PURPOSE: This Functional Capacity Worksheet serves to provide civilian Medical Providers with an overview of some common physical demands our New York Army National Guard Soldiers can be expected to engage in. This worksheet *supplements* the progress notes typed up at any appointment. Input from a soldier's Medical Provider is requested below, to assist us in keeping the soldier safe and healthy while on military orders.

SOLDIER INFORMATION:

Soldier's Name: _____ SSN: _____ Rank: _____

Primary Phone: _____ Primary e-mail: _____

AKO: _____@mail.mil

Unit Name: _____ MOS: _____

Readiness NCO: _____ Phone: _____

Commander: _____ Phone: _____

TO NOTE:

(1) We ***require*** recent medical evaluations / progress notes / diagnostic findings / lab results / imaging reports in order to action an open medical case.

(2) DA PAM 40-501 covers the profiling process in full. Of note:

a. If a medical case has been open for 6 months, or longer, evaluations must come from a ***Specialty Provider*** in order to action it. (i.e. Orthopedist, Neurologist, Endocrinologist, Gastroenterologist)

b. Physical therapists/Chiropractors/etc. can recommend an initial 90-day temporary profile within their scope of practice, but are NOT credentialed to update an existing case. Regulation reads: *"No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician."*

FAX medical progress notes / imaging reports / etc., along with this FUNCAP worksheet 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
Jennifer Butler	JFHQ / 42nd	jennifer.l.butler97.ctr@mail.mil	(518) 270-1522
Krystle Hearley, LMHC	53rd Troop Command	krystle.a.hearley.ctr@mail.mil	(518) 270-1567
Jackie Preville	Board/Deployment	jaquanna.d.preville.ctr@mail.mil	(518) 270-1514

TO AVOID DELAY:* *This worksheet is not complete without attaching progress notes from a recent appointment. Progress notes are required for any profile adjudication.

SOLDIER NAME: _____ LAST FOUR OF SSN: _____

SECTION I (narrative):

REASON FOR PROFILE / DIAGNOSIS : _____

Mechanism/Cause of Injury or Illness: _____

Medications/dosages: (*if not listed on progress note)*_____

_____

MEDICAL PROVIDER'S NARRATIVE: *(complete for bullets not already addressed on progress note)*

(A) Treatments provided (B) Plan of Care (C) Pending referrals (D) Time frame of limitations
(E) Follow-up schedule (F) Prognosis (G) Additional recommended physical restrictions

_____

_____

_____

_____

MEDICAL PROVIDER'S INFORMATION:

Provider Full Name: (print) _____, MD / DO / PA-C / NP / other Date: _____

Provider Full Signature: _____ Medical Specialty: _____

Provider Stamp: Telephone w/Area Code: _____

Fax No. w/Area Code: _____

SECTION II (charts of physical demands):

CAN THE SOLDIER PERFORM THESE FUNCTIONAL MILITARY DEMANDS:	Fully capable	NO	If no, is this limitation permanent?
a. Physically 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				
Timed 2mi run ☐ Yes ☐ No		Prolonged standing -		No? Max: _____
2.5 mi walk ☐ Yes ☐ No		Lifting restriction -		No? Max: _____
800 yd swim ☐ Yes ☐ No		Run at own pace/distance -		No? Max: _____
6.2 mi bike ☐ Yes ☐ No		March with gear on (40-70lb) -		No? Max: _____
Sit-ups ☐ Yes ☐ No				
Push-ups ☐ Yes ☐ No				

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SOLDIER NAME: _____ LAST FOUR OF SSN: _____

ARMY COMBAT FITNESS TEST (ACFT)

*** See attached chart for specific max/min weights for events #1, #2, #4 ***

Event #1 - Maximum Dead Lift (MDL) **Required Event**

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Squat to touch the hands to mid-calf level while maintaining a flat back? ☐ Yes ☐ No
b. Lift a *weighted* bar from the floor with the arms straight at the side? ☐ Yes ☐ No

