DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

July 18, 2001

ALL COUNTY LETTER NO. 01-44

TO: ALL COUNTY WELFARE DIRECTORS
ALL CalWORKs PROGRAM SPECIALIST
ALL CalWORKS WELFARE-TO-WORK COORDINATORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[X] Clarification Requested by One or More Counties
[X] Initiated by CDSS

SUBJECT: REVISED CA 61 MEDICAL REPORT

REFERENCE: MANUAL OF POLICIES AND PROCEDURES (MPP) SECTIONS 41-430 AND 42-712.44

In consultation with representatives of counties and advocates, the CA 61 Medical Report has been revised and replaced with the following new set of forms for use in acquiring information needed for the California Work Opportunity and Responsibility to Kids Program:

- CW 61 (6/01) - Authorization to Release Medical Information
- CW 61A (6/01) - Physical Capacities
- CW 61B (6/01) - Mental Capacities

The CW 61 forms are no longer intended for use in requesting information for the Medi-Cal program. A new form for that purpose, the MC 61 – Medical Report, was released by the California Department of Health Services with All County Welfare Directors Letter 00-47, dated September 19, 2000.

CW 61 – Authorization to Release Medical Information

The CW 61 is now a two-page form with a coversheet. The coversheet is addressed to the health care provider to explain the purpose of information requested in the CW 61, CW 61A and CW 61B. A detailed description of the new form, along with important instructions on how to complete and use it, are contained in Attachment A.

CW 61A, Physical Capacities and CW 61B, Mental Capacities

The CW 61A (based on U.S. Department of Labor standards) and the CW 61B were developed to elicit information on the patient's physical and mental condition to use in making decisions concerning client welfare-to-work participation. At the worker's

discretion and based on the medical information needed, one or both of these forms may be sent to the client's health care provider along with the CW 61. The health care provider is instructed on the CW 61 Coversheet, as well as in Section 2, question 1, to complete the CW 61A and/or CW 61B (if attached), as appropriate. If the worker sends the CW 61A and/or 61B along with the CW 61 to the provider but only the CW 61 is returned, there is no need to insist on return of the other forms if the CW 61 contains the information needed by the county.

Instructions at the top of the CW 61A and CW 61B ask the health care provider to answer the questions, and comment on any functional issues that are relevant to the individual's assigned activity if an assignment is indicated on the form. This is followed by space for the county worker to write in a description of the nature and hours of the assigned CalWORKs activity, if any. This permits the county to request that the forms be completed either before or after the individual's activity(ies) have been assigned.

Implementation

Counties should begin using these new forms as soon as administratively feasible. See Attachment B for information about stock, modification of forms, camera-ready copies, and translations.

Contacts

If you have questions regarding the information in this letter, please contact the following staff for the specified program areas:

This letter and attachment: Vince Toolan, e-mail vtoolan@dss.ca.gov
(916) 654-1808/CALNET 464-1808

Welfare to Work: Milt Yee, e-mail myee@dss.ca.gov
(916) 657-3399/CALNET 437-3399

Eligibility/Deprivation: Linda Lattimore, e-mail llattimore@dss.ca.gov
(916) 653-5830/CALNET 453-5830

Sincerely,
Original signed by Bruce Wagstaff on 7/18/01
BRUCE WAGSTAFF
Deputy Director
Welfare to Work Division

Attachments

c: CWDA
CSAC

ATTACHMENT A

CW 61 – AUTHORIZATION TO RELEASE MEDICAL INFORMATION

- **Instructions on the top of the form** require the county worker to check the box indicating the type of provider who must complete and sign the form(s), as required by regulations in MPP sections 41-430 and 42-712.44. These sections set two different requirements for the type of health care providers who must complete the form. Section 41-430 sets requirements for the providers of information to determine deprivation due to incapacity. Section 42-712.44 sets broader requirements for the type of providers of information to determine disability for welfare-to-work participation. If the CW 61 form(s) are sent to a provider to obtain information to be used to determine deprivation due to incapacity, they must be completed by a "licensed physician or certified psychologist." If the information is needed to verify a disability affecting welfare-to-work participation, the requirements are less restrictive. The forms may be completed by any health care professional licensed or certified by a state to diagnose/treat physical or mental impairments affecting the ability to work or participate in education/training activities including, but not limited to, medical doctors, osteopaths, chiropractors and licensed/certified psychologists.

