Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-2114-ENG 3-22

Request for Medical Opinion

Case number: _____

Date: _____

(Medical provider name/clinic, street address, city/state/zip code)

To: _____

_____

_____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

City/state/zip code: _____

Medical Provider

Please provide the information requested on the back of this form for the person listed below. This request does not represent an offer of payment on the part of the state or county agency. This authorization (see below) will end one year from the date it is signed. Return this form to the person and agency listed above. On the bottom half of this form is a signed authorization to release this information to the human service agency listed.

CLIENT NAME			DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	SPOUSE OR FORMER NAME		

Client

We need to know what your medical provider thinks about your health to decide what programs can help you. We will send this form to the medical provider listed above and ask him/her to answer the questions on the back. If you want, you can get your own letter from the medical provider answering these questions. If you want to use this form, read and sign the "Authorization for Release of Information" section below.

If we do not get these medical facts about you, you may not get help.

Authorization for Release of Information

Giving Permission

I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences

State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

☐ By checking this box and typing my name in the "Client Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

CLIENT SIGNATURE	DATE

☐ By checking this box and typing my name in the "Signature of Spouse/Guardian/Authorized Representative" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE

Do NOT use this form for SMRT applications.

Medical Opinion

Do NOT use this form for SMRT applications

(Mail or fax to agency address/fax number on first page)

Medical provider

NAME
CLINIC

Client

NAME	
CASE NUMBER	DATE OF MOST RECENT EXAM

Based on your knowledge of the patient or client, please respond to the following questions. A county worker will use your response to determine if this person is eligible for cash assistance, Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) or the Child Care Assistance Program (CCAP). It may also serve as a basis for referral to apply for a Social Security disability program or Supplemental Security Income (SSI).

Minnesota Statutes 13.03, subd. 3 allow clients access to private data recorded in their files. Be informed that upon request by the client or his/her representative, this agency is required by law to provide access to the information contained on this form.

1. Diagnosis

2. Will the condition last: ◯ Less than 30 days ◯ Between 30-45 days ◯ More than 45 days ◯ Other

   a. If less than 30 days, how long do you expect the condition to last?

   b. List any **temporary** physical or mental limitations

   c. List any **permanent** physical or mental limitations

3. Have you prescribed a treatment plan? ◯ Yes ◯ No

   If yes, is patient following the treatment plan? ◯ Yes ◯ No ◯ Unknown

4. When will the patient be able to perform employment? (select one)

   ◯ Patient can perform **any** employment now. Hours per day?_____, or week?_____

   ◯ Patient can perform **limited** employment now. Hours per day?_____, or week?_____
   Limitation(s):_____

   ◯ Patient will be able to perform **any** employment starting (date)_____
   Hours per day?_____, or week?_____

   ◯ Patient will be able to perform limited employment starting (date)_____
   Hours per day?_____, or week?_____
   Limitation(s):_____

   ◯ Patient **will not** be able to perform any employment in the foreseeable future.

5. Does the patient have: (check all that apply)

   Developmental disability? ◯ Yes ◯ No ◯ Unknown

   Mental illness? ◯ Yes ◯ No ◯ Unknown

   Learning disability? ◯ Yes ◯ No ◯ Unknown

   Chemical dependency? ◯ Yes ◯ No ◯ Unknown

6. If the diagnosis is Drug Addiction and/or Alcoholism, would there still be a disabling condition if the person were to stop the addictive behavior?

   ◯ Yes ◯ No ◯ Unknown

7. If female, is this person pregnant? ◯ Yes ◯ No

   If yes, what is the date of conception? _____ Due date? _____

8. Comments

☐ By checking this box and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

SIGNATURE	DATE
TITLE	PHONE NUMBER

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်.ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မိတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစိနိုဂ်ံာ်လၢထးအံၤန္ဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)