Crawford Co. Child Support Agency
225 N. Beaumont Rd, Ste 318
Prairie du Chien, WI 53821
Phone (608) 326-0218 Fax (608) 326-1168

MEDICAL STATUS & ABILITY TO WORK REPORT

Patient Name: _____ Date of Birth: _____

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

_____

2. Is this condition temporary _____ 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. Specify the expected duration of the limitation or inability to work:
_____ weeks; _____ months OR _____ unknown _____ permanent
2. State the next scheduled appointment: _____
3. Specify the next step in treatment: _____
4. Please describe any work restrictions (including but not limited to: medications, treatment, recovery, rehabilitation, physical/psychological limitations)

_____

_____

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 Crawford County Child Support Agency. This authorization is valid for one year or until revoked by me.

Patient's signature: _____ Date: _____