- **Section 1, Patient/Client Information and Authorization to Release Information**, now includes boxes to be checked by the patient/client to designate the type of information to be released. Language in this section is also revised to inform the patient/client: a) the authorization may be revoked at any time, b) information requested is needed for specific reasons, and c) the information will be kept in the case file and will not be disclosed without a signed consent for each disclosure, unless the disclosure is specifically required by law.

- **Section 2, Statement of Provider** (formerly Section III), now includes boxes to be checked by the worker to designate the questions to be answered by the health care provider. Questions 1 through 5 request information needed to determine deprivation and ability to participate/work. Questions 6 and 7 are separate and boxes are to be checked by the worker for these questions only when information is needed to determine whether the patient's condition: a) prevents him/her from caring for the child(ren) while the other parent works, and/or b) requires someone in the home to care for the patient. The purpose of these questions is to assist the county in determining childcare needs. These questions are not asked to obtain information to initiate a child protective services referral.

- **Section 2** no longer requires a "diagnosis and prognosis" for the patient. Information needed to meet this CalWORKs program requirement is requested in new questions on the CW 61, CW 61A and CW 61B that focus on the specific mental and physical capacities of the patient and his/her ability to participate in work activities. It is anticipated that these new forms will elicit the necessary information to determine deprivation and welfare-to-work participation while protecting the privacy of client medical information.

Section 3, Provider Certification no longer requires the provider to sign under penalty of perjury. The penalty of perjury statement is not required since the information provided represents an opinion by the provider based on his/her evaluation of the patient, as well as the fact that the regulations allow an authorized representative to sign the form.

ATTACHMENT B

IMPORTANT FORMS INFORMATION

Stock

State produced stock of the English and Spanish language versions for these forms will be available 30 to 60 days after the release of this letter. Stock of each form may be ordered from the CDSS Warehouse upon receipt of the Notice of Form Change (GEN 127), in accordance with the procedures in the County Forms Catalog.

Forms Designation and Modification of Forms

The forms designation for the CW 61, CW 61A and CW 61B is "Required Form – Substitute Permitted." Counties must obtain prior approval from CDSS before implementing a modification or substitution to this and other "Substitute Permitted" forms. The procedures for submission of a change request are outlined in Management and Office Procedures Regulations 23-400.22.

Camera-Ready Copies and Translations

After you receive a copy of an English form, please allow six to eight weeks for the form to be translated and mailed to your CalWORKs Forms Coordinator. Language Translation Services (LTS) will mail camera-ready copies of Spanish, Chinese, Vietnamese and Russian translations as soon as they become available. You do not need to initially request forms from LTS. To order additional camera-ready translated forms, fax your request to LTS at (916) 657-3429 or e-mail it to LTS@dss.ca.gov.

For a camera-ready copy and/or additional copies of an English form, please call the Forms Management Unit (FMU) at (916) 657-1907. If your office has Internet access, you may obtain various forms from the CDSS web page at http://www.dss.cahwnet.gov. If the name, mailing address or e-mail address of your CalWORKs Forms Coordinator changes, please contact FMU by telephone at (916) 654-1282 or by email at fmu@dss.ca.gov.

Your CalWORKs Forms Coordinator is to distribute forms and NOA messages to each program and location. Each county shall provide bilingual/interpretive services and written translations of non-English or limited-English speaking populations as required by the Dymally Alatorre Bilingual Services Act (Government Code Section 7290 et seq.) and by state regulations in the MPP, Division 21, Civil Rights Nondiscrimination, Section 115.

