



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF INCOME MAINTENANCE

BUREAU OF EMPLOYMENT AND TRAINING PROGRAMS
M&M Building
900 North 6th Street
Harrisburg, Pennsylvania 17102

Dear Health Care Provider:

Thank you for partnering with the Department of Public Welfare (DPW). One of the most direct links between the health care provider and DPW is the **Medical Assessment Form PA 635**. You may recognize the **Medical Assessment Form** because you have completed it for patients who are having their employability assessed by DPW for appropriate employment and training requirements associated with cash assistance benefits. DPW engages cash recipients in employment and training to help families move from work to self-sufficiency and a better quality of life.

DPW is working with the Managed Care and Behavioral Health Managed Care Organizations to let you know that a revised Medical Assessment Form PA 635 will soon be in use.

Health care providers are asked to continue to evaluate and place the recipient at **one of four levels of employability**:

- fully employable
- limited employability
- temporary incapacity
- permanently disabled

Health care providers are now also asked to recommend a medical treatment plan that will help remediate the health barriers of those who have:

- limited employability or
- temporary incapacities

DPW is expanding supportive services (including one-to-one case management, home visits, child care, transportation, clothing and training, and work supplies) to assist recipients with meeting the recommended treatment plan so they can recover and take full advantage of the employment and training activities that are available to them.

Your detailed evaluation and recommendations are important to your patients so we can help them realize better lives for themselves and their children!

Thank you for your dedicated care of our shared clientele,
Pennsylvania Department of Public Welfare, Bureau of Employment and Training Programs

NOTE: Other DPW medical assessments such as the PA 1663 and 1664 are not included in this revision and are used to evaluate eligibility for cash assistance other than employability for TANF work requirements.

Revised MEDICAL ASSESSMENT FORM PA 635

Employable recipients of cash assistance for families are required to participate in employment and training to assist them to move their family from welfare to work and self-sufficiency.

When recipients report physical or mental health issues that they believe will keep them from participating in employment and training, they are given a **MEDICAL ASSESSMENT FORM PA 635** to have a medical professional evaluate their employability.

You may have had patients bring you the Medical Assessment Form to be completed. They have 30-days to have the completed form returned to the County Assistance Office.

DPW wants to let you know that the assessment form is being revised and your detailed evaluation is important to your patients so we can help them realize better lives for themselves and their children!

To complete the revised Medical Assessment Form:

- ✓ evaluate the employability of the recipient. If you determine
 - Limited Employability
 - or
 - Temporary Incapacity

Then please

- ✓ recommend a **MEDICAL TREATMENT PLAN**
- ✓ provide a diagnosis and how it impacts employability
- ✓ comment on the recipient's current participation in the medical treatment plan
- ✓ fax or mail the completed form to the County Assistance Office by the due date indicated on the form

LEVELS OF EMPLOYABILITY ARE
<p>↑ EMPLOYABLE able to participate in employment and training activities</p>
<p>↑ LIMITED EMPLOYABILITY able to participate in some hours of employment and training activities</p>
<p>↑ TEMPORARY INCAPACITY unable to participate in employment and training activities for a period less than a year</p>
<p>↑ PERMANENTLY DISABLED unable to participate in employment and training activities</p>

The Department of Public Welfare will offer the recipient assistance with following the medical treatment plan that you recommend!

COMPLETING A REVISED MEDICAL ASSESSMENT FORM SCENARIO & SAMPLE

A patient brings the revised PA 635 Medical Assessment Form with a signed PW 1815 Authorization for Use or Disclosure of Personal Information and a self-addressed stamped envelope to a medical provider's office on 8/1/08. She is requesting an evaluation of employability.

