LEWIS COUNTY
NEW YORK

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 THE PROVIDER: PLEASE COMPELTE ONLY ONE OF THE CHOICES BELOW AND ALL FOLLOWING QUESTIONS

Please choose one of the following boxes and complete the following questions:

☐ **CLIENT IS ABLE TO WORK BUT LIMITED IN ABILITY**

OR

☐ **CLIENT IS COMPLETELY UNABLE TO WORK**

What is the patient's diagnosis? _____
What is the patient's prognosis? _____
Please indicate the **anticipated duration** of the patient's illness/disability:

____less than 30 days
____1---3 months
____3---6 months
____6---9 months
____9---12 months
____more than 12 months/or indefinite

****If you selected Client is Able to Work but Limited in Ability, please complete the next section on the following page**

If you selected client is able to work but limited, please answer the following so we can assign appropriate work activities:
Is this person able to work 20 or more hours each week (80 hours monthly) because of this condition: ☐ Yes ☐ No
Please describe the patient's work limitations (ie. physical limitations or restrictions, environment type, limited hours, etc.):
_____
_____

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

Fax #: 315-376-5328
Attention: