### Health Provider Note

This form must be completed each month by a qualified health provider if you are unable to work due to a health condition.

**General Assistance applicant(s):** Please bring this form to a qualified health provider. Have the health provider complete the information below verifying you are unable to work due to a health issue. If you need more of these forms, please visit our webpage [https://kawerak.org/supportive-services/welfare-assistance/#](https://kawerak.org/supportive-services/welfare-assistance/#), your local Tribal Office, or contact us at the numbers listed above.

**Health Provider:** This individual has applied for welfare assistance services and has reported a health condition that may interfere with their ability to work. Please complete the information below for this applicant who is pursuing self-sufficiency.

<table>
<thead>
<tr>
<th>Patient Name: ____________________________</th>
<th>Date of Birth: ____________________________</th>
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<tr>
<th>Health Provider Name: ____________________</th>
<th>Phone #: ____________________________</th>
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This health note is for the month of: ____________________________ This patient was evaluated on: ____________________________

I am a:  
☐ Physician  ☐ Physician's Assistant  ☐ Health Aide  ☐ Clinician  ☐ Chiropractor  ☐ Nurse  ☐ Audiologist  
☐ Physical Therapist  ☐ Occupational Therapist  ☐ Ophthalmologist  ☐ Other Health Provider: ____________________________

Do you believe this patient can work full time?  
☐ No  ☐ Yes – Please explain: ____________________________

Do you believe this patient can work part time?  
☐ No  ☐ Yes – Please explain: ____________________________

The health issues that prevent this patient from working are (check all that apply):

☐ Permanent  ☐ Temporary  ☐ Episodic  ☐ May Improve Over Time – Please explain: ____________________________

Do you recommend any specific accommodations to help this patient function effectively in a work or training environment if they may one day become employable?  
☐ No  ☐ Yes – Please list accommodations here: ____________________________

Comments – Please attach additional pages as needed: ____________________________

Health Provider’s Business/Agency/Company Name: ____________________________

__________________________                  ____________________________
Health Provider Signature                  Date

General Assistance Applicants - please fax, email, or drop off this completed form with your application.