The patient:

- is age 25
- has one child under the age of 6
- has wrist injuries sustained in an automobile accident several months ago
- had casts removed, but has occupational therapy three times weekly
- has a referral to an OT and appointments are only available between 8:00 am and 4:00 pm Monday through Friday
- currently schedules appointments at 3:00 pm, Mondays, Wednesdays and Fridays
- has attended one of four scheduled appointments
- is recommended to attend OT for 12-weeks (expected to end 10/13/08)
- is expecting another child
- is asking to be excused from all employment and training activities due to her injuries and pregnancy

ON PAGE 1 OF THE MEDICAL ASSESSMENT FORM

- The County Assistance Office (CAO) has indicated that the form must be completed and returned to the CAO by 8/15/08.
 - Patients have 30 days to verify the level of employability so the CAO can act on referring the client to required work activities.
- The medical provider noted that the expected delivery date is 2/15/09.
 - Pregnancy alone does not excuse a client from employment or training activities so, if complications with the pregnancy will limit or prevent work activities, please complete pages 2 and 3 of the assessment.
- The medical provider completed the address and licensing information and signed the medical assessment.

ON PAGE 2 OF THE MEDICAL ASSESSMENT FORM

- The CAO provided the patient's required hours of participation for the medical provider's consideration.
 - Because she has a child under the age of 6, she has a 20-hour per week work requirement and will be referred to a contracted vendor for employment and training activities if she is determined to be employable.
- After examining the patient, discussing the circumstances and evaluating employability, the medical provider determined and checked:
 - Limited Employability – this individual is able to work or participate in training, on a sustained basis, for fewer than the hours that are required per week.
 - The patient's wrist injuries and pregnancy do not prevent participating in appropriate work activities; however, the required OT limits the hours during the week that the patient can participate in employment and training activities.
- The medical provider determined that she could participate 15 hours weekly.
- The medical provider checked:
 - Therapy 4.5 hours per week. Describe: Occupational Therapy
 - This individual is expected to be limited from being able to work or participate in training until 10 / 13 / 2008

ON PAGE 3 OF THE MEDICAL ASSESSMENT FORM

- The medical provider indicated that the Primary Diagnosis is injuries to both wrists and employability is affected by impaired use of wrists.
- The medical provider checked:
 - No, the individual is not following the treatment plan.
 - Having discussed the attendance of the OT appointments with the patient, the medical provider determined that she is not attending appointments as scheduled due to a combination of transportation issues, forgetting the appointments and not fully understanding how OT can help her.

The medical provider's office mails the completed Medical Assessment Form evaluating employability as limited to the CAO in the provided self-addressed stamped envelope before 8/15/08.

The CAO receives the completed assessment and refers the client to a contracted partner for assistance with:

- following the recommended treatment plan, including transportation, help with arranging child care, help with arranging medical appointments, help understanding health care benefits and the values of OT services ; and,
- 15 weekly hours of employment and training activities per week

COUNTY ASSISTANCE OFFICE NAME AND ADDRESS	
Pennsylvania County CAO 123 Road Street Town, PA 12345	
Return To CAO By: 8/15/08	CAO Fax Number: 111-123-1234

CASE IDENTIFICATION				
CO 00	RECORD NUMBER 1234567	CAT C	CSLD 1234	DIST 0
RECORD NAME Patient Name				DATE 07/15/08
WORKER NAME IMCW				

Commonwealth of Pennsylvania Department of Public Welfare

MEDICAL ASSESSMENT FORM

This Medical Assessment Form (PA 635) is needed to determine whether this individual is pregnant, able to participate in employment and training activities, or if he/she is a good candidate for disability benefits.

COMPLETED BY COUNTY ASSISTANCE OFFICE		
Client's Name Patient	Client's Date of Birth 01/01/1983	Client's Phone Number 111-123-4321
Client's Address (Street, City, Zip Code) Patient Address		

Instructions to Medical Provider

This form may be completed by a counselor, social worker, or mental health therapist, but must be agreed upon and signed by a Physician, Psychologist, Physician Assistant or Certified Registered Nurse Practitioner.

Please complete the appropriate section(s) of this form and return (fax or mail) to the County Assistance Office (above) by 08/15/08.

