DEPARTMENT OF CHILDREN AND FAMILIES
Division of Family and Economic Security

Medical Examination and Capacity

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

FOR WISCONSIN WORKS AGENCY USE ONLY			
Patient Name			Date of Birth / /
RETURN COMPLETED FORM TO:			
Wisconsin Works Agency	Agency Worker Name	Phone Number	Fax Number
Street Address, City, State, Zip Code			Date Sent by Agency / /

Dear Medical Professional:

The patient named above is a participant in the **Wisconsin Works (W-2)** program. Wisconsin Works provides job preparation services, training, and case management to eligible parents. To best assign work, training, and education-related activities with appropriate accommodations, it is important the case manager understands the individual's abilities. All health-related information will be kept confidential. A release of information signed by this patient is included with this request.

Directions:
Complete the entire form, including the medical professional contact information section. A handwritten, wet signature is required in blue or black ink. Scan or mail the completed form to the Wisconsin Works agency listed above. Attach the patient's treatment plan, if applicable.

1. Does the patient have a health condition(s) that limits their ability to participate in structured work, training, or education activities for up to 40 hours per week? ☐ Yes ☐ No

   If yes, indicate how long the condition is expected to impact participation:
   ☐ Less than 60 days
   ☐ 2-6 months
   ☐ 6-12 months
   ☐ Ongoing / long-term

2. Provide relevant medical facts, diagnosis, and prognosis only as they directly affect functional capacity:

3. Identify the patient's physical ability (*select boxes in each column and specify limitation when applicable*):

a.) **Ability to lift and carry:**

☐ No functional limitation
☐ Limited to: lbs.

b.) **Ability to sit for 8-hour workday (with breaks):**

☐ No functional limitation
☐ Limited to: hours

c.) **Ability to stand/walk for 8-hour workday (with breaks):**

☐ No functional limitation
☐ Limited to: hours

d.) **Fine motor skill ability:**

☐ No functional limitation
☐ Specify motor skill limitation(s):

e.) **General movement ability:**

☐ No functional limitation
☐ Specify general movement limitation(s):

4. Considering this patient's condition(s) and abilities, which types of structured Wisconsin Works activities can the patient successfully participate in? **Select the checkboxes below if you believe the patient can successfully participate in:**

☐ Work experience/on the job training
☐ Job readiness, resume and interview preparation, job skill development
☐ Life skills or barrier-focused activities (e.g., budgeting, childcare, housing, health-related supports)
☐ Adult Basic Education
☐ High School Equivalency Diploma or similar program
☐ Vocational training
☐ Technical college occupational education program
☐ Other:

5. Does the patient require adaptive devices, accommodations, or modifications to participate successfully in work, training, or education activities *(e.g., mobility aids, assistive device for ambulation, need to alternate positions frequently, limits on pushing and pulling, accommodations for bending and crouching, modified hand or foot controls, assistive technology, part-time or flexible work schedule, hybrid work arrangement, modified lighting, ergonomic equipment)*?

☐ Yes ☐ No

If yes, describe what is needed:

6. Indicate any functional limitation *(e.g. physical, postural, durational, sensory, interpersonal)* related to the patient's condition(s) for the following abilities:

Reading:
☐ No limitation ☐ Specified limitation/barrier:

Writing:
☐ No limitation ☐ Specified limitation/barrier:

Computer Operating:
☐ No limitation ☐ Specified limitation/barrier:

Work in a Group Setting:
☐ No limitation ☐ Specified limitation/barrier:

7. Recommend activities and services that you believe may help this patient further address their condition(s) and functional capacity *(e.g., physical rehabilitation, counseling, medical treatment)*:

8. How often do you anticipate the patient's condition(s) will result in being absent from work and/or other Wisconsin Works activities?
☐ Never ☐ Once per month ☐ 2-3 times per month ☐ 4 or more times per month

9. Estimate the number of hours (up to 40) per week this patient can participate in work or education activities within these recommendations: hours per week.

10. Based on the patient's condition(s), do you recommend this patient to apply for Social Security Income/Disability with advocacy from the Wisconsin Works agency?
☐ Yes ☐ No

11. Given this patient's current medical condition(s), suggest when from now the recommendations you have provided should be reviewed:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other: / /

MEDICAL PROFESSIONAL CONTACT INFORMATION		
Name of Professional Provider	Title	Telephone Number
Signature of Professional Provider (*Wet Signature Required*)		Date Signed / /