Check means Soldier may participate in ACFT Event #1 (MDL) - 3-rep Maximum Dead Lift ☐ **May Participate**

Event #2 – Standing Power Throw (SPT)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Grasp a *weighted* medicine ball with both hands and bend at the hips/knees to lower it between the legs? ☐ Yes ☐ No
b. Throw a *weighted* medicine ball backward and overhead? ☐ Yes ☐ No

Check means Soldier may participate in ACFT Event #2 (SPT) – Standing Power Throw ☐ **May Participate**

Event #3 – Hand Release Push-up (HRP)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Perform a standard push-up from start to finish? ☐ Yes ☐ No
b. Lie down in a push-up position and move both arms out to the side, extending the elbows to a T position? ☐ Yes ☐ No

Check means Soldier may participate in ACFT Event #3 (HRP) – Hand Release Push-up ☐ **May Participate**

Event #4 – Sprint Drag Carry (SDC) **Required Event**

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Sprint 50 meters? ☐ Yes ☐ No
b. Grasp a two-handled strap and move backwards pulling a *weighted* sled? ☐ Yes ☐ No
c. Move in a lateral direction while leading with the left foot and repeat while leading with the right foot? ☐ Yes ☐ No
d. Move in a forward direction while carrying a *weighted* kettle bell in each hand? ☐ Yes ☐ No

Check means Soldier may participate in ACFT Event #4 (SDC) – Sprint-Drag-Carry ☐ **May Participate**

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SOLDIER NAME: _____ LAST FOUR OF SSN: _____

Event #5 – Leg Tuck (LTK)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Grasp with both hands, and hang from, a metal bar with a 1.25 inch diameter? ☐ Yes ☐ No

b. Flex hips and knees while flexing the elbows and extending the shoulders to bring the knees to the elbows? ☐ Yes ☐ No

Check means Soldier may participate in ACFT Event #5 (LTK) – Leg Tuck ☐ **May Participate**

Event #6 – Aerobic Event **Required Event**

Default Event - 2 Mile Run (2MR)

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Run 2 miles on level terrain? If no, see below for an alternate aerobic event ☐ Yes ☐ No

Check means Soldier may participate in ACFT Event #6 (2MR) – 2 Mile Run ☐ **May Participate**

Alternate Aerobic Event

* Alternate Cardio Event is only to be included if Soldier is deemed unable to participate in the 2 mile run listed above *

Given this Soldier's permanent joint condition or restriction is he/she able to:

a. Ride a stationary bike for 25 minutes? (15k) ☐ Yes ☐ No

b. Row an ergometric rowing machine for 25 minutes? (5k) ☐ Yes ☐ No

c. Swim laps in a pool for 25 minutes? (1k) ☐ Yes ☐ No

Event #1 -- https://www.youtube.com/watch?v=Eef09p0NIrM&spfreload=10

Event #2 -- https://www.youtube.com/watch?v=ihpqz2Wtooc&spfreload=10

Event #3 -- https://www.youtube.com/watch?v=1jMmXpHktn0

Event #4 -- https://www.youtube.com/watch?v=e74I7lgNu_8&spfreload=10

Event #5 -- https://www.youtube.com/watch?v=bXSHlJVjpIM&spfreload=10

For overall information on the ACFT and for links to ACFT training apps, visit the link -- https://www.army.mil/acft/

MEDICAL PROVIDER'S INFORMATION:

Provider Full Name: (print) _____, MD / DO / PA-C / NP / other Date: _____

Provider Full Signature: _____ Medical Specialty: _____

Provider Stamp:

TO AVOID DELAY:* *This worksheet is not complete without attaching progress notes from a recent appointment. Progress notes are required for any profile adjudication.

