CLERMONT COUNTY OHIO

BOARD OF COUNTY COMMISSIONERS
DAVID L. PAINTER • CLAIRE B. CORCORAN • BONNIE J. BATCHLER
Department of Job and Family Services • Child Support Enforcement

Ability to Work Form

A Health Care Provider (HCP) must complete & return this form by fax or email to Child Support Enforcement (CSE).

TO: Child Support Enforcement Fax #: (513) 732-7444
Attn: _____ (_____@jfs.ohio.gov)

RE: **Disability Statement Concerning:** _____ DOB: _____
SS#: XXX-XX-_____ SETS #(s): _____

Instructions: Complete Steps 1 – 3

IMPORTANT NOTICE: To prevent future enforcement of this Court Order for support, this form must be submitted annually from the date of the signature, or by the end date of the patient's inability to work, whichever is sooner.

Step 1: Please describe the patient's diagnoses and/or medical conditions either:

- ☐ for which you are treating the patient; -OR-
- ☐ that are reflected in the patient's medical records available to you as a treating HCP.

The undersigned health care provider is licensed in the state of _____ and has treated the patient referenced above for: _____
_____
_____

Step 2: Please indicate the patient's ability to work. (Check only one block & complete relevant section. (*CSE requires reassessment and submission of an updated Ability to Work Form if HCP states able to return to work on "To Be Determined" or "TBD" within 6 months, or "never," annually from date of submission.)*

☐ Unable to work opinion based on current HCP/patient interaction:

It is my opinion, to a reasonable degree of medical certainty, the patient was unable to work from _____ to _____ due to the condition(s)/diagnoses listed above.

Patient will be able to return to work on _____.

☐ Unable to work opinion based on review of medical records:

It is my opinion, to a reasonable degree of medical certainty and following a review of the patient's medical records, the patient was unable to work from _____to _____due to the condition(s)/diagnoses in his/her records, and I have listed above.

Patient will be able to return to work on _____.

☐ Able to work opinion

It is my opinion to a reasonable degree of medical certainty that the patient is NOT PREVENTED FROM WORKING due to the condition(s)/diagnoses listed above.

Step 3: Please sign, date, & fill in the blanks below. Then return this form to CSE by fax or email.

/S/_____ _____
Health Care Provider's Signature Date of Signature

Printed Name & Title: _____
HCP Office Address: _____
City/State/Zip code: _____