MONROE COUNTY DEPARTMENT OF HUMAN SERVICES
PSYCHOLOGICAL ASSESSMENT FOR DETERMINATION OF EMPLOYABILITY
(ALL SECTIONS MUST BE COMPLETED)

PLEASE RETURN MEDICAL STATEMENT TO:

Monroe County Department of Human Services

☐ 691 St Paul St
Rochester, NY 14605

☐ 111 Westfall Rd
Rochester, NY 14620

Team: _____ Worker: _____ Phone: _____ Fax: _____

Due to MCDHS worker by _____

DATE OF EVALUATION: _____ PROVIDER: _____

CLIENT IDENTIFICATION:

NAME: _____ CASE #: _____

ADDRESS:

_ _____ _____ _____ _____
Street City State Zip

SS# (last 4 digits): _ _____ CIN: _ _____ DOB: _ _____

Is the client a Veteran? ☐ Yes ☐No

Does client have an active SSI/SSD application pending? ☐ Yes ☐ No

Date client became a patient at your practice: _____ Date of Last Examination: _____

How many times have you evaluated the above patient in the past 12 months: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining physician to disclose to the Department of Human Services any information provided, any diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that the information provided by this authorization may be redisclosed by the recipient of this information and will no longer be protected by the Health Insurance Portability and Accountability Act as protected health Information. However, the information will only be released pursuant to the New York State Social Services Law, the New York State Public Health Law and other applicable federal and state laws and regulations. I understand that this information will be treated as confidential.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

(1) **CHIEF COMPLAINT(S)/HISTORY OF PRESENT ILLNESS:**

_____

_____

_____

_____

(2) **PSYCHIATRIC HISTORY**:

_____

_____

(3) **MEDICAL HSTORY** - Please list all past medical conditions:

(4) **CURRENT MEDICATIONS:**

Date 1st Prescribed	Medication	Dosage	Frequency

LIST THE SIDE EFFECTS CLIENT EXPERIENCES WITH MEDICATION, IF ANY: _____

(5**) CURRENT TREATMENT PROGRAM(S) (INCLUDING ALCOHOL/CHEMICAL DEPENDENCY)/OTHER KNOWN BEHAVIORAL HEALTH:**

Program Name: _____ Telephone #: _____

Address: _____

Treatment Program Contact: _____ Title: _____

Date of First Treatment: _____ Treatment Type: _____

Treatment Schedule: Days: _____ Time: _____ Date of Last Examination: _____

Has individual's condition improved as a result of this treatment? Yes ☐ No☐

If no, please explain: _____

(6) CURRENT LEGAL APPOINTMENTS, OBLIGATIONS (e.g. drug court/probation, etc.):

(7) EPISODES ATTRIBUTED TO PSYCHIATRIC AND/OR SUBSTANCE ABUSE CONDITIONS:

Check column that applies	Never	On Occasion	Frequent
Medical hospitalizations or emergency room visits	☐	☐	☐
Acute psychiatric hospitalization	☐	☐	☐
Hospitalization for alcohol/drug abuse	☐	☐	☐
Interacts appropriately with others	☐	☐	☐
Prior attempts at alcohol/drug abstinences	☐	☐	☐
Passing out or black-out episodes	☐	☐	☐
Repetitive violent actions towards self or others	☐	☐	☐
Loss of job or failure to complete education or training program	☐	☐	☐
Behavior interferes with activities of daily living	☐	☐	☐
Suicide attempt	☐	☐	☐
Decompensation (episodes of psychosis)	☐	☐	☐

(8) MENTAL STATUS EXAMINATION: (most recent date)

☐ Mental status examination was indicated and results are: _____

(9) **DIAGNOSTIC IMPRESSION:** Must be completed by Psychiatrist or Psychologist

List all psychiatric diagnoses. Include psychiatric and alcohol/drug addiction diagnosis using DSM IV classification

AXIS I: _____

_____

AXIS II: _____

_____

AXIS III: _____

_____

AXIS IV: _____

_____

AXIS V: _____

_____

(10) EMPLOYABILITY DETERMINATION:

A. **FUNCTIONAL LIMITATIONS/CLINICAL OBSERVATIONS**:	**Normal Functioning** No evidence of limitation	**Moderately Limited** Unable to function 10-25% of the time	**Very Limited** Unable to function 25% or more of the time	**Insufficient Data**
Demonstrates the capacity to follow, understand and remember simple instructions and directions	☐	☐	☐	☐
Demonstrates the capacity to perform simple and complex tasks independently	☐	☐	☐	☐
Demonstrates the capacity to maintain attention and concentration for role tasks	☐	☐	☐	☐
Demonstrates the capacity to regularly attend to a routine and maintain a schedule	☐	☐	☐	☐
Demonstrates the capacity to maintain basic standards of hygiene and grooming	☐	☐	☐	☐
Demonstrates the capacity to perform low stress and simple tasks	☐	☐	☐	☐

DOES PATIENT DEMONSTRATE THE CAPACITY TO USE PUBLIC TRANSPORTATION: ☐ **YES** ☐ **NO**

B. **EMPLOYABILITY:**
Indicate which of the following four statements best describe the individual's condition and elaborate, if indicated. Please note that the responsibility for determining employability related to substance abuse is determined solely by the district's Certified Alcohol and Substance Abuse Counselor (CASAC)

COMPLETE ONE SECTION ONLY (Continued on next page)

1. ☐ Individual demonstrates ability to participate in activities (e.g. work, education, and training) for up to 40 hours per week, does not have any limitations, and does not require any treatment/rehabilitation or assessment by the district's CASAC.

2. ☐ Individual demonstrates ability to participate in activities (e.g. work, education, and training)

☐ for up to 40 hours ***with reasonable accommodations listed on next page- Section C***

☐ OR _____ hours per week ***with reasonable accommodations listed on next page - in Section C***

Expected Duration: _____ weeks/months/years(s)

Specify treatment, diagnosis and/or referral recommendations, including referral to the district's CASAC for substance abuse assessment:

Reason: ***If less than 40 hours, list the reason(s) individual is unable to participate in full-time activities***:

3. ☐ Individual is unable to participate in any activities except treatment or rehabilitation (include treatment/rehabilitation)

Expected Duration: _____

	Specify treatment, diagnosis and/or referral recommendations, including referral to the district's CASAC for substance abuse assessment: Reason: ***If less than 40 hours, list the reason(s) individual is unable to participate in full-time activities***:
	4. ☐ Individual appears permanently disabled, condition is not expected to improve, and is unable to participate in any activities. SSI Referral is based on: Is referral to the district's CASAC for substance abuse assessment is recommended: Yes ☐ No ☐

C. **REASONABLE ACCOMMODATIONS:** Must be completed if any box from # 2 on previous page is checked

Describe any necessary reasonable accommodations which are **recommended** based on identified disabilities:

_____

_____

Describe any working conditions, environments or work activities which are **contraindicated**:

_____

_____

_____

MEDICAL PROFESSIONAL'S INFORMATION: *Form must be completed & signed by a Licensed Behavioral Health Professional.*

Name: _____

Address: _____

Board eligible or certified specialty: _____

Signature of Behavioral Health Professional: _____

Date form completed: _____

Phone: _____