DEAR HEALTH CARE PROVIDER:

The California Work Opportunity and Responsibility to Kids (CalWORKs) program requires that non-exempt individuals participate in work, training, or educational activities for 32 or 35 hours (for one or two-parent households, respectively) per week. CalWORKs participants must make "satisfactory progress" in their activities.

We ask your help in evaluating this individual by providing us with information regarding how his/her mental or physical condition will affect the ability to participate in a work/training program. With this information, we can better assign the participant to an appropriate activity. It will also help us to determine if the participant's condition will enable him/her to participate or successfully complete 32 or 35 hours per week of work and/or training requirements.

Please complete Section 2 of the attached form and sign (or have your authorized representative sign) the Certification in Section 3. Please also complete the Physical Capacities and/or Mental Capacities form(s), as appropriate.

Thank you for your assistance.

WORKER NAME	
WORKER PHONE NUMBER	FAX NUMBER

AUTHORIZATION TO RFI FASE

COUNTY USE ONLY					
CASE NAME:	CASE NUMBER:				
WORKER NAME:	WORKER NUMBER:				

	THORIZATION TO RELEASE								
ME	EDICAL INFORMATION	WORKER NAME:	WORKER NAME:				WORKER NUMBER:		
	ction I must be completed by the patient/clipresentative) checked below: (County worked Licensed physician or certified psychological Health care professional licensed or cert work or participate in education/training licensed/certified psychologists.	er to check appropriat st. ified by a state to dia	te box belov agnose/treat	v.) physical or mental in	npairments	affecting th	e ability to		
	SECTION 1. PATIENT/CLIENT IN	NFORMATION AN	ID AUTH	ORIZATION TO R	ELEASE I	NFORM <i>F</i>	ATION		
NAM	IE OF PATIENT/CLIENT (<i>LAST, FIRST, MIDDLE)</i>	SEX (CIRCLE) BI	RTH DATE 	SOCIAL SECURITY NUMBER	AGE(S) OF	CHILD(REN) IN H	HOME		
la	uthorizeNAME OF PROVIDER	of		CLINIC OR MEDICAL	GROUP				
to release information to the county welfare department from my records on the conditions checked below:									
	☐ Physical Condition ☐ Mental 0	Condition \Box C	ther (Descr	ibe)					
this by trai file law	now this authorization may be used by the case authorization at any time, except for inform the county welfare department to determining activities that I can take part (participal and will not be disclosed without my signed v. I have read this form (or had this form read)	mation that has alread ne eligibility for cash a ate) in, and the CalWo ed consent for each d	ly been give aid or food : DRKs servic isclosure ur completed.	on to the welfare departs stamps. It is also need tes that I need. This in alless the disclosure is I know I can get a cop	tment. This ded to decinformation value specifically by of this form	s information de the type will be kept required or	n is needed e of work or in the case allowed by		
PATII	ENT/CLIENT SIGNATURE		RELATION	SHIP TO PATIENT, IF NOT SELI	-	DATE SIGNED			
SIGN	IATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON	I ACTING FOR PATIENT/CLIEN	IT			DATE SIGNED			
	95(CTION 2. STATE	MENT OF	PPOVIDED	<u> </u>				
The	e information requested is needed to evaluark assignment. Please answer the following Questions 1	te eligibility for public g questions as indicate	assistance	for the person named a		o determine	e his/her		
1.									
2.	Onset Date of Condition	The condition is	Chronic	☐ Acute, expected	to last until_				
3.	Is the patient actively seeking treatment?	\square YES \square NO	Next appoir	ntment date					
4.	Is this person able to work? If YES, how many hours per day?					. 🗆 YES	\square NO		
5.	Does this person have any limitations that affect his/her ability to work or participate in education or training? . \square YES \square NO						\square NO		
6.	It is necessary to determine whether child the other parent to work. Does the patient the child(ren) in the home?	t's condition prevent h	im/her from	providing care for		. 🗆 YES	□NO		
7.	Does the patient's condition require some	one to be in the home	to care for	him/her?		. 🗆 YES	\square NO		
	SECTION 3. PROVIDER CERTIFICATION								
SIGNATURE OF PROVIDER OR PROVIDER'S AUTHORIZED REPRESENTATIVE DATE				DATE SIGNE	SIGNED				
PRINT NAME AND TITLE/SPECIALTY			PHONE NUMI	PHONE NUMBER					
		ADDRESS IF DIFFERENT	0.7	~	()		ZID CODE		
JIKE	EET ADDRESS (MAILING	G ADDRESS, IF DIFFERENT)	CIT	1	STATE		ZIP CODE		