



Submit completed form to Agency listed below:

Examination Report & Certification (MED-1)

PART 1: Completed by Client

Please print clearly

CLIENT INFORMATION

Client Name: _____ Date of Birth: MM / DD / YYYY
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Case #: _____

CONSENT TO RELEASE INFORMATION

I hereby authorize my medical provider(s) to disclose to the New Jersey Division of Family Development and/or any representative of my county social services agency any medical information that is necessary to determine whether I am eligible for a deferral from work activities. I understand that my consent is for the above-mentioned purposes, and that I may refuse to consent. This authorization is valid for one year from the date indicated below or upon written notice to withdraw my consent.

Client Signature: _____ Date: MM / DD / YYYY

PART 2: Completed by Medical Professional

A. MEDICAL PROFESSIONAL INFORMATION

NOTICE TO MEDICAL PROFESSIONAL

Work First New Jersey (WFNJ) is the state’s public assistance program, which imposes work requirements and time limits on program recipients, as required by law. The goal of WFNJ is to provide training and educational work activities that will assist program recipients in obtaining a job. **These work activities include but are not limited to classroom programs such as literacy, job readiness, occupational skills training, and trade education.**

The client named above is a WFNJ recipient and is requesting a deferral from a 30-35 hour full-time work activity and/or time limit requirement due to their reported medical condition. The information requested is necessary for this agency to decide whether your patient is eligible for a work activity deferral. In your evaluation, consider whether your patient may be able to participate in a classroom setting, despite the inability to work full-time.

This report must be based on your complete, in-person medical evaluation. This information must be furnished within 15 days by faxing and/or mailing the completed form to the address above. Your failure to complete this form **will not** in itself result in a loss of benefits (cash assistance, housing, etc.) for the client.

Medical Group Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Medical Professional’s Name: _____
Email: _____ Phone #: _____ Fax #: _____
License #: _____ Area(s) of Specialty: _____

B. PATIENT INFORMATION

1. Date of first patient exam: MM / DD / YYYY 2. Date of most recent patient exam: MM / DD / YYYY
3. Clinical diagnosis with applicable ICD-CM/DSM codes and the onset of diagnosis: _____

2. Please provide a brief summary of any relevant clinical findings and the dates of relevant testing and lab work that led to this diagnosis: _____

3. What medications have been prescribed related to the client's diagnosis: _____

4. Are you the medical professional regularly treating the patient for the diagnosis listed above? Yes No
- a. If yes, what is the present recommended treatment plan? _____
- b. If no, state your recommended treatment plan: _____

5. Is there any indication of current behavioral health and/or substance use issues that are not being treated under your care? Yes No
6. Is the sole reason for the patient's inability to participate in a work activity, for 30-35 hours, due to behavioral health and/or substance use issues? Yes No

C. ABILITY TO PARTICIPATE IN A WORK ACTIVITY

Based on your medical opinion of your patient's current capabilities as they relate to work, please select one of the following:

Please remember: Work activities include but are not limited to classroom programs such as literacy, job readiness, occupational skills training, and trade education.

FULL-TIME EMPLOYABILITY

This individual is able to work full-time or participate in a work activity, on a sustained basis, for the 30-35 hours that are required per week with the following reasonable accommodations, (if any): _____

PART-TIME EMPLOYABILITY

This individual is able to work or participate in a work activity, on a sustained basis, for less than the 30-35 hours that are required per week with the following reasonable accommodations, (if any): _____

TEMPORARILY UNABLE TO PARTICIPATE IN A WORK ACTIVITY

This individual's physical/mental condition precludes them from participating in any form of work activity, on a sustained basis, at this time, but the condition is expected to improve within 12 months. This individual's temporary condition is expected to prevent work or participation in training until MM / DD / YYYY .

PERMANENTLY DISABLED FOR THE PURPOSES OF A WORK ACTIVITY

This individual has a physical or mental condition that is expected to last for 12 months or more and precludes any form of work activity on a sustained basis. As a result, the individual may be a candidate for Social Security Disability or Supplemental Security Income – which requires the client's condition to possibly last for a continuous period of at least 12 months or result in death.

D. CERTIFICATION

I certify that all of the information provided on this form is true, correct, and complete to the best of my professional knowledge. I further certify that the diagnosis and assessment of the patient's health condition are based on their medical condition as determined by examination and knowledge of the patient's medical history. I recognize that I may be called to testify concerning this report and that any false information may subject me to criminal and/or civil penalties. I understand that if additional information is needed in order to clarify the information provided, I may be contacted and asked to provide such information.

Medical Professional Signature: _____

Date: MM / DD / YYYY

OFFICIAL USE ONLY

Med-1 Form received: MM / DD / YYYY

Client's physician contacted: MM / DD / YYYY

The client's physician stated that:

Referral made to: One-Stop BHI/SAI LSNJ SSI Project

CWA/MWA Representative Name: _____ Date: MM / DD / YYYY

DEFERRAL DETERMINATION:

Denied

Approved

Start: MM / DD / YYYY End: MM / DD / YYYY