

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 COMPLETE 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

Attention: _____

#250