KAWERAK, INC.

Kawerak, Inc. Education, Employment & Supportive Services Division
Tribal Welfare Assistance Department – 110 East Front Street, Suite 201
P.O. Box 948, Nome, AK 99762 ♦ Toll Free: 1-800-478-5230 ♦ Phone: 907-443-4370 or 907-443-4367
Fax: 907-308-6934 ♦ Email: welfare@kawerak.org ♦ Website: www.kawerak.org

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/#, 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.

Patient Name: _____ Date of Birth: _____

Health Provider Name: _____ Phone #: _____

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.