SOLDIER NAME: _____ LAST FOUR OF SSN: _____

SECTION III (body systems check-in):

CARDIOVASCULAR RISK ASSESSMENT (Check one)

___ NOT APPLICABLE, or

___ **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

___ NOT APPLICABLE, or

___ ATTACH COPY OF LAB WORK Glycosylated Hemoglobin (HgbA1c):_____Date:_____

PULMONARY RISK ASSESSMENT

___ NOT APPLICABLE, or

___ATTACH SLEEP STUDY RESULTS FOR **SLEEP APNEA**:

Brief summary of results:

Equipment Used for Treatment: _____

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

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

___ATTACH PULMONARY FUNCTION TEST FOR **ASTHMA**:

Brief summary of results:

FEV1 Pre:_____

FEV1 Post:_____

BEE STING ALLERGY ASSESSMENT

___ NOT APPLICABLE, or

Type of reaction: **Local** / **Systemic** If systemic, age of reaction: _____

Does patient carry EPI-pen for bee sting allergy? _____

Does patient carry EPI-pen for any other allergies?___

*ATTACH ALLERGY TEST RESULTS (Allergy test required if **"YES"** answer)*

Provider Full Signature: _____

TO AVOID DELAY:* *This worksheet is not complete without attaching progress notes from a recent appointment. Progress notes are required for any profile adjudication.

Appendix 3 to Annex A, HQDA EXORD 219-18

Army ACFT FY20 Standards (As of 1 Oct 19)

Points	MDL	SPT	HRP	SDC	LTK	2MR		
100	340	12.5	60	1:33	20	13:30		
99		12.4	59	1:36		13:39		
98		12.2	58	1:39	19	13:48		
97	330	12.1	57	1:41		13:57		
96		11.9	56	1:43	18	14:06		
95		11.8	55	1:45		14:15		
94	320	11.6	54	1:46	17	14:24		
93		11.5	53	1:47		14:33		
92	310	11.3	52	1:48	16	14:42		
91		11.2	51	1:49		14:51		
90	300	11.0	50	1:50	15	15:00		
89		10.9	49	1:51		15:09		
88	290	10.7	48	1:52	14	15:18		
87		10.6	47	1:53		15:27		
86	280	10.4	46	1:54	13	15:36		
85		10.3	45	1:55		15:45		
84	270	10.1	44	1:56	12	15:54		
83		10.0	43	1:57		16:03		
82	260	9.8	42	1:58	11	16:12		
81		9.7	41	1:59		16:21		
80	250	9.5	40	2:00	10	16:30		
79		9.4	39	2:01		16:39		
78	240	9.2	38	2:02	9	16:48		
77		9.1	37	2:03		16:57		
76	230	8.9	36	2:04	8	17:06		
75		8.8	35	2:05		17:15		
74	220	8.6	34	2:06	7	17:24		
73		8.5	33	2:07		17:33		
72	210	8.3	32	2:08	6	17:42		
71		8.2	31	2:09		17:51		
70	200	8.0	30	2:10	5	18:00	HVY	Minimum
69		7.8	28	2:14		18:12		
68	190	7.5	26	2:18	4	18:24		
67		7.1	24	2:22		18:36		
66		6.8	22	2:26		18:48		
65	180	6.5	20	2:30	3	19:00	SIG	Minimum
64	170	6.2	18	2:35		19:24		
63	160	5.8	16	2:40		19:48		
62	150	5.4	14	2:45	2	20:12		
61		4.9	12	2:50		20:36		
60	140	4.5	10	3:00	1	21:00	MOD	Minimum
59				3:01		21:01		
58				3:02		21:03		
57				3:03		21:05		
56				3:04		21:07		
55		4.4	9	3:05		21:09		
54				3:06		21:10		
53				3:07		21:12		
52				3:08		21:14		
51				3:09		21:16		
50	130	4.3	8	3:10		21:18		

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 25, Suite 336, 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:	11. Date or event on which this authorization will expire:
❑ At request of individual ☑ Other: to determine medical readiness	At conclusion of open medical case or _____ (if date specified)
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.**

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

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 25, Suite 336, 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