Healthcare Provider Statement of Abilities for FANF Financial Assistance

Name of FANF applicant/recipient

Authorized healthcare provider:
Name:
Address:
Phone:

RID # and/or Case # (if known)

Please return via mail or fax to:
Medical Exemption Unit
Bureau of Family Assistance, DHHS
129 Pleasant Street, Brown Building
Concord, NH 03301-3857
Fax: (603) 271-4637

You are receiving this form because you are a healthcare provider for the individual named above.

The Financial Assistance to Needy Families (FANF) program requires individuals to participate for a minimum of 20 to 30 hours per week in activities that help prepare them for self-sustaining, unsubsidized employment.

The individual named above reports that he or she is either limited or unable to participate in activities due to a medical and/or psychological condition. We need your professional assessment to help us determine this individual's abilities and limitations with regard to preparatory and work-related activities.

Only the following currently licensed healthcare providers are authorized to complete and sign this form: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Alcohol and Drug Counselors (Master LADCs only), Psychologists (board certified), Pastoral Psychotherapists, Independent Clinical Social Workers, Clinical Mental Health Counselors, and Marriage and Family Therapists.

The attached form has 2 sections. Please complete and return the appropriate section(s):
Section 1: For healthcare providers treating a physical condition.
Section 2: For healthcare providers treating a psychological condition.

Your patient should provide you with a signed Authorization for Release of Protected Health Information for FANF Financial Assistance (BFA Form 752A) providing permission to release the information on this form (BFA Form 752) to DHHS. Please fax or mail this completed form (BFA Form 752) directly to the Medical Exemption Unit using the contact information above.

If you have any questions, please call the Medical Exemption Unit at (603) 271-9511, option 2.

Preparatory and Work-Related Activities

There are many preparatory and work-related activities offered to individuals in the FANF work program. Individuals can participate in activities adapted to meet his or her needs and abilities. Activities include:

- **Barrier resolution:** This may include counseling or other services designed to minimize or resolve a personal issue or other barriers to employment.
- **Education or training:** This may include basic or adult education, ESL, or other education or training programs that promote employability.
- **Work-related activities:** This may include paid or unpaid work, or structured, supervised work activities that provide the individual the opportunity to experience and acquire the general workplace behaviors, attitudes, skills, and knowledge necessary to obtain and retain paid work.

Once completed, this form is valid for up to 6 months.
Section 1—Physical Abilities
(Complete if treating a physical condition.)

Only the following currently licensed healthcare providers are authorized to complete and sign this form for physical abilities—please check the corresponding box to indicate your profession:

- [ ] Physician
- [ ] Physician Assistant
- [ ] Advanced Practice Registered Nurse

Patient's name: ____________________________________________

Diagnosis: __________________________________________________

How does the patient's condition limit his or her activities?

- [ ] Yes
- [ ] No

Can perform sedentary activities. This includes frequent sitting or occasional standing/walking, such as classroom situations, desk work, and counseling or other appointments.

- [ ] Yes
- [ ] No

Can perform light work activities. This includes frequent walking, lifting of objects weighing 10 pounds, or the operation of simple equipment.

- [ ] Yes
- [ ] No

Can perform medium work activities. This includes frequent reaching, bending, or lifting of objects weighing 25 pounds and activities involving fine manual dexterity or coordination.

- [ ] Yes
- [ ] No

Can perform heavy work activities. This includes frequent physical exertion in a taxing work position, such as lifting and dragging heavy objects weighing 50 pounds or more.

- [ ] Yes
- [ ] No

With normal breaks, please indicate the maximum daily time the patient can:

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>1 hour</th>
<th>2 hours</th>
<th>3 hours</th>
<th>4 hours</th>
<th>5 hours</th>
<th>6 hours</th>
<th>7 hours</th>
<th>8+ hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Walk</td>
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<td></td>
</tr>
</tbody>
</table>

Is the patient taking any medication that negatively affects his or her abilities?

- [ ] No
- [ ] Yes

Please list any limitations or accommodations: ____________________________________________

With the above-noted accommodations in place (if any), is the patient able to participate in educational, training, or work-related activities?

- [ ] No
- [ ] Yes

If yes, indicate the number of hours the patient can participate per week:

- [ ] 31 or more hours
- [ ] 26 to 30 hours
- [ ] 21 to 25 hours
- [ ] 20 hours
- [ ] 1 to 19 hours

Authorized healthcare provider signature ___________________________ Date ____________

Authorized healthcare provider printed name (with credentials) ___________________________ Phone ________

Payment of any separate charge for completing this form is the responsibility of the patient.
Section 2—Psychological Abilities
(Complete if treating a psychological condition.)

Only the following currently licensed healthcare providers are authorized to complete and sign this form for psychological abilities—please check the corresponding box to indicate your profession:

- [ ] Physician
- [ ] Physician Assistant
- [ ] APRN
- [ ] Psychologist (board certified)
- [ ] Clinical Mental Health Counselor
- [ ] Pastoral Psychotherapist
- [ ] Independent Clinical Social Worker
- [ ] Alcohol and Drug Counselor (MLADC only)
- [ ] Marriage and Family Therapist

Patient’s name: ____________________________________________

Diagnosis: ____________________________________________________________________________________________

How does the patient’s condition limit his or her activities? ____________________________________________________________________________________________

What is the expected duration of the patient’s condition? ____________________________________________________________________________________________

For each activity listed below, rate the patient’s limitation in each area using the following terms:

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Marked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interact appropriately with others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain socially acceptable behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask questions or request help when necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhere to basic standards of neatness and hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aware of normal hazards; take precautions</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Remember locations and work-like procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Understand and remember short, simple instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Maintain attention for extended periods</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sustain routine without frequent supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Make simple work-related decisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Concentrate, persist, or maintain pace</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adapt to change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the patient taking any medication that negatively affects his or her abilities?  [ ] No  [ ] Yes

Please list any limitations or accommodations: ____________________________________________________________________________________________

With the above-noted accommodations in place (if any), is the patient able to participate in educational, training, or work-related activities?

[ ] No  [ ] Yes  If yes, indicate the number of hours the patient can participate per week:

- [ ] 31 or more hours  [ ] 26 to 30 hours  [ ] 21 to 25 hours  [ ] 20 hours  [ ] 1 to 19 hours

Authorized healthcare provider signature __________________________ Date __________ Phone ________________

Authorized healthcare provider printed name (with credentials) __________________________________________

Payment of any separate charge for completing this form is the responsibility of the patient.