Healthcare Provider Statement of Abilities for FANF Financial Assistance

Name of FANF applicant/recipient	**RID # and/or Case # (if known)**

Authorized healthcare provider: **Name:** **Address:** **Phone:**	**Please return via mail or fax to:** Medical Exemption Unit Bureau of Family Assistance, DHHS 129 Pleasant Street, Brown Building Concord, NH 03301-3857 **Fax:** (603) 271-4637

You are receiving this form because you are a healthcare provider for the individual named above.

The Financial Assistance to Needy Families (FANF) program requires individuals to participate for a minimum of 20 to 30 hours per week in activities that help prepare them for self-sustaining, unsubsidized employment.

The individual named above reports that he or she is either limited or unable to participate in activities due to a medical and/or psychological condition. We need your professional assessment to help us determine this individual's abilities and limitations with regard to preparatory and work-related activities.

Only the following currently licensed healthcare providers are authorized to complete and sign this form: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Alcohol and Drug Counselors (Master LADCs only), Psychologists (board certified), Pastoral Psychotherapists, Independent Clinical Social Workers, Clinical Mental Health Counselors, and Marriage and Family Therapists.

The attached form has 2 sections. Please complete and return the appropriate section(s):
Section 1: For healthcare providers treating a physical condition.
Section 2: For healthcare providers treating a psychological condition.

Your patient should provide you with a signed *Authorization for Release of Protected Health Information for FANF Financial Assistance* (BFA Form 752A) providing permission to release the information on this form (BFA Form 752) to DHHS. Please fax or mail this completed form (BFA Form 752) directly to the Medical Exemption Unit using the contact information above.

If you have any questions, please call the Medical Exemption Unit at (603) 271-9511, option 2.

Preparatory and Work-Related Activities

There are many preparatory and work-related activities offered to individuals in the FANF work program. Individuals can participate in activities adapted to meet his or her needs and abilities. Activities include:

- **Barrier resolution:** This may include counseling or other services designed to minimize or resolve a personal issue or other barriers to employment.
- **Education or training:** This may include basic or adult education, ESL, or other education or training programs that promote employability.
- **Work-related activities:** This may include paid or unpaid work, or structured, supervised work activities that provide the individual the opportunity to experience and acquire the general workplace behaviors, attitudes, skills, and knowledge necessary to obtain and retain paid work.

Once completed, this form is valid for up to 6 months.

Section 1—Physical Abilities

(Complete if treating a physical condition.)

Only the following currently licensed healthcare providers are authorized to complete and sign this form for *physical* abilities—**please check the corresponding box to indicate your profession:**

☐ Physician ☐ Physician Assistant ☐ Advanced Practice Registered Nurse

Patient's name: ______________________________

Diagnosis: ______________________________

How does the patient's condition limit his or her activities? ______________________________

____

What is the expected duration of the patient's condition? ______________________________

Please assess the patient's ability to participate in activities by circling the appropriate answer:

Yes	**No**	Can perform **sedentary** activities. This includes frequent sitting or occasional standing/walking, such as classroom situations, desk work, and counseling or other appointments.
Yes	**No**	Can perform **light** work activities. This includes frequent walking, lifting of objects weighing 10 pounds, or the operation of simple equipment.
Yes	**No**	Can perform **medium** work activities. This includes frequent reaching, bending, or lifting of objects weighing 25 pounds and activities involving fine manual dexterity or coordination.
Yes	**No**	Can perform **heavy** work activities. This includes frequent physical exertion in a taxing work position, such as lifting and dragging heavy objects weighing 50 pounds or more.

With normal breaks, please indicate the maximum daily time the patient can:

Activity	**None**	**1 hour**	**2 hours**	**3 hours**	**4 hours**	**5 hours**	**6 hours**	**7 hours**	**8+ hours**
Sit									
Stand									
Walk									

Is the patient taking any medication that negatively affects his or her abilities? ☐ **No** ☐ **Yes**

Please list any limitations or accommodations: ______________________________

____

With the above-noted accommodations in place (if any), is the patient able to participate in educational, training, or work-related activities?

☐ No ☐ Yes **If yes, indicate the number of hours the patient can participate per week:**

☐ 31 or more hours ☐ 26 to 30 hours ☐ 21 to 25 hours ☐ 20 hours ☐ 1 to 19 hours

______________________________ ______________ ______________

Authorized healthcare provider signature **Date** **Phone**

____

Authorized healthcare provider printed name (with credentials)

Payment of any separate charge for completing this form is the responsibility of the patient.

Section 2—Psychological Abilities

(Complete if treating a psychological condition.)

Only the following currently licensed healthcare providers are authorized to complete and sign this form for *psychological* abilities—**please check the corresponding box to indicate your profession:**

- ☐ Physician
- ☐ Physician Assistant
- ☐ APRN
- ☐ Psychologist (board certified)
- ☐ Clinical Mental Health Counselor
- ☐ Pastoral Psychotherapist
- ☐ Independent Clinical Social Worker
- ☐ Alcohol and Drug Counselor (MLADC only)
- ☐ Marriage and Family Therapist

Patient's name: ______________________________

Diagnosis: ______________________________

How does the patient's condition limit his or her activities? ______________________________

____

What is the expected duration of the patient's condition? ______________________________

For each activity listed below, rate the patient's limitation in each area using the following terms:

None	No deficit; ability is not limited
Mild	Individual can perform the activity satisfactorily most of the time
Moderate	Individual can perform the activity satisfactorily some of the time
Marked	Individual has no useful ability to function

Activity	**None**	**Mild**	**Moderate**	**Marked**
Interact appropriately with others				
Maintain socially acceptable behavior				
Ask questions or request help when necessary				
Adhere to basic standards of neatness and hygiene				
Aware of normal hazards; take precautions				
Remember locations and work-like procedures				
Understand and remember short, simple instructions				
Maintain attention for extended periods				
Sustain routine without frequent supervision				
Make simple work-related decisions				
Concentrate, persist, or maintain pace				
Adapt to change				

Is the patient taking any medication that negatively affects his or her abilities? ☐ **No** ☐ **Yes**

Please list any limitations or accommodations: ______________________________

____

With the above-noted accommodations in place (if any), is the patient able to participate in educational, training, or work-related activities?

☐ No ☐ Yes **If yes, indicate the number of hours the patient can participate per week:**

☐ 31 or more hours ☐ 26 to 30 hours ☐ 21 to 25 hours ☐ 20 hours ☐ 1 to 19 hours

______________________________ ______________________________

Authorized healthcare provider signature **Date** **Phone**

____

Authorized healthcare provider printed name (with credentials)

Payment of any separate charge for completing this form is the responsibility of the patient.