State of Illinois
Department of Human Services

MEDICAL EVALUATION - SOCIAL INFORMATION

Application Date: _____ Case Number: _____

Name of Person Being Evaluated: _____ Case Name: _____

Social Security Number of Person Being Evaluated: _____ Case Address:
(Required)

Date of Birth: _____

Gender: ◯ Male ◯ Female Alternate Contact: _____

Complete for the person whose medical condition is being evaluated.

Medical History

The person's description of any physical or mental/emotional problems and treatment received, including dates of treatment:

Has the person seen a doctor in the last twelve months? ◯ Yes ◯ No

If "Yes", enter name, telephone number and date of visit for each doctor seen.

Doctor's Name	Telephone Number	Date/Dates Seen

Has the person been admitted to the hospital within the last twelve months? ◯ Yes ◯ No

If "Yes", enter name of the hospital and the reason for the hospitalization.

Hospital Name	Reason for Hospitalization

Describe any alcohol or substance abuse problems that the person may have. Include dates of past treatment.

For Temporary Assistance for Needy Families, describe any physical or mental/emotional problems of a family member, if any. If listed, enter care needed and identify who provides the care.

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Economic Status

The person's primary source of support is: _____

Describe any disability benefits the person has had or is currently receiving:

Length of time the person has been receiving assistance: _____

Has the person applied for Social Security or Supplemental Security Income Benefits? ◯ Yes ◯ No

If the person has applied for Social Security or Supplemental Security Income Benefits, what is the status of the application?

Education

What is the highest grade completed by the person? _____ What was the person's age at time of completion? _____

Is the person able to read and write English? ◯ Yes ◯ No

Is the person able to speak English? ◯ Yes ◯ No

If the person cannot speak English, what language is spoken? _____

Work History

Has the person ever worked? ◯ Yes ◯ No

If the person has no work history, what has been his or her major activity? _____

If the person has a work history, give details regarding his or her last three jobs.

Job Title and Duties	Dates of Employment	Reason for Leaving	Full Time	Part Time
			◯	◯
			◯	◯
			◯	◯

Other Treatment

Has the person had any treatment in the last twelve months, including treatment for mental health issues, physical therapy, or substance abuse? ◯ Yes ◯ No

If the person has had treatment within the last twelve months, list provider, reason for treatment and dates of treatment.

Provider	Reason	Dates

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Has the person received benefits or assistance from any of the following agencies in the last twelve months?

Division of Rehabilitation Services	◯ Yes	◯ No
Office of Mental Health	◯ Yes	◯ No
Division of Developmental Disabilities	◯ Yes	◯ No
Division of Alcohol and Substance Abuse	◯ Yes	◯ No
Department on Aging	◯ Yes	◯ No

Other Treatment

Describe anything that would be helpful in making a determination of the person's ability to work.

Appearance:

Mental Ability, including ability to understand:

Behavior:

Have you observed anything else that would affect the person's physical or mental limitations or difficulties? If so, specify and describe limitations.

For Temporary Assistance for Needy Families (TANF), have you observed anything else that may limit the person's ability to work or participate in Work and Training activities?

Temporary Assistance to Needy Families (TANF) Family Care Barrier

The person being cared for is: ◯ Spouse ◯ Child

Name of TANF client providing care: _____

If the person is a child, does the child attend school or special education classes? ◯ Yes ◯ No

If the person is a child and attending school or special education classes, how many days per week does he/she attend? ___

If the person is a child and attending school or special education classes, how many hours per day does he/she attend? ___

How does the child get to and from school? _____

How long does it take to get to and from school? _____

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Does someone have to assist the child on and off transportation? ◯ Yes ◯ No

If the child requires assistance on and off transportation, who provides that assistance? _____

Are there any other resources available to help with the care of the child or spouse, such as other agency providing transporation or care or another relative helping with care?

Enter a description of the child or spouse's schedule, including how many times they have classes, treatments, or other medical appointments. Indicate if the client is responsible for taking them to these appointments. Also list the na,es, ages and school status of other children in the home. List adults in the home and indicate whether or not they provide any help with the person requiring care.

Additional Comments and Information - All Programs

Use this space to provide any additional comments or information that might be of use and importance to the clinet's case.

Caseworker: _____ Caseworker Telephone Number: _____

Caseload Number: _____ Date: _____

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