 654, which requires that each state use all available sources of information to locate absent parents or alleged absent parents. This information will be used solely to enforce Wisconsin child support laws. The information will not be used for commercial purposes or private gain. You are authorized to release the information by s. 49.22(2m) Wis. Stats. Please give the most recent information you have and date it was valid. Return the completed form to the Agency address above. A covered entity under the Health Insurance Portability and Accountability Act (HIPPA) may disclose protected health information to the extent that disclosure is required by law or to an agency performing a government regulatory program [45 C.F.R. s. 164.512(a) & (d)(1)(iii)].

Authorization: I hereby agree that my medical provider may discuss the content of this form with the Monroe County Child Support Agency. This authorization is valid for one year or until revoked by me.

Patient's signature: _____ Date: _____

BY PROVIDING THS DOCUMENT TO THE MONROE COUNTY CHILD SUPPORT AGENCY YOU ARE HEREBY ADVISED THAT THIS DOCUMENT IS NOT CONSIDERED A MEDICAL RECORD AND WILL NOT BE KEPT CONFIDENTIAL AS A PART OF YOUR CHILD SUPPORT MATTER.