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 RELEASE MEDICAL INFORMATION

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

Section I must be completed by the patient/client. Sections 2 and 3 are to be completed by the type of provider *(or his/her authorized representative)* checked below: *(County worker to check appropriate box below.)*

☐ Licensed physician or certified psychologist.

☐ Health care professional licensed or certified by a state to diagnose/treat physical or mental impairments affecting the ability to work or participate in education/training activities including, but not limited to, medical doctors, osteopaths, chiropractors, and licensed/certified psychologists.

SECTION 1. PATIENT/CLIENT INFORMATION AND AUTHORIZATION TO RELEASE INFORMATION

NAME OF PATIENT/CLIENT *(LAST, FIRST, MIDDLE)*	SEX *(CIRCLE)*	BIRTH DATE	SOCIAL SECURITY NUMBER	AGE(S) OF CHILD(REN) IN HOME
	M F	- -	- -	

I authorize_____ of _____

NAME OF PROVIDER — CLINIC OR MEDICAL GROUP

to release information to the county welfare department from my records on the conditions checked below:

☐ Physical Condition ☐ Mental Condition ☐ Other *(Describe)*_____

I know this authorization may be used by the county welfare department for up to one year to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the welfare department. This information is needed by the county welfare department to determine eligibility for cash aid or food stamps. It is also needed to decide the type of work or training activities that I can take part (participate) in, and the CalWORKs services that I need. This information will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had this form read to me) after it was completed. I know I can get a copy of this form if I ask for it.

PATIENT/CLIENT SIGNATURE	RELATIONSHIP TO PATIENT, IF NOT SELF	DATE SIGNED

SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR PATIENT/CLIENT	DATE SIGNED

SECTION 2. STATEMENT OF PROVIDER

The information requested is needed to evaluate eligibility for public assistance for the person named above and to determine his/her work assignment. Please answer the following questions as indicated by check mark:

☐ Questions 1 through 5 ☐ Question 6 ☐ Question 7

1. Does the patient have a medically verifiable condition that would limit or prevent him/her from performing certain tasks? . . . . . ☐ **YES** ☐ **NO**

   If YES, complete the rest of this form, and the Physical Capacities and/or Mental Capacities form *(if attached)*, as appropriate.
   If NO, just complete the Health Care Provider Certification Section below.

2. Onset Date of Condition _____. The condition is ☐ Chronic ☐ Acute, expected to last until_____

3. Is the patient actively seeking treatment? ☐ **YES** ☐ **NO** Next appointment date _____

4. Is this person able to work? . . . . . ☐ **YES** ☐ **NO**
   If YES, how many hours per day?_____

5. Does this person have any limitations that affect his/her ability to work or participate in education or training? . ☐ **YES** ☐ **NO**

6. It is necessary to determine whether child care needs to be provided to enable the other parent to work. Does the patient's condition prevent him/her from providing care for the child(ren) in the home? . . . . . ☐ **YES** ☐ **NO**

7. Does the patient's condition require someone to be in the home to care for him/her? . . . . . ☐ **YES** ☐ **NO**

SECTION 3. PROVIDER CERTIFICATION

SIGNATURE OF PROVIDER OR PROVIDER'S AUTHORIZED REPRESENTATIVE	DATE SIGNED

PRINT NAME AND TITLE/SPECIALTY	PHONE NUMBER
	( )

STREET ADDRESS *(MAILING ADDRESS, IF DIFFERENT)*	CITY	STATE	ZIP CODE

PHYSICAL CAPACITIES

CASE NAME	DATE

PATIENT NAME:	CASE NUMBER	SSN:

This form is intended to determine the extent, if any, that this person's current physical condition would interfere with his/her ability to work or participate in a CalWORKs activity. Please address specific functional issues that are relevant to this person's assigned activity, if an assignment is indicated below. Attach additional documentation, if necessary.

