



# Barron County Child Support Agency

335 E. Monroe Avenue, Room 300

Barron, WI 54812

Telephone: 414.615.2596

Fax: 715.537.6849

childsupport@co.barron.wi.us

## 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 \_\_\_\_\_.

- 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.

Attached is an "Ability to Work" 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 upon the receipt of any benefits award, including past benefits. You are to provide the Child Support Agency copies of any updates or information 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) **All** information related to any form of monetary compensation you may be entitled to regarding your medical condition.

*This list is intended to be a general guideline to parties whose ability to work is impacted by a medical condition or illness. It is not all-inclusive and there may be specific additional requirements under your court order.*

**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.**



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## ABILITY TO WORK REPORT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of injury/illness: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Prognosis: \_\_\_\_\_

\_\_\_\_\_

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

Patient is PERMANENTLY & TOTALLY DISABLED as of \_\_\_\_\_ (date)

Patient is TEMPORARILY DISABLED and unable to work as of \_\_\_\_\_ (date)

#### AND

Will be reevaluated on \_\_\_\_\_ (date)

#### OR

Patient has been referred to \_\_\_\_\_ for further treatment/opinion. Address/City/State/Phone: \_\_\_\_\_

Patient is TEMPORARILY or PARTIALLY DISABLED & has the following work restrictions as of \_\_\_\_\_ (date) through \_\_\_\_\_ (date) as follows or attached: \_\_\_\_\_

AND  Will be reevaluated on \_\_\_\_\_ (date)

Patient is able to work with restrictions as stated above 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: \_\_\_\_\_