CalWORKs Ability to Perform Work or Training

Medical conditions of _____ _____
that impedes patient's ability to work. ***Name of patient*** ***SSN***

1. Does the patient have a limitation that significantly affects the patients' ability to be regularly employed or participate in training program ☐ 20-hours ☐ 30-hours ☐ 35-hours a week? **Yes** ☐ **No** ☐

2. What date did this condition first prevent your patient from working or training ☐ 20-hours ☐ 30-hours ☐ 35-hours a week? hours a week? _____(date).

   If there were breaks, please specify months and years

	Month	**Year**		**Month**	**Year**
From	_____	_____	to	_____	_____
	_____	_____	to	_____	_____
	_____	_____	to	_____	_____
	_____	_____	to	_____	_____
	_____	_____	to	_____	_____

3. Is this condition(s) expected to last more than 30 days? **Yes** ☐ **No** ☐
If "**yes"**, anticipated date when the Patient could perform ☐ 20-hours ☐ 30-hours ☐ 35-hours a week off work or training: _____.
Date

4. Is there an appropriate medical treatment available? **Yes** ☐ **No** ☐

5. Is the patient actively seeking treatment? **Yes** ☐ **No** ☐

_____ _____ _____
Doctor Name Doctor Signature Title, license or certification

_____ _____
Doctor's Address Doctor's Phone number & email