COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
EMERGENCY OUTREACH BUREAU
CALWORKS MENTAL HEALTH SUPPORTIVE SERVICES

DMH CALWORKS BULLETIN NO. 07-02
COMPLETION OF AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND MENTAL CAPACITIES FORMS

December 1, 2007

TO: All DMH CalWORKs Mental Health Supportive Services Providers

FROM: Elizabeth Gross, Mental Health Clinical Program Head
CalWORKs Program

SUBJECT: Completion of Authorization to Release Medical Information (CW 61) & Mental Capacities (CW 61B) forms

1. Purpose
2. Background
3. Usage of forms
4. Procedures

1. PURPOSE

The purpose of this Bulletin is to provide instructions to providers for completion of the Authorization to Release Medical Information (CW 61) & Mental Capacities (CW 61B) forms. These forms are to replace the GN 6051 "Verification of GAIN Exemption" form and are required to provide information to the GAIN Service Worker (GSW) when the participant's mental condition prevents him/her from participating 32 hours weekly (35 hours for two parent families) in GAIN activities. The CW 61 is used for participants who request exemptions on the basis of a physical and/or mental condition or because they are caring for an ill household member. The CW 61B is used to elicit information on the participant's mental condition when making decisions concerning the participant's Welfare-to-Work participation.

2. BACKGROUND

The Welfare-to-Work (WtW) plan developed mutually by the participant and the CalWORKs GAIN Worker (GSW) mandates a single parent or caretakers in families on welfare to work or participate in WtW activities for 32 hours a week (35 hours for two parent families). Through self acknowledgement or when the participant appears to have a mental health problem that interferes with job search or employment, the GSW will refer the participant for a clinical assessment. If the mental health provider and the participant agree to begin treatment services, mental health treatment becomes part of the participant's Welfare-to-Work plan. CalWORKs mental health supportive services are specifically designed to assist individuals to overcome barriers hindering them from obtaining and retaining employment.

DPSS allows exemptions from participation in WtW activities to individuals 60 years of age or older, those under 16 years of age, those 16 or 17 years old and attending school full time, individuals disabled for 30 days or more with medical proof of disability, and parents caring for a child under 12 months old. A pregnant woman whose pregnancy prevents her from participating or to work can also be exempted. Non-parent caretakers who are caring for a dependent or ward of the court or at-risk of foster care may be exempted if the county determines that caretaking responsibilities make it impossible for the caretaker to be regularly employed or to participate in Welfare-to-Work activities. Also those caring for an ill or incapacitated household member may be exempted if the caretaking responsibilities prevent the caretaker from being regularly employed or from participating in WtW activities.

3. USAGE OF THE CW 61 and CW 61B

When the participant is unable to participate successfully in concurrent WtW activities due to the severity of symptoms and severe impairment in functioning, the provider may exempt the participant from WtW activities. The exemption for mental health reasons is an option to be used in cases of severe impairment and is not intended to be used routinely. As of November 19, 2007, DPSS Administration has indicated that exemption should not be automatically requested if the participant is not able to participate the full 32 hours weekly. Rather, the provider may complete the GN 6006B form indicating the participant's ability to participate part-time in concurrent WtW activities. The provider will have 90 days to provide treatment and to continue to assess the participant's motivation and ability to participate in additional activities. If, at the end of that first progress reporting period, the provider determines that the participant is unable to participate full time, or is unlikely to make progress in the coming three months, then an exemption might be more appropriate. When the provider deems an exemption to be appropriate, the provider should limit the initial exemption period to 90 days.

4. PROCEDURES

The GSW completes the top portion of the forms and gives the two-page CW 61 (including coversheet) and CW 61B to the participant to take to take to his/her mental health provider. The CW 61 must be completed and returned within 10 days. The CW 61B form is optional. When the completed CW 61 form(s) is returned, the GSW shall evaluate to determine if the exemption will be approved or denied.

A **licensed** clinician must complete the form. The provider may either give the completed form to the participant for delivery to the GSW and/or mail it to the GSW. Once exempt, the participant must volunteer for GAIN as an "Exempt volunteer" and request mental health services as a volunteer in order for the provider to continue to bill CalWORKs for any services. The client may choose not to volunteer and would then not be required to participate in any WTW activities, including mental health treatment. If the participant fails to volunteer, mental health services will not be billable under CalWORKs. The participant then has an option to receive mental health services under Medi-Cal, if medical necessity is met. However, a referral to a non-CalWORKs clinician would then be required.

If the provider opts to complete the CW 61B form, s/he may complete only those sections that are applicable and write N/A in the others. The information regarding the participant's limitations in different categories of functioning is evaluated to determine an appropriate WtW assignment. This determination is made only when the participant's exemption is denied or the participant is an exempt volunteer. Welfare-to-Work assignments shall not conflict with the participant's abilities or limitations. A copy of the completed CW 61 and CW 61B shall be permanently retained in the participant's medical record.

Upon completion of the exemption form(s), the provider should discuss the benefits of becoming an exempt volunteer. If the participant indicates intent to volunteer, you may write "Volunteer GAIN Participant" on the CW 61 to alert the GSW.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

CW 51 (7/01) COVERSHEET - REQUIRED FORM - SUBSTITUTE PERMITTED

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

CW 61 (7/01) REQUIRED FORM - SUBSTITUTE PERMITTED

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY | CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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:

CW 61B (6/01) REQUIRED FORM - SUBSTITUTE PERMITTED