Doctor's Statement

MUNICIPALITY OF SOUTH PORTLAND
GENERAL ASSISTANCE
25 COTTAGE ROAD
SOUTH PROTLAND, ME 04106
207 767 7617 FAX: 207 767 7620

State regulations require that persons receiving assistance work or participate in activities to prepare them for work unless they are physically or mentally incapable of working. Any information you provide is confidential by Maine State Statutes.

The person named below has applied for General Assistance from the City of South Portland.

Name: _____

I, _____ hereby give my consent to the City of South Portland General Assistance, 25 Cottage Road, South Portland, ME to receive any and all medical information from the named health provider.

TO: _____ DATE: _____

CLIENT NAME: _____ DOB: _____

CLIENT ADDRESS _____

This client of the GENERAL ASSISTANCE PROGRAM has stated they are presently disabled.

In order to determine the eligibility of the above-named client to receive the assistance he/she is requesting, we require the following information:

1. Nature and extent of the illness, disability or injury: _____

_____

2. In your opinion is the client able to:	**YES**	**YES** (WITH LIMITATIONS)	**NO**
(a) work at a regular job/employment?	____	____	____

How many hours per week? _____

IF NO please explain:

_____

_____

_____

(b) attend school or classes?	____	____	____
(c) do city workfare?	____	____	____

IF **YES WITH LIMITATIONS**, please state limitations, i.e. light duty, limited hours/days, restrictions on lifting, movement, standing,
etc.

_____

3. If disabled, length of time he/she will be unable to work or perform items under #2 above: _____

If unknown at this time, give date of next evaluation: _____

4. If disabled, in your opinion, would this client benefit from the services of the Dept. of Vocational Rehabilitation for retraining or education?

_____

5. In your opinion, is this client so disabled that he/she should apply for disability benefits? _____

6. Does this illness or condition require medication? _____

If so, please specify: _____

7. If client is not considered permanently disabled, what can this client do to help themselves become work-ready?

_____

8. Date you last evaluated this patient for this disability _____

9. Additional information/comments, if any: _____

_____

Doctor's Name (please print): _____

Doctor's Signature _____ Dated: _____

Agency: _____

<u>Any information you provide is confidential by Maine State Statute</u>. We thank you for your cooperation. The information may be returned via the client or faxed to 207- 767-7620 or mailed to: 25 Cottage Road, South Portland, ME 04106 Attn: General Assistance