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: