



MEDICAL VERIFICATION FORM TO BE COMPLETED BY LICENSED PHYSICIAN

Client/Patient Name: _____ Last 4 Digits SSN: _____

The information you provide on this form will not affect Billing, Reimbursement from Medicaid, Pursuing SSI/SSDI, Worker’s Compensation or Disability Determination.

The Welfare Transition program is a work readiness program for low-income families. The program philosophy is that most individuals can do something, even if activities are limited to a few hours per week. The Welfare Transition program provides cash assistance and services in exchange for participation in activities. To assign appropriate activities, it is important for us to have an idea of tasks/assignments that are reasonable for this participant. Thank you for taking the time to complete this form. We look forward to providing the best individualized service to your patient.

- 1. What is the specific diagnosis of illness/injury of the client/patient?
2. Is this condition permanent or temporary? If temporary, indicate estimated duration #Months.
3. PARTICIPATION IN ACTIVITIES:
a) Is the client/patient able to sit for 30 minutes at a time?
b) Is the client/patient able to stand for 30 minutes at a time?
c) WHAT IS THE MAXIMUM NUMBER OF HOURS ALLOWED IN AN ACTIVITY PER WEEK?
4. If this individual is pregnant, what is the expected date of delivery? Is this a high-risk pregnancy?
5. Is (s)he required to attend physical therapy, counseling or any other type of therapy, counseling or any other type of therapy/regular appointments? If yes, how often?
6. Date of patient’s most recent office visit:

Physicians – please provide a “hand written” signature when completing this form, thank you!

Name of Licensed Physician (Printed) Signature of Licensed Physician Phone Number

Mailing Address (Include city, state and zip code)

Physician’s License Number (as per Chapter 458 or Chapter 459 F.S.) Date Completed

ME, OS, DO, ACN only

PRIVACY ACT STATEMENT:

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes. INCLUDES HIPAA LANGUAGE AND REQUIREMENTS

An equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. All voice telephone numbers on this document may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711.