HEALTH STATUS REPORT

First and Last Name of Individual Seeking Evaluation: ____________________________________________

ICCIS ID Number, if known: ______________________________________________________________

HEALTH CARE/MENTAL HEALTH CARE PROFESSIONAL: The Child Care Assistance Program (CCAP) provides financial assistance with child care expenses to help adults maintain employment so their family can be self-sufficient. A requirement of CCAP participation is that parents must participate in an eligible activity of work or in a job training or educational program to receive assistance, unless one or both parents have been determined, by a health care or mental health care professional, to be incapacitated. For CCAP purposes, incapacitated means “physically incapable of caring for children in the family, or temporarily unable to participate in an eligible activity, as determined by a health care or mental health care professional” 7 AAC 41.360(d).

The person named above has reported being incapacitated. Please evaluate this person’s capacity to participate in an eligible activity of work, job training, or educational program; or to care for children in the family. This information is needed to determine the family’s eligibility to participate in the CCAP.

Date of Examination: ________________________  Diagnosis/Condition: __________________________

1. Does the patient have a physical or mental health condition which limits their ability to:
   Work full time ☐ Yes ☐ No or Work part time ☐ Yes ☐ No
   Is the condition considered to be permanent? ☐ Yes ☐ No
   If patient can work part-time, how many hours per day? __________________
   If the condition is temporary, how long do you expect the condition to limit the patient’s ability to work? __________________

   Attend job training or an educational program full time ☐ Yes ☐ No or Attend job training or educational program part time ☐ Yes ☐ No
   Is the condition considered to be permanent? ☐ Yes ☐ No
   If patient can attend job training or an educational program part-time, how many hours per day? _________
   If the condition is temporary, how long do you expect the condition to limit the patient’s ability to attend job training or an educational program? __________________

   Provide care for the children of the family full time? ☐ Yes ☐ No or provide care for the children of the family part time ☐ Yes ☐ No
   Is the condition considered to be permanent? ☐ Yes ☐ No
   If patient can care for the children of the family part-time, how many hours per day? _________________
   If the condition is temporary, how long do you expect the condition to limit the patient’s ability to care for the children of the family? __________________
2. Is the patient taking any medications that may cause side effects impacting their ability to participate in work, job training or an educational program, or to provide care for the children of the family?
☐ Yes  ☐ No

Printed Name of Health Care/Mental Health Care Professional

__________________________________________________

Signature of Health Care/Mental Health Care Professional

Date:__________________________________________  Contact Phone:_________________________________

Address:__________________________________________________________________________________

Please fax the completed form to the number indicated below.

Child Care Assistance Program Representative Printed Name

__________________________________________________

Job Title:________________________________________ Fax Number:_________________________________