CITY OF CHAMPAIGN TOWNSHIP
General Assistance-Transitional Assistance Office
53 E. Logan St.
Champaign, IL 61820
Phone: (217) 403-6120
Andrew J. Quarnstrom, Supervisor

CERTIFICATION OF MEDICAL STATUS

Date of Request: **Name:**
Address: **Date of Birth:**
Social Security # **Client Case Number:**

PURPOSE: This form documents the current and ongoing medical status of the applicant (patient) identified above for the purpose of qualifying and recertifying for General Assistance-Transitional Assistance benefits. It does not constitute as a finding of disability. ***The law defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment (s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.*** To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other full-time job in the national economy. **This form must be completed by the patient's physician, physician assistant or advanced nurse practitioner who has diagnosed the patient.**

PROVIDER CERTIFICATION:

Has this patient been in care with your clinic/practice within the last 6 months? [ ] Yes [ ] No

___ **Based upon my medical evaluation, I have diagnosed the patient listed above with the chronic medical condition (s) indicated below and I certify that the patient is in need of ongoing treatment including prescription drugs, chemotherapy or radiation for this condition (s):**

____ Cancer patient requiring chemotherapy - except non-melanoma skin cancer
____ Terminally ill (see definition on reverse side)
____ Heart Disease - Cardiac failure/coronary artery disease, bypass or stents
____ Kidney Problems (failing or on dialysis)
____ Cystic Fibrosis
____ Spinal Cord injuries
____ Chronic Diabetes or Diabetes Insipidus or Diabetes Mellitus Types 1 & 2
____ Chronic seizure disorder
____ Chronic mental illness (see definition on reverse side)
____ Bipolar Disorder
____ Chronic hypertension
____ Multiple Sclerosis
____ Other (Specify)

Diagnosis_____

___ **I certify that I have examined the patient named above and this patient does NOT require prescription drugs, chemotherapy or radiation for their chronic condition or illness.**

B. Treatment Discontinued

[ ] Is non-compliant with appointments [ ] Has relocated out of town
[ ] Is non-compliant with medication [ ] Has transferred medical care
[ ] Other _____

DEFINITIONS
Acute and Chronic Medical Conditions

The following definitions are offered as guidance in making a medical determination of whether the individual listed on the reverse side of this form presents "chronic mental illness" or is "terminally ill." These definitions are only guidelines and are not intended to replace your professional medical judgment in a specific case. These definitions do generally reflect the conditions for which the GA-TA Program is intended:

What is a "Medically Determinable Impairment"?
A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings-not only by the individual's statement of symptoms.

Chronic Mental Illness: An individual with "chronic mental illness" suffers from a very serious mental illness and exhibits significant deficiencies in functioning. A chronic mental illness is more than a severe emotional disturbance, and is marked by the presence of (1) a psychosis of some kind, (2) a mental disorder that is marked by a loss of contact with reality, and (3) by a deterioration in personality and social functioning. A determination of chronic mental illness means that the individual shows involvement generally consistent with the following Medicaid definition of "chronically mentally ill adult. **"Chronically mentally ill adult"** means an individual 18 years of age or older (1) who has been diagnosed as having a schizophrenic, major affective, or paranoid disorder, or other severe mental disorder with a documented history of persistent psychotic symptoms not caused by substance abuse; **and** (2) whose role functioning is impaired in at least two of the following three ways:

(A) inability to function independently in the role of worker, student, or homemaker;
(B) inability to engage independently in personal care or community living activities; or
(C) inability to exhibit appropriate social behavior, resulting in intervention by the mental health system or judicial system.

Terminally Ill: Reference Medicare and Medicaid definition used for hospice care:
"Terminally Ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (42 C.F.R. 418.3)

By signing, I certify that this patient is unable to work due to a psychological or physical disability. PLEASE USE YOUR COMPANY STAMP OR SEAL on the back of this form to validate that this form has been completed at your location.

(Dr.) Provider Name: (Print) Date: _____

_____

Title:_____Specialty:_____

Signature: _____

Address: _____

City/State/Zip Code: _____

Phone/Fax: _____