DEPARTMENT OF FINANCE
CITY OF CHICAGO

Dear Provider:

RE: Your patient's participation in the *Chicago Lives Healthy* wellness program

The reverse side of this form must be completed if a person who otherwise must participate in the City of Chicago's employee wellness program in order to earn the associated incentive wishes to have participation requirements waived based on a medical condition. Please read the activities listed below and provide specific information as to what specific medical condition(s) would prevent participation in the program, or make it unreasonably difficult or medically inadvisable. Please be aware that an individual's preference to not participate or opposition to the program on philosophical grounds alone is not a sufficient basis for a participation waiver. Likewise, the existence of an on-going physician-patient relationship alone is not a sufficient basis for waiver.

The requirements for participation in the *Chicago Lives Healthy* wellness program include:

- Obtaining a **biometric screening** with a finger-stick blood test to measure cholesterol, triglycerides and glucose. Height, weight, waist circumference, blood pressure and BMI are also recorded during the screening. Screenings can be performed at the participant's doctor's office or at scheduled community and work locations.

- Completing a **Well-Being 5 Assessment** (WB5) which is a series of confidential questions that assesses life and environmental factors that are critical to the participant's health, well-being and the ability to improve both. The WB5 can be completed on-line or on paper and typically takes less than 15 minutes to complete.

- Completing a **Health Advisor Call** with a health professional to discuss the results of the biometric screening and WB5. The health professional will help the participant create a personalized well-being plan. The call typically takes less than 15 minutes to complete.

- Meeting **ongoing quarterly participation** requirements. A participant does not have to engage in physical activities or meet specific health goals like losing weight, reducing blood pressure or changing lipid profiles. The participant will meet participation requirements by engaging in telephonic coaching, meeting with a pharmacist in face-to-face meetings or using a combination of computer based tracking activities in concert with telephonic coaching sessions to support weight loss or smoking cessation.

Please complete the form on the reverse of this page. Thank you for your assistance.

The *Chicago Lives Healthy* Wellness Program

City of Chicago's Wellness Program: *Chicago Lives Healthy* – Enrollment Waiver Request-**Please Print**

Employee's UID No.: _____ Date:_____

Employee's Name: _____

Spouse's Name: _____

TO BE COMPLETED BY THE PHYSICIAN

1. Patient's Name: _____
2. Current Diagnosis: _____
3. Date of Diagnosis: _____ 4. Date Last Treated: _____
4. Is the patient currently working? Yes ___ No ___
5. Is the patient currently unable to perform his/her job functions? Yes ___ No ___
6. Is the patient currently totally disabled? Yes ____ No ____ Date of Disability: _____
7. Is the patient currently on a medical leave of absence from employment? Yes ___ No ___
   a. Effective Date of Leave: _____
   b. Expected Return to Work Date: _____
   c. Type of Leave: Medical Leave_____ Maternity Leave ____ Other ____
   d. If other, please list type of leave: _____

Physician's Recommendation:

Is the patient capable of participating in the City of Chicago's wellness program?

Yes _____ No _____

If you have indicated that the patient cannot participate in the program, please **list the specific limitations** that prevent the patient from participating in the required wellness program activities as described on the reverse of this page:

Signature of Physician or Practitioner: TIN No.: Date :

_____ _____ _____

To be signed by the person requesting the waiver:

I hereby attest that all of the information provided on behalf of myself is true and accurate. I authorize the above provider, _____, to release the information requested on this form to the City of Chicago Benefit Office for the purpose of verifying my request to waive enrollment into the City of Chicago's Wellness program.

Signature: _____ Date: _____

Return the original completed form (completed by both you and your doctor or by your spouse and his/her doctor) to the Chicago Benefit Office at the address below:

City of Chicago
Wellness Participation Review Committee
Chicago Benefits Office 333 S. State Street – Room 400
Chicago, IL 60604-3978