WAYNE TOWNSHIP GOVERNMENT

Trustee Andy Harris

Faithfully Serving with Trust and Integrity

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Medical Statement

Client Name: _____Case Number: _____

Address: _____Social Security Number (last 4 digits): _____

The client listed above has applied for Township Emergency Assistance with the Wayne Township Trustee's Office. Eligibility standards for assistance require all able-bodied persons to be working or seeking employment. State law gives trustees the ability to investigate the situation of persons requesting Township Assistance. The above named client has told our office of an inability to work because of a physical, mental or emotional problem. Please help us verify the information given to us by completing the form below. **State law IC 12-20-6-7 mandates that the trustee collect this information within 72 hours.** Thank you for your help.

In regard to the ability to work, as outline above, I have examined the client and have given the following diagnosis:

The client is: Please check all that apply. If a client is unable to work, please indicate if they would benefit from Vocational Rehabilitation and/or Goodwill programs.

_____ Able to Work **_____ Unable to do ANY Work**

_____Able to work with restrictions (as indicated): _____
_____
_____

Possible release date for restrictions: _____

_____ Able to attend/participate in training programs (Vocational Rehabilitation and/or Goodwill Programs)

_____ Fully Disabled **Date of Disability: _____**

_____ Following all recommended treatments and keeping appointments

_____ Is not following all recommended treatments or keeping all appointments

Name of examining physician: _____

Name of Office, Hospital or Clinic: _____ Date of last exam: _____

Physician Address and Phone Number: _____

Physician's Signature: _____Date: _____

****Disclosure Statement****

I give permission for all of the above information to be released to the Wayne Township Trustee's Office for the purposes of assessing my application for township assistance. I understand that the information they gather is confidential and will be used only for the purposes of investigating my application for assistance, and will not be re-disclosed to any other entity. Please cooperate fully with the Trustee's Office to help expedite this process. This authorization is valid for a period of 180 days from the date below. I understand I may revoke this authorization by notifying the parties in writing, but that revoking authorization will have no impact upon actions already taken in compliance with this form. I understand that if I refuse to sign this authorization, my request for assistance may be affected.

Client's Signature: _____Date: _____