BRIDGES



# **INITIAL** BRIDGES DISABILITY VERIFICATION FORM

This form must be completed by the practitioner rendering the relevant diagnosis. A Bridges Ongoing Disability Verification Form will need to be completed every 90 days to support an individual's continued eligibility in the program.

| **PATIENT NAME:** | **DOB:** |
|---|---|

**The purpose of the Bridges program is to support young adults as they work to attain self-sufficiency.**

The above-named individual is seeking housing and case management services through the Bridges program administered by Ohio Department of Job & Family Services. **To qualify for these services, the above-named individual must meet at least one of the following criteria**:

a. Completing secondary education or a program leading to an equivalent credential
b. Enrolled in an institution which provides post-secondary or vocational education
c. Participating in a program or activity designed to promote, or remove barriers to, employment
d. Employed for a least 80 hours per month
**e. Incapable of doing any of the previously described educational or employment activities in (a) through (d) due to a diagnosed physical or mental health condition**

As stated in (e) above, an individual shall be considered incapable of performing activities for the purposes of Bridges, if said individual has a physical or mental health condition which substantially impedes his/her ability to:

a. Participate in educational activities in a secondary or post-secondary institution or a program leading to an equivalent credential for at least 9 educational credit hours or the equivalent of more than a part-time student, or;
b. Work a job for at least 80 hours per month; or
c. Participate in a program or activity designed to promote, or remove barriers to, employment that totals at least 80 hours per month

1. Does the individual named above have a **physical** condition that substantially impedes him/her from:

a. Participating in educational activities more than part-time in a secondary or post-secondary institution, or vocational program? ☐ YES ☐ NO

b. Working a job for at least 80 hours per month? ☐ YES ☐ NO

c. Participating in a program or activity designed to promote, or remove barriers to, employment that totals at least 80 hours per month? ☐ YES ☐ NO

If YES: Diagnosis: _____ Diagnosis Code: _____

Diagnosis: _____ Diagnosis Code: _____

Diagnosis: _____ Diagnosis Code: _____

d. Please describe the functional limitations and specifically how this diagnosis currently limits your patient's ability to engage in education, work or employment program: **REQUIRED to be completed or your patient cannot be determined eligible for our program.**

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e. Do you believe the individual will be able to resume routine activity in the next 90 days? ☐ YES ☐ NO

Please list approximate date individual is able to resume routine activity: _____

2. Does the individual named above have a **mental health** condition that substantially impedes him/her from:

   a. Participating in educational activities more than part-time in a secondary or post-secondary institution, or vocational program? ☐ YES ☐ NO

   b. Working a job for at least 80 hours per month? ☐ YES ☐ NO

   c. Participating in a program or activity designed to promote, or remove barriers to, employment that totals at least 80 hours per month? ☐ YES ☐ NO

If YES: Diagnosis: _____ Diagnosis Code: _____

Diagnosis: _____ Diagnosis Code: _____

Diagnosis: _____ Diagnosis Code: _____

   d. Please describe the functional limitations and specifically how this diagnosis currently limits your patient's ability to engage in education, work or employment program: **REQUIRED to be completed or your patient cannot be determined eligible for our program.**

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   e. Do you believe the individual will be able to resume routine activity in the next 90 days? ☐ YES ☐ NO

Please list approximate date individual is able to resume routine activity: _____

**PROVIDER INFORMATION:** Please complete the provider information below.

| | |
|---|---|
| **Provider Name (Print):** | **License#:** |
| **Provider Signature:** | **Date:** |
| **Professional Title:** ☐ **Physician** ☐ **Psychiatrist** ☐ **Psychologist** ☐ **Physician Assistant** ☐ **Nurse Practitioner** ☐ **LISW** ☐ **LPCC** ☐ **LICDC** | |

| | |
|---|---|
| ODJFS OFFICE USE ONLY: | SACWIS Case#: |

Thank you for your help in providing this information so that we may begin services as soon as possible.