

Instructions For Completion of JFS 01628 Bridges Disability Verification Form

Bridges, administered by the Ohio Department of Job and Family Services, provides financial and case management services to eligible individuals who emancipated from the custody of the public children's services agency. To qualify for these services, at least one of the following eligibility criteria must be met:

1. Completing secondary education or a program leading to an equivalent credential at 70% of required attendance.
2. Enrolled in an institution which provides post-secondary or vocational education for at least 7 educational credit hours or the equivalent of more than a part-time student.
3. Participating in a program or activity designed to promote, or remove barriers to, employment for a least 80 hours every 30 days.
4. Employed for a least 80 hours every 30 days.

For an individual incapable of doing any of the above identified activities due to a diagnosed physical or mental health condition, they may qualify for services through Bridges based on a documented health condition diagnosed by a licensed qualified practitioner.

To meet eligibility due to a health condition, a Bridges Disability Verification Form (JFS 01628) must be completed.

If you believe your patient qualifies for services through Bridges due to a health condition, please note the following:

1. All fields on the form must be completed.
 - Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process by necessitating follow-up contact for clarification and/or additional information.
2. The form must be completed by a licensed practitioner qualified to assess, diagnose, and treat the health conditions identified on the form.
3. The form should clearly document specific impediments that hinder the patient from meeting at least one, or a combination, of the other program criteria.
4. At a minimum, the form must be completed every 90 days, even for ongoing or lifelong conditions.

Ohio Department of Job and Family Services
BRIDGES DISABILITY VERIFICATION FORM

Ohio Administrative Code Chapter 5101:2-50 requires that a Bridges Disability Verification Form be completed for any individual requesting to meet program eligibility due to a health condition. The form must be completed, in its entirety, by a licensed practitioner qualified to assess, diagnose, and treat the health conditions identified on the form.

SECTION I: PATIENT INFORMATION		
Patient Name <i>(first and last)</i>	Date of Birth <i>(mm/dd/yyyy)</i>	
SECTION II: HEALTH CONDITION(S)		
Please list the physical and/or mental health condition(s) that substantially impedes him/her from meeting one of the four Bridges eligibility criteria, on a part-time basis. NOTE: Bridges defines part time as a minimum of 70% of required attendance for a secondary education program or equivalent credential, 7 credit hours for post-secondary, 80 hours every 30 days for employment, employment programs, and when an individual is combining any of the four criteria.		
Diagnosis	Diagnosis Code	<input type="checkbox"/> Physical <input type="checkbox"/> Mental
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SECTION III: SUMMARY OF LIMITATIONS		
This section is REQUIRED to be completed or your patient cannot be determined eligible for our program.		
Please describe the functional limitations and specifically how the identified diagnosis(es) currently limits your patient's ability to engage in educational activities, work, or employment program on a part-time basis:		
a) Completing secondary education or a program leading to an equivalent credential at 70% of required attendance?		
b) Enrolled in an institution which provides post-secondary or vocational education for at least 7 educational credit hours or the equivalent of more than a part-time student?		

c) Working a job for at least 80 hours every 30 days?

d) Participating in a program or activity designed to promote, or remove barriers to, employment that totals at least 80 hours every 30 days?

Do you believe the individual will be able to resume routine activity in the next 90 days? Yes No

Please list approximate date individual can resume routine activity Date

SECTION IV: PROVIDER INFORMATION

I certify that the above information is true, accurate and complete. I certify that I am licensed and qualified to assess, diagnose, and treat the above-named individual for the identified condition(s) on this form.

Provider Name Date

Provider Signature

License # License Type

Agency/Organization Name:

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SACWIS Case ID: