Healthcare Provider Statement

Case Name:	Medical Record #:	Referring Worker:
Case Number:	☐ New Application	Worker PCN:
Birthdate:	☐ Re-evaluation	Phone Number:
Contra Costa County - Fax Numbers: ☐ Pleasant Hill (925) 228-0405	☐ Richmond (510) 942-3886	☐ Antioch (925) 608-5998

AUTORIZACIÓN DEL PACIENTE. Autorizo a que se dé a conocer mi información médica, incluida información relativa al abuso de sustancias y condiciones psiquiátricas. Esta información la necesita el Departamento de Empleo y Servicios Humanos del Condado de Contra Costa con el fin de verificar mi discapacidad para los programas de Asistencia General (GA) y Abogacía de SSI. Esta información también es necesaria para decidir si puedo trabajar, participar en un entrenamiento laboral, o cumplir con los requisitos del programa. Esta información será mantenida confidencialmente en el historial de mi caso y no se distribuirá sin mi firma autorizándola, a menos que la distribución de dicha información sea específicamente requerida o permitida por la ley. He leído este formulario, o me lo han leído. Esta autorización es válida por un año desde la fecha de la firma, o hasta el día _______________.

X____

Firma del Paciente **Fecha**

X____

Firma del testigo, intérprete o representante autorizado **Fecha**

HEALTH CARE PROVIDER STATEMENT

(To Be Completed by Health Care Provider)

DEAR HEALTH CARE PROVIDER: The General Assistance Program needs your help in evaluating this individual. Please complete the information below. Persons considered as "Employable" have no verifiable physical or mental disability, which precludes them from maintaining gainful employment. Please provide information regarding how their mental or physical condition will affect their ability to work or to comply with some or all of the program requirements.

PATIENT STATES S/HE IS UNABLE TO WORK DUE TO:

☐ **Physical Condition and/or** ☐ **Mental Condition**

1. Patient was last seen on _____/______/_____

2. Next Medical Appointment: ______/______/_____

3. Degree of Employability. Note that patient may be required to look for full time employment and may be assigned up to an 8-hour day work experience, involving physically demanding tasks, indoors or outdoors:

☐ Employable.

☐ Temporarily unable to work from _____/_____/_____ until: _____/_____/_____

Onset Date:______/_____/_____

☐ Permanently unemployable due to ☐ Physical or ☐ Mental disability

Onset Date: _____/_____/_____

4. Does the patient require ongoing treatment for this or other physical or mental condition?

5. ☐ YES ☐ NO

6. If yes, is the patient currently receiving such treatment? ☐ YES ☐ NO

7. Does the patient have alcohol or other substance abuse problems?
☐ YES ☐ NO ☐ UNKNOWN

8. Is the patient able to understand, participate in, and comply with the following types of activities?

☐ Yes ☐ No Able to understand the requirement to appear at scheduled places and times.
☐ Yes ☐ No Able to explain or understand the reason for failure to comply with a program requirement.
☐ Yes ☐ No Able to keep appointments at scheduled places and times.
☐ Yes ☐ No Able to obtain information and to mail or submit forms to the Department, such as the monthly reporting form, other forms requesting eligibility information, and other required documents.

9. Does the patient require a special diet? ☐ YES ☐ NO
If yes, duration:______/______/_____

10. Other/Notes:

____
____
____
____

Health Care Provider Name / Title	**Hospital / Clinic Location**	**Date**
Form Completed by /Title	**Telephone #**	**Date**

The sole purpose of this form is to provide services for General Assistance recipients in Contra Costa County