MEDICAL STATEMENT

Individual's Name: _____ Individual's Date of Birth: _____

The purpose of this document is to certify that the above individual qualifies as severely disabled or blind, as defined by the U.S. AbilityOne Commission (41 C.F.R. § 51-1.3). Through the AbilityOne Program, Melwood seeks to provide opportunities for people who face barriers to employment through vocational training and supports.

ABILITYONE DEFINITION OF PEOPLE WITH A SEVERE DISABILITY:

In correspondence and policy, the term "significant disability" is synonymous with the term "severe disability" as defined in 41 U.S.C. 8501 and the applicable regulations.

A person other than a blind person who has a significant physical or mental impairment (a residual, limiting condition resulting from an injury, disease, or congenital defect) which so limits the person's functional capabilities (mobility, communication, self-care, self-direction, work tolerance or work skills) that the individual is unable to engage in normal competitive employment over an extended period of time.

(1) Capability for normal competitive employment shall be determined from information developed by an ongoing evaluation program conducted by or for the nonprofit agency and shall include, as a minimum, a preadmission evaluation and a reevaluation at least annually of each individual's capability for normal competitive employment.

(2) A person with a significant mental or physical impairment who is able to engage in normal competitive employment because the impairment has been overcome or the condition has been substantially corrected is not "other significantly disabled" within the meaning of the definition.

ABILITYONE DEFINITION OF BLINDNESS:

An individual or class of individuals whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity, if better than 20/200, is accompanied by a limit to the field of vision in the better eye to such a degree that its widest diameter subtends an angle no greater than 20 degrees.

Understanding employee impairment helps us make appropriate modifications for training and job duties to be excluded and/or modified. This increases employee success by making the environment more conducive and preventing exacerbation of impairments.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize Melwood Horticultural and Training Center to use and disclose my employment information and my protected health information for the purpose of employment and vocational support services. This authorization for release gives Melwood Horticultural and Training Center my permission to talk with the following individual:

Name: _____

Address: _____

Agency: _____

Phone: _____

Extent of Authorization

I understand that when I authorize the release of my health record information including information relating to the diagnosis, treatment, and health care services provided or to be provided to me, it identifies my name, address, social security number. The following information I wish to disclose to the fore mentioned individual. (Please check all that apply.)

- o Individual Work Plan
- o Assessment / Recommendations
- o Medical Health Information
- o Corrective Action
- o Social Security Number
- o Individual Eligibility Evaluation (IEE)
- o Progress of Services
- o Salary / Job Title / Dates of Employment
- o Other:_____

For the purpose of: Coordination of Services and/or Consultation

Effective Dates: From_____ To_____

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. I may revoke this Authorization at any time, in writing, except to the extent that Melwood Horticultural and Training Center has already made a disclosure. My written revocation will become effective when Melwood Horticultural and Training Center receives it. I understand that if I authorize disclosure of protected health information, Melwood Horticultural and Training Center may further disclose this information, and Federal law may no longer protect it. I understand that I have the right to inspect or receive a copy of the information I am consenting to release.

_____ _____

Individual's Signature Date

_____ _____

Guardian's Signature *(if applicable)* Date

MEDICAL PROFESSIONAL MUST COMPLETE AND SIGN THIS SIDE OF THE DOCUMENT

Individual's Name: _____ Individual's Date of Birth: _____

List the individual's physical and/or mental diagnosis, impact to functional limitations, and duration of diagnosis:

Diagnosis	Functional Limitations *(Select all that apply)*	Duration *(Select one)*	Additional Comments *(If applicable)*
	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ Work Tolerance ☐ Work Skills **Explain Limitations:**	☐ Permanent ☐ Temporary ☐ Partial ☐ Total	
	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ Work Tolerance ☐ Work Skills **Explain Limitations:**	☐ Permanent ☐ Temporary ☐ Partial ☐ Total	
	☐ Mobility ☐ Communication ☐ Self-Care ☐ Self-Direction ☐ Work Tolerance ☐ Work Skills **Explain Limitations:**	☐ Permanent ☐ Temporary ☐ Partial ☐ Other	

By signing below, I certify and affirm that the above-named individual has a significant disability as described above.

Medical Professional's Name:_____ Phone: _____

Medical Professional Credentials: _____ Medical Practice Name: _____

Address: _____

Medical Professional's Signature: _____ Date: _____

Place professional stamp with Practice Name, Address, and Phone here.

Please send questions or completed forms to pod@melwood.org