Healthcare Provider's 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		

PATIENT'S AUTHORIZATION. I authorize the release of medical information, including information which may be related to substance abuse and/or psychiatric conditions. This information is needed by the Contra Costa County Employment and Human Services Department for the purpose of verification of disability for General Assistance and SSI Advocacy programs. It is also needed to determine my ability to work, participate in training activities, or my ability to comply with program requirements. This information will be kept in my case file, and it will not be disclosed without my signed consent, unless the disclosure is specifically authorized by law. I have read this form or had this form read to me. This authorization is valid for one year from the signing date, or until _____.

X_____

Patient's Signature **Date**

_____

Signature of Witness, Interpreter, or Authorized Representative **Date**

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 his/her 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 _____/_____/_____ to Date: _____/_____/_____

   Onset Date: _____/_____/_____

   ☐ Permanently Unemployable due to: ☐ Physical ☐ Mental disability
   Onset Date: _____/_____/_____

4. Does the patient require ongoing treatment for this or other physical or mental condition?
   ☐ YES ☐ NO

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

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

7. Is the patient able to understand, participate 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
   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