Reset Form

Ohio Department of Job and Family Services

BASIC MEDICAL

SECTION I: IDENTIFYING INFORMATION TO BE COMPLETED BY WORKER

Assistance Group Number	Recipient ID	DOB	Sex	County Name

Client Last Name	Client First Name	MI	County Address

Client Address	Client Phone	City	Zip Code

City	Zip Code	SSN	Caseworker/Case Mgr	Caseload ID	County Phone

SECTION II: TO BE COMPLETED BY PHYSICIAN

Are you the individual's primary care physician? ☐ Yes ☐ No

Physical Examination / Vital Signs

Height	Weight	Pulse Rate	Blood Pressure	Respiratory Rate

HEENT	Respiratory Rate

Chest	Heart

Extremities	Neurological

Visual Acuity	OS	OD

ROM	Spine	Joints

A. Pregnancy verification only	Date of test	Expected date of delivery

B. Describe the client's medical conditions (physical and mental) [Include appropriate ICD-9CM, DSM-IIIR and/or DSM-5 codes(s)]

C. History of these problems (Onset, duration, treatment, prescribed medications, prognosis, etc.)

D. Health Status:
- ☐ Improving
- ☐ Improving Without Tx
- ☐ Improving With Tx
- ☐ Good/Stable With Tx
- ☐ Poor But Stable
- ☐ Deteriorating

E. Physical/psychological/psychiatric findings (Please also complete G and/or JFS form[new form number]for Mental Impairments as appropriate):

F: Are additional studies or treatment indicated? If yes, specify.

Client Last Name	Client First Name	MI	Recipient ID	SSN

Considering the combined effects of the medical conditions noted above, please answer the following:

G. Physical Functional Capacity Assessment

	No	Yes	Hours
1. Are standing/walking affected?	☐	☐	
If yes, how many hours in an 8-hour workday can patient stand/walk?	☐	☐	
How many hours without interruption?	☐	☐	
2. Is sitting affected?	☐	☐	
If yes, how many hours in an 8-hour workday can patient sit?	☐	☐	
How many hours without interruption?	☐	☐	
3. Are lifting/carrying affected?	☐	☐	

If yes, up to how many pounds can patient lift/carry frequently? (up to 2/3 of 8 hour day)

☐ Up to 5 lbs. ☐ 6-10 lbs. ☐ 11-20 lbs. ☐ 21-25 lbs. ☐ 26-50 lbs. ☐ 51-100 lbs.

If yes, up to how many pounds can patient lift/carry occasionally? (up to 1/3 of 7 hour day)

☐ Up to 5 lbs. ☐ 6-10 lbs. ☐ 11-20 lbs. ☐ 21-25 lbs. ☐ 26-50 lbs. ☐ 51-100 lbs.

	None	Not Significantly Limited	Moderately Limited	Markedly Limited	Extremely Limited
4. Are the following functions affected? If so, how?					
Pushing/pulling					
Bending					
Reaching					
Handling					
Repetitive foot movements					
Seeing					
Hearing					
Speaking					

5. What observations and/or medical evidence led to your findings in questions G1 - G4? Please provide examples of specific physical limitations:

After taking the appropriate history and performing the relevant examination, do you believe the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than nine months?
☐ Yes ☐ No

Will disclosure of this information to the client have an adverse effect? ☐ Yes ☐ No

I hereby certify under penalty of law that the above information is a true and accurate description of my patient's medical condition at this time to the best of my knowledge. I understand that I may be reported to the State Medical Board and/or be subject to *criminal or civil prosecution* should I knowingly make false or misleading statements or provide altered or false documentation that results in my patient being inappropriately determined to be eligible for the Disability Financial Assistance program.

Physician's Signature	Signature Date	**Date of Last Exam**

Physician's Name *(Please print)*	Specialty

Address			
City	State	Zip Code	Physician's Phone