Iowa Department of Human Services

Report on Incapacity

Today's date:
Case #:
Worker #:

Please return this form by . Thank you.

Completed by Patient – Patient Permission

I give Dr. _____ or _____ agency permission to share information about my condition with the Department of Human Services (DHS) or PROMISE JOBS staff. This includes results of examinations, lab tests, and hospital records.

My permission to release information also includes the following and is limited to information about the patient's capacity to care for their children or to participate in work or training:

Mental health information ☐ Yes ☐ No Substance abuse information ☐ Yes ☐ No
HIV-related information ☐ Yes ☐ No

I understand:

- Information will be kept confidential and used only to determine if I am eligible for benefits or to what extent I am able to participate in work or training.
- I have the right to see this information at any time.
- I can stop my permission by writing to the person giving the information and to the person getting the information. Any information that has already been shared before I stopped my permission may be used as stated on this form.

This permission will stop 60 days after the date below.

Print Name of Patient	Patient's Birth Date
Signature of Patient	Date
Patient's Address	

Completed by Medical Professional

1. Patient's diagnosis:

   Is the patient's condition (check one) ☐ Temporary ☐ Progressive ☐ Permanent

2. Treatment:

   Is the patient currently under medical supervision or treatment? ☐ Yes ☐ No

   If yes:

   Date last seen _____ When is the next recommended examination? _____

   What is probable duration of treatment? _____

   List any treatment schedule or medication side effects that may interfere with work or training:

   Does the patient require continuous in-home care by a family member or other caregiver?
   ☐ Yes ☐ No

3. Capacity for participation:

Child care:

Is the patient able to care for the children in the home? ☐ Yes ☐ No

If no, do you expect the patient to be able to care for the children in the future and if so, when?

Employment:

Is patient able to perform work of any kind? ☐ Yes ☐ No

If yes, estimate number of hours per week: ☐ 30-40 ☐ 20-29 ☐ 10-19 ☐ Less than 10

If no, or if hours are limited, expected duration of limitation? _____

List any physical or mental limitations or conditions that may interfere with work (such as, lifting limitations, driving, frequent seizures, fears of crowds):

Suggested accommodations:

Classroom training:

Is the patient able to participate in classroom training or instruction? ☐ Yes ☐ No

If yes, estimate number of hours per week: ☐ 30-40 ☐ 20-29 ☐ 10-19 ☐ Less than 10

If no, or if hours are limited, expected duration of limitation? _____

List any physical or mental limitations or conditions that may interfere with training (such as, lifting limitations, driving, frequent seizures, fears of crowds):

Suggested accommodations:

4. Would you recommend this patient apply for long-term disability benefits? ☐ Yes ☐ No

For other comments, please attach additional sheets.

Signature of Medical Professional	Print Name of Medical Professional	Date of Report	Phone Number

To Medical Professional: Please return the completed report in the enclosed envelope.

Questions??? Please contact:

[Worker Name] at [Worker Phone Number] or by Fax at [Worker Address]