Vermont Department for Children and Families
Economic Services Division

210A

Training and Employment Medical Report for General and Emergency Assistance and 3SquaresVT

☐ GA ☐ 3SquaresVT

To the physician/provider: The individual referred below must comply with certain regulations requiring participation in training or employment activities. Exemptions from these requirements are permitted when an individual has a medically determined illness, injury, or physical or mental impairment or when an individual has an obvious mental or physical limitation temporarily preventing participation in training or employment. Health Care Providers can complete the medical report below. Other providers should review the 2nd page of this document.

Name:_____ **DOB:**_____ **Last 4 SSN:**_____

General and Emergency Assistance and 3SquaresVT Medical Report

Payment for the examination needed to complete this report will be made to you on the same basis as payment under Medicaid. ***No payment will be made solely for completion of this report.***

---

1. Are you currently treating this individual for a condition or illness? ☐ Yes ☐ No

2. *Based on your examination, does this individual have any illness, injury, or physical or mental condition that would justify exemption from training or employment requirements? ☐ Yes ☐ No

3. Diagnosis:_____

4. Prognosis:_____

5. How long do you expect this illness, injury or condition to last? (*Please check one*)

☐ 1 Week ☐ 3 months ☐ One Year or more
☐ 2 Weeks ☐ 4 months
☐ 1 Month ☐ 6 months
☐ 2 Months ☐ 9 months

6. Please list this individual's primary care physician:_____

7. **If the individual named above is unable to work , could they work in any other type of employment?** ☐ Yes ☐ No
If yes, please specify any limitations:

Comments/Remarks:

Provider name *(please print)*:_____ Provider number:_____

Address:_____ Telephone number:_____

Provider Signature:_____ Date:_____

3SquaresVT Only
Time Limited Benefits Work Requirement Exemption

To the provider: The individual referred below must comply with certain regulations requiring participation in training or employment activities. Exemptions from this requirement are permitted in instances where an individual, who does not meet the medically determined illness, injury or physical or mental impairment on page one of this form, presents with an obvious mental or physical limitation that temporarily prevents participation in training or employment.

Please complete and return this section of the form so this person's eligibility for 3SquaresVT can be established.

Name:_____ **DOB:**_____ **Last 4 of SSN:**_____

1. Please describe your professional relationship with the above individual:

☐ ICAN Provider ☐ Housing Case Manager ☐ Department of Corrections

☐ Other *(List Agency and Title)*:_____

2. Is the individual able to participate in training and employment 20 hours per week averaged 80 hours per month? ☐ Yes ☐ No

3. How many months do you anticipate the individual cannot meet the work requirement? _____

4. Please provide details about why this individual cannot meet their work requirement:

Provider name *(please print)*:_____ Provider number:_____

Address:_____ Telephone number:_____

Provider Signature:_____ Date:_____