JEFFERSON COUNTY
CHILD SUPPORT AGENCY

311 S Center Ave. Rm C2070
Jefferson, WI 53549
www.jeffersoncountywi.gov

childsupport@jeffersoncountywi.gov
Phone: 920-674-7255
Fax: 920-674-7435

Medical Documentation Requirements

If a medical or health condition has rendered you unable to do any type of work or has limited your ability to work and pay child support and a doctor has made that determination, provide the following documentation to the Child Support Agency on or before_____. It is the payer's responsibility to provide the Ability to Work form to the Child Support Agency. If the payer is representing by an attorney, the payer should consult with his/her attorney.

1) **MEDICAL STATEMENT** from your doctor providing information as to the nature of your illness/condition, the length of time you are unable to work, how your condition effects your ability to work, the anticipated length of time you will be incapacitated, the treatment you are receiving for the condition, and when you will be reevaluated.

   On the backside is an *"Ability to Work Report"* form designed to assist your doctor in providing the information the Agency requires to determine your work status.

2) If you apply for **SOCIAL SECURITY DISABILITY,** a copy of all information regarding your condition that you supplied to the Social Security Administration. You must update the Agency, in writing, of the status of your claim and also upon the receipt of any benefits award, including past benefits. You are to provide to the Child Support Agency copies of any updates or information received from the Social Security Administration.

3) If you apply for **WORKER'S COMPENSATION,** the name of the insurer and employer involved in the claim, copies of all medical documentation regarding your ability to work, including functional capacity reports and vocation reports. You must update the Agency, in writing, of the status of your claim, receipt of any worker's compensation, including lump sum payments or temporary disability.

4) **Any** and all information related to any form of monetary compensation you may be entitled to regarding your medical condition.

Failure to provide the requested information may result in court action as it may be presumed that you are capable of working and paying your child support obligation.

ABILITY TO WORK REPORT

Patient Name: _____ Date of Birth: _____

Date of injury/illness:_____ Diagnosis: _____

Prognosis:_____

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PLEASE COMPLETE THE FORM BY SELECTING THE OPTION(S) THAT APPLY:

☐ Patient is **PERMANENTLY, TOTALLY DISABLED** and UNABLE TO WORK as of _____(date)

☐ Patient is **TEMPORARILY, TOTALLY DISABLED** and UNABLE TO WORK as of _____(date)

☐ Patient is **PERMANENTLY, PARTIALLY DISABLED** & has the following work restrictions as of:

_____ (date) through _____.(date) as follows or attached:

_____

_____

☐ Patient is **TEMPORARILY, PARTIALLY DISABLED** & has the following work restrictions as of:

_____ (date) through _____. (date) as follows or attached:

_____

_____

☐ Patient will be re-evaluated on_____(date)

☐ Patient has been referred to _____ for further treatment/opinion.

Address/City/Phone _____

☐ Patient is able to work **with** restrictions as of_____(date)

☐ Patient is released to return to work **without** restrictions as of_____(date)

Medical Provider's Signature (No Stamps)_____Date:_____

Medical Provider's Printed or Stamped Name:_____

Address:_____Phone:_____