This person is assigned to:_____

_____

(Description of nature and hours of assigned CalWORKs activity)

1. In an 8-hour workday, patient can stand/walk: *(Check ✔)* ☐ No Restrictions

   Hours at one time: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Total hours during day: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Comments:

2. In an 8-hour workday, patient can sit: *(Check ✔)* ☐ No Restrictions

   Hours at one time: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Total hours during day: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Comments:

3. Is patient restricted in using hands/fingers for repetitive motions? *(Check ✔)* ☐ No Restrictions

   ☐ Yes - please explain _____

4. Is patient restricted in using feet for repetitive movements, such as in operating foot controls? *(Check ✔)* ☐ No Restrictions

   ☐ Yes - please explain _____

5. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.? *(Check ✔)* ☐ No Restrictions

   ☐ Yes - please explain _____

PHYSICAL CAPACITIES (CONTINUED)

6. Patient can lift/carry: *(Check ✔)* ☐ No Restrictions

Maximum lbs:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80+
Never:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0 - 2.5 hrs/8-hr day)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently: (2.5 - 5.5 hrs/8-hr day)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Constantly: (5.5+ hrs/8-hr day)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

7. Patient is able to: *(Check ✔)* ☐ No Restrictions

	Never	**Occasionally** (0 - 2.5 hrs/8-hr day)	**Frequently** (2.5 - 5.5 hrs/8-hr day)	**Constantly** (5.5+ hrs/8-hr day)
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Below knees	☐	☐	☐	☐
Waist to knees	☐	☐	☐	☐
Waist to chest	☐	☐	☐	☐
Chest to shoulders	☐	☐	☐	☐
Above shoulders	☐	☐	☐	☐

Comments:

8. Is patient involved with treatment and/or medications that might affect his/her ability to work? *(Check ✔)* ☐ YES ☐ NO

If Yes, please explain the limitations/affect:

9. Please describe any other limitations on the individual's ability to work and/or participate in an education/training assignment and accommodations needed:

HEALTH CARE PROVIDER (OR DESIGNEE) SIGNATURE	PHONE NUMBER	DATE
	( )	

HEALTH CARE PROVIDER NAME AND ADDRESS:

MENTAL CAPACITIES

CASE NAME	DATE

PATIENT NAME:	CASE NUMBER	SSN:

Please indicate the extent, if any, that this person's current mental condition would interfere with his/her ability to work or participate in a CalWORKs activity. Please address those specific issues that are relevant to this person's assigned activity, if an assignment is indicated below. Attach additional documentation, if necessary.

This person is assigned to:_____

_____

(Description of nature and hours of assigned CalWORKs activity)

1. **Present Daily Activities:** Describe the degree of assistance or direction this person needs to properly care for his/her work, training and/or educational affairs. Describe the ways, if any, that the patient's daily work, training and/or educational activities are affected as a result of the patient's mental condition.

2. **Social functioning:** Describe the patient's capacity to interact appropriately and communicate effectively with co-workers, instructors, other students, and members of the public, etc. Describe the way, if any, that this is affected as a result of the patient's condition.

3. **Task Completion:** Describe the patient's ability to: complete everyday workplace, training, and/or educational routines; follow and understand simple written or oral instructions, sustain focused attention, etc. Describe the way, if any, that this ability is affected as a result of the patient's condition.

4. **Adaptation to Work or Work-like Situations:** Describe the patient's ability to adapt to stresses common to the work, training, or educational environment, including decision making, attendance, schedules, and interaction with supervisors or instructors. Describe the way, if any, that this ability is affected as a result of the patient's condition.

PROVIDER/EVALUATOR (OR DESIGNEE) SIGNATURE	PHONE NUMBER	DATE

PROVIDER/EVALUATOR NAME AND ADDRESS: