


 DEPARTMENT OF SOCIAL SERVICES
 P: 315-376-5400 | F: 315-376-4112

 Jennifer Jones
 Commissioner
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Lewis County Medical Assessment Form for SNAP

Client/Patient Information:
Case #: _____

Patient Name _____

Address: _____

CIN: _____ **DOB:** _____

The person named above requests verification of their health condition for program participation. Please fill out this form. You or the person should send the completed form to the local Department of Social Services.

Client/Patient Authorization I authorize the release of medical information and/or documentation of participation in a substance use rehabilitation program requested to the Department of Social Services. I understand that this information will be treated as confidential.

 Client Signature:

 Date:

To be completed by healthcare professional:

1. Is this person pregnant?

 Yes No NA

If yes, due date: _____

OR

2. Is this person participating in a substance use treatment, rehabilitation, or counseling program?

 Yes No

If yes, what is the expected program end date: _____

OR

3. Is the patient able to work and/or participate in work activities without any limitations?

 Yes No

If answered YES to #3, STOP and sign form on next page- CLIENT IS ABLE TO PARTICIPATE IN WORK ACTIVITIES

SEE NEXT PAGE

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TO THE PROVIDER, PLEASE COMPLETE ONLY ONE OF THE BELOW CHOICES

CLIENT IS WORK-LIMITED

Is the patient able to work and/or participate in work activities **with limitations**? ___ Yes ___ No
If yes, please describe work limitations (ie. physical limitations or restrictions, environment type, limited hours

Is the patient able to work a minimum of 20 hours per week? ___ Yes ___ No

CLIENT IS UNABLE TO WORK

Is the patient **unable** to work and/or participate in work activities? ___ Yes ___ No

What is the patient's diagnosis? _____

If the patient is unable to work, please indicate the **anticipated duration** of the patient's inability to work due to this illness/disability:

___ less than 30 days

___ 1---3 months

___ 3---6 months

___ 6---9 months

___ 9---12 months

___ more than 12 months/or indefinite

I certify that the information provided above is true and accurate.

Name (please print) _____

Title/profession _____

Provider Address and phone # _____

Signature

Date

*This form may be signed by any of the following: physician, physician's assistant, nurse practitioner, osteopath, licensed or certified psychologist, substance use counselor, certified mental health counselor, licensed independent clinical social worker, licensed certified social worker, and certified midwife. For purposes of verifying a person's participation in a rehab or counseling program (Question #2), the director of the program or the individual's counselor may also sign this statement.

Please forward the completed form to:

Lewis County Department of Social Services
PO Box 193
Lowville NY 13367
Attention: _____