Confirmation of Pregnancy
If this individual is pregnant, give expected delivery date. <u>02/15/09</u> <small>Date</small>
<small>NOTE: IF PREGNANCY DOES NOT AFFECT THIS INDIVIDUAL'S ABILITY TO WORK, ONLY COMPLETE SECTION I OF THIS FORM.</small>

SECTION I MEDICAL PROVIDER INFORMATION <i>Please complete this entire section.</i>	
Printed Name of Medical Provider <u>Dr Medical Provider</u>	
Medical License Number <u>#</u> NPI Number <u>#</u> <small>(If Applicable)</small>	
Phone Number (111) <u>123-5678</u>	
Address: <u>Address</u>	
<p><i>I certify that all of the information provided on this form is true, correct and complete to the best of my professional knowledge. I further certify that, the diagnosis and assessment related to this client's health condition are based on his/her medical condition as determined by examination and knowledge of this client's medical history.</i></p> <p><i>I understand and agree that the diagnosis and supporting documentation may be subject to review by the Department of Public Welfare's Medical Review Team.</i></p> <p>Signature of medical provider must be original or the form is invalid. Rubber stamps, labels or other reproductions are not acceptable.</p>	
<u>preparer signs</u> <small>Prepared By</small>	<u>date</u> <small>Date</small>
<u>medical provider signs</u> <small>Signature of Medical Provider</small>	<u>date</u> <small>Date</small>

SECTION II EMPLOYABILITY

IF CHECKBOX 1 OR 2 IS SELECTED FOR THIS INDIVIDUAL, **DO NOT** COMPLETE SECTION III.

IF EMPLOYABLE, THIS INDIVIDUAL WILL HAVE THE REQUIREMENT TO WORK OR PARTICIPATE IN TRAINING FOR 20 HOURS PER WEEK. PLEASE SELECT ONE OF THE FOLLOWING BASED ON YOUR BEST ESTIMATE OF THE INDIVIDUAL'S CURRENT CAPABILITIES:

1. **EMPLOYABLE -**

This individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above).

with the following reasonable accommodations: _____

2. **LIMITED EMPLOYABILITY - Please check all that apply.**

This individual is able to work or participate in training, on a sustained basis, for fewer than the hours that are required per week (see above). Approximately how many hours can the individual participate per week? 15

with the following reasonable accommodations _____

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

Prescribed Medication

Therapy: 4.5 hours per week Describe: OT

Follow-up with specialist: Specialty _____ Name of Physician _____

Referral Made for Patient? _____

Other (describe): _____

This individual is expected to be limited from being able to work or participate in training for the number of hours indicated above on a sustained basis, until 10/13/08
Date

3. **TEMPORARY INCAPACITY - Please also complete Section III.**

This individual's physical or mental condition precludes him/her from participating in ANY FORM of employment or training activity, on a sustained basis, at this time, but the condition is expected to improve within 12 months.

This individual's temporary incapacity is expected to prevent working or participation in training until ____/____/____
Date

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

Prescribed Medication

Therapy: _____ hours per week Describe: _____

Follow-up with specialist: Specialty _____ Name of Physician _____

Referral Made for Patient? _____

Other (describe): _____

4. **DISABLED - Please also complete Section III.**

This individual has a physical or mental condition that is expected to last for 12 months or more, and precludes ANY FORM of employment, on a sustained basis, of at least 30 hours per week. The individual is a candidate for Social Security Disability or Supplemental Security Income.

The disability begin date ____/____/____
Date

SECTION III DIAGNOSIS (ES)

Include name of each Diagnosis with ICD-9 code and description. Please explain how each diagnosis affects the client's ability to work.

Primary Diagnosis: *Injuries to both wrists*

Employability is affected by injuries - OT required

Secondary Diagnosis:

Tertiary Diagnosis:

Other Diagnosis:

The individual is following the prescribed treatment plan.

Yes No Don't Know If No, indicate:

- Not taking medication as prescribed
- Not following up with specialist
- Not eligible or appropriate for needed medication or treatment. Explain: _____

Other (describe): *Pt is not attending scheduled OT due to transportation issues and forgetting appointments.*