

Medical Opinion

Do NOT use this form for SMRT applications
(Mail or fax to agency address/fax number on first page)

Medical provider:

NAME
CUNIC

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.

- Diagnosis: Stimulant Use Disorder Severe (F1520)
- Will the condition last: Less than 30 days Between 30-45 days More than 45 days Other: _____
 - If less than 30 days, how long do you expect the condition to last? _____
 - List any **temporary** physical or mental limitations: Ø
 - List any **permanent** physical or mental limitations: Ø
- Have you prescribed a treatment plan? Yes No
If yes, is patient following the treatment plan? Yes No Unknown
- When will the patient be able to perform employment? (Check 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.
- 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
- 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
- If female, is this person pregnant? Yes No
If yes, what is the date of conception? _____ Due date? _____
- Comments: _____

SIGNATURE	TITLE	PHONE NUMBER	DATE
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