Clear Form

Minnesota Department of **Human Services**

DHS-2114-ENG 5-12

Request for Medical Opinion

Date: **Case number:**

(Medical provider name, clinic, address, zip code)

To:

Worker name:
Agency name:
Agency address:
City, state, zip code:
Worker phone: Fax:

Medical Provider: Please provide the information requested on the back of this form for the person listed below. This request does not represent an offer of payment on the part of the state or county agency. This authorization (see below) will end one year from the date it is signed. Return this form to the person and agency listed above. On the bottom half of this form is a signed authorization to release this information to the human service agency listed.

Person name:
Address:
City/state/zip code:

Birth date:
Social Security number:
Spouse or former name:

Client: We need to know what your medical provider thinks about your health to decide what programs can help you. We will send this form to the medical provider listed above and ask him/her to answer the questions on the back. If you want, you can get your own letter from the medical provider answering these questions. If you want to use this form, read and sign the "Authorization for Release of Information" section below.

If we do not get these medical facts about you, you may not get help.

Authorization for Release of Information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE	DATE	Original copy for agency Provide copy to client
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	

Do NOT use this form for SMRT applications.

Over

Medical Opinion

Do NOT use this form for SMRT applications

(Mail or fax to agency address/fax number on first page)

Medical provider:		**Client:**	
NAME		NAME	CASE NUMBER
CLINIC		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.

1. Diagnosis: _____
   _____
   _____

2. Will the condition last: ☐ Less than 30 days ☐ Between 30-45 days ☐ More than 45 days ☐ Other: _____
   a. If less than 30 days, how long do you expect the condition to last? _____
   b. List any **temporary** physical or mental limitations: _____
   _____
   c. List any **permanent** physical or mental limitations: _____
   _____

3. Have you prescribed a treatment plan? ☐ Yes ☐ No
   If yes, is patient following the treatment plan? ☐ Yes ☐ No ☐ Unknown

4. 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.

5. 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

6. 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

7. If female, is this person pregnant? ☐ Yes ☐ No
   If yes, what is the date of conception? _____ Due date? _____

8. Comments: _____
   _____

SIGNATURE	TITLE	PHONE NUMBER	DATE

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណាត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មានេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (10-09)

ADA5 (3-12)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency’s ADA coordinator.