dpss

Los Angeles County Department of Public Social Services
**Physical Health Assessment for General Relief**

Date:
Case Name:
Case Number:
District Name:
District Address:
Worker Name:
Worker File Number:
Worker Phone Number:

**Medi-Cal Status:** ☐ No Medi-Cal ☐ Pending Medi-Cal ☐ Pending Plan Selection

DEAR MEDICAL PROVIDER:

Your patient is applying for General Relief from the Los Angeles County Department of Public Social Services (DPSS).

Please provide the requested information regarding the severity and duration of your patient's physical medical condition. An individual who reports or is believed to have significant behavioral health impairment will be referred by DPSS to the Department of Mental Health or Department of Public Health for an exam.

**Section 1: Behavioral Health:**

Is there a psychiatric or substance abuse problem that may prevent work? ☐ **YES** ☐ **NO**

**Section 2: Presumptive Disability**

<table>
<tr><td colspan="2">Does your patient meet one (or more) of these conditions? ☐ YES ☐ NO<br><br>If any condition below is present, please answer YES and skip to the bottom of this form and sign.</td></tr>
<tr><td>Amputation of two limbs or of one leg at the hip</td><td>Total deafness in both ears</td></tr>
<tr><td>Longstanding medical condition resulting in confinement to a bed, requiring a wheelchair, walker, or crutches for mobility</td><td>Total Blindness (best corrected visual acuity 20/200 or visual field less than 20 degrees) in both eyes</td></tr>
<tr><td rowspan="3">Stroke, more than three (3) months old, spinal cord injury, cerebral palsy, or muscular/ skeletal disease with marked difficulty walking (use of braces, crutches, walker), speaking, or coordination of the hands or arms</td><td>Down Syndrome</td></tr>
<tr><td>Mental impairment requiring assistance with self-care or Activities of Daily Living (ADL)</td></tr>
<tr><td>End Stage Renal Disease on chronic dialysis</td></tr>
<tr><td>Amyotrophic Lateral Sclerosis (ALS), a.k.a. Lou Gehrig's disease</td><td>Cancer with metastases</td></tr>
<tr><td>Symptomatic Human Immunodeficiency Virus (HIV) or current Acquired Immune Deficiency Syndrome (AIDS)</td><td>Terminal illness, receiving hospice care, with life expectancy of six (6) months or less to live</td></tr>
</table>

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**Section 3: Functional Impairment**

Is there a medical condition(s) that prevents the patient from engaging full-time in any of the following sedentary activities in an occupational setting because he or she is medically prevented from:

-Performing **frequent** (about 2/3 of an eight (8) hour work day) **sitting**; **fingering** and **handling**

-Performing **occasional** (up to 1/3 of eight (8) hour work day) **stand/walk**; **lift** 10lbs; **bend**; **reach**

-Demonstrating grossly normal cognitive ability because of a non-psychiatric condition

☐ **YES**, the patient's medical condition prevents fulltime sedentary work as described above.

What duration are you estimating the impairment from sedentary work to last?

☐ 3 months ☐ 6 months ☐12 months ☐ Other_____ ☐ Likely permanent

☐ **NO**, the patient's medical condition does not prevent fulltime sedentary work.

However, ☐ there are restrictions/ limitations that prevent other activities:

☐ Occasional 20lb lifting ☐ Frequent standing/walking

☐ Occasional 50lb lifting ☐ Other _____

I declare that the above medical evaluation is true to the best of my knowledge.

_____ _____
Medical Provider Name (print and sign) Date

_____ _____
Clinic Name and Address Phone Number

Please return this completed form to DPSS electronically, if your site has an electronic connection to DPSS. Otherwise, please fax the completed form to (562) 695-0423.

Clinic Stamp

Patient Name

Date of Birth