FUNCTIONAL CAPACITY PACKET (FUNCAP)

PURPOSE: To determine need for medical profiling. The included Functional Capacity Worksheet assists in fulfilling the medical readiness requirements, and is NOT complete without attaching medical documentation *(i.e. progress notes from the visit, evaluation, consultation, diagnostic findings, lab results, imaging)*

FUNCAP CHECKLIST:

☐ Soldier's Name: ______________________________ SSN: ______________________________

Rank: __________ Primary phone: ____________________

Primary e-mail: ____

AKO:____@mail.mil

☐ Unit ____ MOS: ______________

Readiness NCO: ______________________________ Phone: ______________________________

Commander Name: ______________________________ Phone: ______________________________

☐ Medical treatment documents attached
(i.e. Medical evaluation/ progress notes, Specialty Consultations / diagnostic findings/ lab results/ imaging (X-ray reports, MRI/ CT Reports related to diagnosis)

☐ FUNCAP Worksheet completed (pages 2 and 3)
(if case is over 6 months old evaluation must be completed by a ***Specialist*** *for this condition (i.e. Orthopedist, Neurologist, Gastroenterologist)*

☐ Doctor has completed, signed, dated and stamped FUNCAP (pages 2 and 3)

☐ Release of Information (ROI) signed and attached *(needed initially, and periodically)*

- *Use Dept of Veterans Affairs specific release form if being treated at VA medical center or CBOC.*
- *Use NYS Dept of Health form for any private doctor seen for this condition.*

☐ **FAX** number to Medical Command Case Management: **(518) 270-1523** or **scan/e-mail** to appropriate Case Manager:

Patricia Hopson, LMSW	27 IBCT	patricia.a.hopson10.ctr@mail.mil	(518) 270-1521
Angela Jones, RN	JFHQ / 42nd	angela.m.jones5.ctr@mail.mil	(518) 270-1522
Krystle Kilmer, LMHC	53rd Troop Command	krystle.a.kilmer.ctr@mail.mil	(518) 270-1567
Jaquanna Preville (Jackie)	Boards/Deployments	Jaquanna.d.preville.ctr@mail.mil	(518) 270-1514

Medical Profile Requests will NOT be processed if ANY of the above information is missing. Missing or inaccurate information will result in the packet being returned to the unit without action, further delaying profile adjudication. FAX: (518) 270-1523

FUNCTIONAL CAPACITY PACKET (FUNCAP)

Functional Capacity Worksheet

MEDICAL STATEMENT BY PRIVATE HEALTH PROVIDER

This evaluation is based solely on the professional opinion of the provider. Your medical opinion is one piece of information and no negative action against the patient will occur based on this evaluation. Please include **a specific diagnosis.** If your patient requires medication, include the name of the medication(s) and dosage(s). If not a new medication, include the dose history (i.e. increasing or decreasing) and medication changes, if any.

SOLDIER NAME: ____ LAST FOUR OF SSN:________________

REASON FOR PROFILE/ DIAGNOSIS: ____

Mechanism of Injury/ Cause of Injury/ Illness: ____

Medications:____

Functional Activities required for service:	**YES**	**NO**	**Is this limitation permanent?**
a. Physically and/or mentally able to carry and fire individual assigned weapon? (7 lbs)			
b. Ride in a military vehicle wearing usual protective gear without worsening condition?			
c. Wear helmet (3-9 lbs), body armor (21 lbs) and load bearing equipment (10 Lbs) without worsening condition?			
d. Wear protective mask (gas mask) and MOPP 4 (chemical suit) for at least 2 continuous hours per day?			
e. Move greater than 40 lbs (e.g. duffle bag) while wearing usual protective gear (helmet, weapon, body armor, LBE- 47lbs.) up to 100 yards?			
f. Live and function, without restrictions in any geographic or climatic area without worsening the medical condition?			

APFT	**Yes**	**No**	**Is this limitation permanent?**	**Alternate for 2 mi run**	**Yes**	**No**	**Is this limitation permanent?**
2 mi Run				Walk (2.5mi)			
Sit-ups				Swim (800 m)			
Push ups				Bike (6.2 mi)			

- Lifting restrictions?___________lbs
- Standing restrictions?___________time
- Marching with standard field gear (up to 40-70lbs)__________time____________distance

Providers Findings: Include **(1)** Diagnosis, **(2)** Treatments, **(3)** Prognosis, **(4)** any other Specific Restrictions, **(5)** Time limitations and **(6)** Recommended follow-up schedule: ____

____

____

____

______________________________ *Expected timeframe when full duty can be considered:* ______________

☐ **Provider, this form must be accompanied by a copy of your CURRENT EVALUATIONS and/or PROGRESS NOTES.**

Provider Full Name: (print) ____ Date: _______________

Provider Full Signature:____Provider Degree: (MD, PA-C, etc)_______________

Provider Medical Specialty or Specialties: ____

Provider stamp: Telephone No with Area Code: ________________________

Fax No with Area Code: ____________________________

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FUNCTIONAL CAPACITY PACKET (FUNCAP)

Functional Capacity Worksheet

SOLDIER NAME: ______________________________ **LAST FOUR OF SSN:**______________

Additional Medical Assessment: (for Cardiac, Pulmonary or Diabetes)

Not applicable

CARDIOVASCULAR RISK ASSESSMENT (Check one):

Class I, Normal Military Duty- Patients with cardiac disease but resulting in no limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.
Additional comments: ____

Class II, Slightly Limited- Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.
Additional comments: ____

Class III, Moderately Limited- Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.
Additional comments: ____

Class IV, Severely Limited- Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases.
Additional comments: ____

DIABETIC RISK ASSESSMENT:

RESULTS OF: Glycosylated Hemoglobin (HgbA1c):______________(Attach copy) Date: ______________

PULMONARY RISK ASSESSMENT:

Sleep Apnea Required Info: **ATTACH SLEEP STUDY**

Equipment Used for Treatment: ____________________

Diagnosis (circle one): Severe / Moderate/ Mild

Apnea- Hypopnea Index **WITHOUT** treatment: __________

Apnea- Hypopnea Index **WITH** Treatment: ____________

Asthma: Pulmonary Function Test **ATTACH RESULTS**

FEV1

Pre:___________

Post:___________

Provider Full Name: (print) ______________________________ Date: ______________

Provider Full Signature: ______________________________ Provider Degree (MD, PA-C, etc)__________

Provider Medical Specialty or Specialties: ______________________________________

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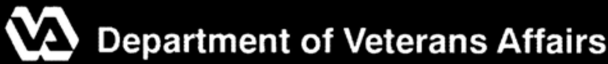
OMB Number: 2900-0260
Estimated Burden: 2 minutes



REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NYARNG Medical Command, 1 Buffington Street, Bldg 120, Watervliet, NY 12189
Fax: (518) 270-1523

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☑ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

All medical documents related to:___________________. To include all MRI/X-ray, Progress notes, lab reports, etc.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Medical Case Management for the New York Army National Guard

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on ____________ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
NYARNG Medical Command, 1 Buffington Street, Bldg 120, Watervliet, NY 12189 FAX: (518) 270-1523

9(a). Specific information to be released:
- Medical Record from (insert date)______________________to (insert date) ______________________
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- Other:_______________________________________

____

Include: (*Indicate by Initialing*)

________**Alcohol/Drug Treatment**

________**Mental Health Information**

________**HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here______________ I authorize ____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

New York Army National Guard Medical Command Case Management
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: At request of individual; ✔ Other: **to determine medical readiness**	11. Date or event on which this authorization will expire: **At conclusion of open medical case**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_______________________________________ Date: ______________________________
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**