Santa Cruz County
Human Services Department
P.O. Box 1320
Santa Cruz, CA 95060
888-421-8080

BEHAVIORAL HEALTH CLINICIAN'S CONFIDENTIAL REPORT

Case Name:
Case Number:
Last Four (4) Digits of Social Security Number:

I authorize release of requested information from my record for the use of the Santa Cruz County Human Services Department. I know this authorization may be used by the Santa Cruz County Human Services Department for up to one year from this date to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the agency. This information is needed to determine eligibility for cash aid or food assistance. It is also needed to decide the type of work or training activities that I can participate in. I have read this form (or had this form read to me) before I signed my name. I know I can get a copy of this form if I ask for it.

Patient's Signature_____ Date_____

Clinician: Please complete this report evaluating the individual listed below for mental health conditions that may prevent them from being able to work.

Patient's Name:	Dateof Birth:
Address:	
Date of Examination:	Diagnosis Code:
Diagnosis:	
Onset of Condition:	

Functional Assessment

	Unable To Determine	Not Significantly Limited	Moderately Limited	Markedly Limited *(see below)*
A. UNDERSTANDING AND MEMORY				
1 The ability to remember work-like procedures.	1 ☐	2 ☐	3 ☐	4 ☐
2. The ability to understand and remember very short and simple instructions.	1 ☐	2 ☐	3 ☐	☐
B. SUSTAINED CONCENTRATION AND PERSISTENCE				
3. The ability to carry out very short and simple instructions.	1 ☐	2 ☐	3 ☐	4 ☐
4. The ability to maintain attention for extended periods- two hour segments or more.	1 ☐	2 ☐	3 ☐	4 ☐
5. The ability to maintain regular attendance, and be punctual within customary tolerances. (These tolerances are usually strict.)	1 ☐	2 ☐	3 ☐	4 ☐
6. The ability to sustain ordinary routine without special supervision.	1 ☐	2 ☐	3 ☐	4 ☐
7. The ability to work in coordination with or proximity to others without being unduly distracted by them.	1 ☐	2 ☐	3 ☐	4 ☐
8. The ability to make simple work-related decisions.	1 ☐	2 ☐	3 ☐	4 ☐
9. The ability to complete a normal workday and work-week without interruptions from psychologically based symptoms and to perform consistent pace without an unreasonable number and length of rest periods.	1 ☐	2 ☐	3 ☐	4 ☐
C. SOCIAL INTERACTION				
10. The ability to ask simple questions or request assistance.	1 ☐	2 ☐	3 ☐	4 ☐
11. The ability to accept instructions and respond appropriately to criticism from supervisors.	1 ☐	2 ☐	3 ☐	4 ☐
12. The ability to get along with co-workers and peers without unduly distracting them or exhibiting behavioral extremes.	1 ☐	2 ☐	3 ☐	4 ☐

D. ADAPTATION

13. The ability to respond appropriately to changes in a routine — 1 ☐ 2 ☐ 3 ☐ 4 ☐

14. The ability to be aware of normal hazards and take appropriate precautions. — 1 ☐ 2 ☐ 3 ☐ 4 ☐

* A marked limitation is more than moderate, but less than extreme. An individual need not be totally precluded from performing an activity to have a marked limitation as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively. *Please describe the mental health diagnosis that is the source of any limitations noted:*

Does this individual's mental health condition prevent them from working?

☐ **NO** ☐ **YES** If yes, is this situation:

☐ Temporary (If temporary, condition will improve in): _____ (months)

☐ Persistent (not able to work for 12 mos. or more)

If condition is persistent has it existed for 12 months or more?: ☐ yes ☐ no ☐ insufficient information to make determination

Will the condition prevent engagement in substantial gainful activity? ☐ yes ☐ no ☐ insufficient information to make determination

(Social Security Admin defines gainful activity as earnings of more than $800 per month.)

☐ Other: (Explain) _____

Does the patient have work restrictions related to their mental health condition(s)?

☐ **NO** ☐ **YES** If yes, please describe any other significant limitations such as work environment, number of hours worked, interactions with supervisors and/or customers, ability to utilize public transportation to get to and from employment.

I recommend that patient be referred for an evaluation of physical health conditions that may prevent them from being able to work.

☐ **NO** ☐ **YES** If yes, please state reason.

Alcohol and Other Drugs

Alcoholism: ☐ Yes ☐ No ☐ Probable *(Explain)* _____

Drug Abuse: ☐ Yes ☐ No ☐ Probable (Explain) _____

Clinician's Name (Please Print) | Specialty

Clinician's Signature | Date

Address

Clinician's License # (required)

Telephone Number

Fax Number

If the person completing this form is not a medical doctor, please sign below:

Name (Please Print) | Title (Please Print)

Signature | Date