Community Options

JOBS HEALTH STATEMENT

Participant please complete the following section(s).		
Name:		**Social Security #:**
Diagnosis/Illness:		**Date of onset condition:**
Please tell us why you need a modified plan:		
How long you will need a modified plan? ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months		
Health Care Provider:	**Title:**	**Phone Number:**
Business/Hospital Name & Address:		
My signature authorizes my healthcare provider to disclose medical/psychological information to Community Options for the purpose of determining the level of my involvement in the Job Opportunities and Basic Skills (JOBS) Program.		
Participant Signature:		**Date:**

Healthcare Professional please complete the following section(s).	
In your medical opinion, is the patient capable of participating in Jobs Skills Training, Education, or Work related activities?	
☐ **No**	**If No, indicate the length of time at which the individual will need to remain excused from program requirements:** ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months
☐ **Yes**	**If Yes, how many of hours per week can the participant participate in activities:**
Please describe the treatment plan, include any prescribed medications and restrictions:	
Next scheduled appointment Date and Time:	
Healthcare Provider Signature:	**Date:**
Office use only: In lieu of Healthcare Provider signature, I attest that I was able to verify the following information from the Health Care Provider via phone and/or document inspection. (If there is a document, please attach document to form).	
Community Options Staff:	**Date:**