Date:	Participant's Name:	CIN Number:	OBWP:

Participation Ability Request Form – Primary Caretaker

Patient Name:	Relationship to Participant:

It is our goal to assist the HCJFS Collaborative client named above in preparing for transition from welfare-to-work. The client states that (s)he must serve as the primary caregiver for the patient named above and is, therefore, unable to participate as required. Please give careful consideration in completing this form. The information that you provide will be used to determine activities this client may be able to participate in and duties (s)he may be able to perform, even if there are some limitations.

PATIENT AUTHORIZATION SECTION

My signature below authorizes the release of medical data to the Hamilton County Job and Family Services Collaborative.
Patient Signature (Parent/guardian signature if patient less than 18 years old):

MEDICAL PRACTITIONER:

Please complete the form and return to the fax # or address listed below no later than: _____.

PATIENT DIAGNOSIS:

1. Does the Patient Require a relative to provide medically necessary, full-time care? ☐ **No;** ☐ **Yes**
Comments:

2. Does caring for the patient prevent the caregiver from participating in the following: working, volunteering, training, or attending school?
☐ **No;** ☐ **Yes – If yes,** please indicate onset of inability and for how long the inability to participate in the above activities is expected to last. Onset date: _____ Duration: _____

3. If patient is under the age of 6, can the patient attend a childcare facility for at least 20 hours per week?
☐ **Yes;** ☐ **No – If no,** unable to attend _____ months from this date.

Physician Signature	Specialty	Date
Physician Address		Physician Phone