MEDICAL RELEASE/PHYSICIAN'S STATEMENT

SECTION I - TO BE COMPLETED BY STAFF

Name of Patient	Date of Birth	Social Security No.
Ms. Yeano Hunter	04/18/1972	
Case Name(caregiver)	**Case No.**	**Patient's Usual Job**
Ms. Yeano Hunter	1015577196	

HHSC Office Address/Mail Code/FAX No.

PO Box 149027 Austin TX 78714-9027 Fax: 1-877-447-2839

SECTION II - TO BE COMPLETED BY PHYSICIAN

The patient named above has applied for benefits with our agency. Federal and state regulations require that persons receiving benefits work or participate in activities to prepare them for work unless they are physically or mentally incapable of working. This patient claims that disability. Please complete the appropriate parts. After you complete the form, you may give it to the client or mail it to HHSC at the address in Section 1.

PART A - DISABILITY:

To what extent is the individual able to work or participate in activities to prepare for work? Please check **one** of the following boxes:

1) The individual is able to work, or participate in activities to prepare for work, **without restrictions:**
   a) ☐ Full time (40 hours/week)
   b) ☐ **Part time at ____hours/week**

2) The individual is able to work, or participate in activities to prepare for work, **with restrictions: (Please complete Part B and C)**
   a) ☐ Full time (40 hours/week)
   b) ☒ **Part time at 20 hours/week**

3) The individual is unable to work, or participate in activities to prepare for work, at all: **(Please complete Part C)**
   a) ☒ The disability is permanent.
   b) ☐ The disability is not permanent and is expected to last more than 6 months.
   c) ☐ The disability is not permanent and is expected to last 6 months or less.

PART B - TANF HARDSHIP

What can this individual do now? Check the appropriate boxes that are applicable during a workday:

Maximum hours per workday:	2	4	6	8	Other
Sitting	☐	☐	☐	☒	☐
Standing	☐	☐	☒	☐	☐
Walking	☐	☐	☒	☐	☐
Climbing stairs/ladders	☐	☐	☐	☐	☐ 1 flight only
Kneeling/Squatting	☐	☐	☐	☐	☒ limited
Bending/Stooping	☐	☐	☐	☐	☒ Poor balance
Pushing/Pulling	☐	☐	☐	☐	☒ limited
Keyboarding	☐	☐	☐	☒	☐
Lifting/Carrying	☐	☐	☐	☐	☐ Less than 10 lbs.
Other (please describe)					

IN-HOME AND FAMILY SUPPORT PROGRAM

PHYSICIAN STATEMENT OF DISABILITY

Date 5/10/17

Patient Name Yeano Hunter

Address 8800 S. Braeswood Blvd #214
Hou, Tx. 77031

Case Specialist, Address, Phone

The following medical information is needed to determine this individual's eligibility for the In-Home and Family Support Program. The program is intended to assist families in maintaining an individual with a physical disability IN THE HOME. **PLEASE COMPLETE ALL ITEMS BELOW.** If you have questions, please contact the case manager at the address and phone number above.

I. MEDICAL DIAGNOSIS: Abnormality of Gait
Right leg weakness 2° Spinal injury
Spasticity

II. APPROXIMATE DATE OF ONSET OF DISABLING CONDITION..... Age 12

Approx. Date of Onset

III. FUNCTIONAL LIMITATIONS (check all SUBSTANTIAL limitations that apply):

- ☐ Self-Care
- ☐ Receptive and Expressive Language
- ☐ Learning
- ☒ Mobility
- ☐ Self-Direction
- ☐ Capacity for Independent Living
- ☐ Economic Self-Sufficiency
- ☐ Other (specify): _____

IV. EXPECTED DURATION OF DISABILITY: Permanent

V. PROGNOSIS: FAIR

VI. RECOMMENDATIONS/OTHER COMMENTS: Her disability is permanent, She has unstable gait and is a fall risk.

VII. _____ 6-16-17
Signature-Physician Date

Physician's Name(please type or print) CHINYERE AWA

Physician's Mailing Address 6300 westpark Drive Suite 212, Hou Tx 77057

Telephone No. 713 541 4442

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