PLEASE READ INSTRUCTIONS BEFORE COMPLETING FORM

COMPLETION INSTRUCTIONS - EMPLOYABILITY ASSESSMENT FORM (GR 61)

An individual with a physical or mental disability which temporarily or permanently precludes him or her from any gainful employment may be eligible for General Relief, GR. This form must be completed to document the disability.

To implement these requirements, we are asking you to complete this form for an applicant/recipient for General Relief.

Who may complete assessment: The assessment may be performed only by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist.

Who signs the form: Only the individual who performed the employability assessment may sign the form. The signature must be original, or an e-signature. Signature stamps, clinic stamps, labels, and other facsimilies **are not** acceptable.

General form completion requirements: The information on the form and attachments must be complete and legible.

The inability of county staff to read your material will result in the client's application being delayed and the form being returned to you for clarification. If possible, the form and any attachments should be typed.

If all questions are not answered fully, the client's application will be delayed and the form returned to you for completion.

EMPLOYABILITY SECTION

Long Term Disabled: Check this block if the client should be considered chronically disabled and, therefore, unable to work. When making this determination, you must consider whether the client is unable to engage in ***any gainful employment*** by reason of any medically determinable physical or mental impairments. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, ***not*** only by the individual's statement of symptoms.

Temporarily Disabled: There are two blocks for use in evaluating a client who is ***temporarily disabled*** - one for a client whose disability is expected to last 6 months or more, and one for a client whose disability is expected to last less than 6 months. Check the appropriate block if the client has an injury or condition that temporarily prevents the client from working in any gainful employment. Once the injury or ailment is resolved, the client can work. The date shown is when the temporary disability is expected to end. A client whose disability is expected to last 6 or more months may be a candidate for Social Security Disability or SSI benefits.

Employable: Check this block if, based on your examination, it is not appropriate to check either the Long Term or Temporarily Disabled blocks,the client is able to work 25 hours or more a week.

EXAMINATION RESULTS SECTION

This section must be fully completed so that it clearly establishes the basis for your decision that the client is either temporarily or chronically disabled. Simply providing a diagnosis is not sufficient. You must provide information about the ***basis*** for your diagnosis and assessment. Further, documentation sufficient to support your decision, for example medical records, X-rays, and lab reports, must be available for further review if required.

Questions: Contact the General Relief assistance line (415) 473-3450

HHS NAME AND ADDRESS

Marin County Health & Human Services
General Relief Program
120 N. Redwood Drive
San Rafael, CA 94903
(415) 473-3450

CASE IDENTIFICATION			
CO 21	**CASE** NUMBER	**EW**	DATE
PARTICIPANT NAME			

MARIN COUNTY HEALTH & HUMAN SERVICES
EMPLOYABILITY ASSESSMENT FORM

NOTE FROM WORKER:

Complete Section I. Take this form to your provider, have them complete Section II and return it to your worker by:

SECTION I (Must be completed by applicant/recipient for General Relief)

PLEASE PRINT OR WRITE CLEARLY. BE SURE TO SIGN YOUR NAME AND DATE THIS FORM IN THE APPROPRIATE SPACE BELOW.

NAME:	BIRTHDATE:	SOCIAL SECURITY NO.:
ADDRESS:	TELEPHONE NUMBER:	
CITY:	STATE:	ZIP CODE:

BRIEFLY EXPLAIN WHY YOU BELIEVE YOU CANNOT WORK:

I authorize_____ of _____to release information to the county
(PROVIDERS NAME) (CLINIC/FACILITY/MEDICAL GROUP NAME)

welfare department from my records on the conditions checked below:
☐ Physical Condition ☐ Mental Condition ☐ Other (Describe)_____
I know this authorization may be used by the county welfare department for up to one year to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the welfare department. This information is needed by the county welfare department to determine eligibility for ongoing cash aid. It is also needed to decide the type of work or training activities that I can take part (participate) in, and the General Relief services that I need. This information will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed bylaw. I have read this form (or had this form read to me) after it was completed. I know I can get a copy of this form if I ask for it.

_____ _____ _____
(SIGNATURE) GENERAL RELIEF APPLICANT/RECIPIENT PRINT NAME DATE

AFTER YOU HAVE COMPLETED THIS SECTION, ARRANGE FOR AN APPOINTMENT WITH A LICENSED PHYSICIAN (MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY), PHYSICIAN'S ASSISTANT, CERTIFIED REGISTERED NURSE PRACTITIONER, OR PSYCHOLOGIST. GENERAL RELIEF BENEFITS CAN BE AUTHORIZED FOR YOU, AS AN EMPLOYABLE PARTICIPANT, PRIOR TO THE COMPLETION OF THIS FORM. YOUR REQUEST FOR WORK EXEMPT STATUS CANNOT BE REVIEWED UNTIL THE FULLY-COMPLETED FORM IS RETURNED TO THE COUNTY.

RETURN TO: GENERAL RELIEF UNIT
WORKER:_____
120 N. REDWOOD DRIVE
SAN RAFAEL, CA 94903

SECTION II (To be completed by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist)

The information on this form will be used by the Marin County Health & Human Services (HHS) , to make an assessment of your patient's qualification for General Relief benefits based on his or her inability to work. Please complete this section based on your evaluation of the patient's statement in Section I, your examination of the patient, and your use of other medical procedures.

EMPLOYABILITY (Check only one) ***Participant Name:*** ***Case Number:***

1. ☐ **LONG TERM DISABLED - 12 MONTHS OR MORE -** Has a **chronic** physical or mental disability which precludes any gainful employment. The patient is a candidate for Social Security Disability or SSI.

2. ☐ **TEMPORARILY DISABLED - 6 MONTHS OR MORE -** Is currently disabled due to a temporary condition as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment.

   The temporary disability began _____ (DATE) and is expected to last until _____ (DATE) .

   The patient may be a candidate for Social Security Disability or SSI benefits.

3. ☐ **TEMPORARILY DISABLED - LESS THAN 6 MONTHS -** Is currently disabled due to a temporary condition as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment.

   The temporary disability began _____ (DATE) and is expected to last until _____ (DATE) .

4. ☐ **EMPLOYABLE -** The patient's physical and/or mental condition is such that he or she can work **25 hours or more per week**.

EXAMINATION RESULTS: (Both parts of this section must be completed if **#1, #2** or **#3** above is checked. If not completed, the client will be ineligible for General Relief.)

1. DIAGNOSIS (Primary and Secondary):

PRIMARY:

SECONDARY:

2. ASSESSMENT BASED UPON: (Check all that apply)

- ☐ A. PHYSICAL EXAMINATION
- ☐ B. REVIEW OF MEDICAL RECORDS
- ☐ C. CLINICAL HISTORY
- ☐ D. APPROPRIATE TESTS AND DIAGNOSTIC PROCEDURES
- ☐ E. OTHER (Specify) _____

AS A LICENSED MEDICAL PROVIDER, I CERTIFY THAT I HAVE READ AND COMPLIED WITH THE ATTACHED INSTRUCTIONS AND THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE. I FURTHER CERTIFY THAT MY DIAGNOSIS AND ASSESSMENT ARE BASED SOLELY ON THE PATIENT'S CONDITION AS DETERMINED BY MY EXAMINATION. I UNDERSTAND AND AGREE THAT MY DIAGNOSIS AND SUPPORTING DOCUMENTATION MAY BE SUBJECT TO REVIEW BY THE HHS DEPARTMENT .

MEDICAL PROVIDER (PRINT NAME):	TELEPHONE NO.:
ADDRESS:	

SIGNATURE | TITLE | DATE