

MUNICIPALITY OF ROCKLAND
GENERAL ASSISTANCE
270 PLEASANT STREET
ROCKLAND, ME 04841
207-596-0302 FAX: 207-594-9481

Doctor's Statement

TO: _____ DATE: _____

CLIENT NAME: _____ DOB: _____

CLIENT ADDRESS: _____

This client of the **GENERAL ASSISTANCE PROGRAM** has stated they are presently disabled.

In order to determine the eligibility of the above-named client to receive the assistance he/she is requesting, we need the following information:

1. Nature and extent of the illness, disability or injury: _____

2. In your opinion is the client able to:	<u>YES</u>	<u>YES</u> (WITH LIMITATIONS)	<u>NO</u>
(a) work at a regular job/employment?	_____	_____	_____
(b) seek work/do job searches?	_____	_____	_____
(c) attend school or classes?	_____	_____	_____
(d) do city workfare?	_____	_____	_____

IF **YES WITH LIMITATIONS**, please state limitations, i.e. light duty, limited hours/days, restrictions on lifting, movement, standing, etc. _____

3. If disabled, length of time he/she will be unable to work or perform items under #2 above: _____
If unknown at this time, give date of next evaluation: _____

4. If disabled, in your opinion, would this client benefit from the services of the Dept. of Vocational Rehabilitation for retraining or education? _____

5. In your opinion, is this client so disabled that he/she should apply for disability benefits? _____

6. Does this illness or condition require medication? _____

If so, please specify: _____

7. If client is not considered permanently disabled, what can this client do to help themselves become work-ready? _____

8. Date you last evaluated this patient for this disability _____

9. Additional information/comments, if any: _____

Doctor's Name (please print): _____

Doctor's Signature _____ Dated: _____

Agency: _____

Any information you provide is confidential by Maine State Statute. We have asked the above client to return this information to us by _____, if possible. We thank you for your cooperation. The information may be returned via the client, faxed to 207 _____ or mailed to:

Informational Memo

TO:

Doctors, Nurse Practitioners, MSW and all other treating Medical/ Physiological Providers

Re: Doctors Statements to be completed for General Assistance

This memo is to inform treating professional of clients seeking assistance the purpose of this form. This form is not intended to determine disability as it relates to seeking Social Security Benefits. It is to determine if they are able to work at all or with restrictions. In completing this form please try to distinguish between disabled and disadvantaged. For example if a client/patient is without transportation but walks multiple blocks on a daily weekly basis to City Center, Library, and the grocery store caring heavy bags of groceries and other daily errands this office will call into question if the patient is restricted from looking for work or doing workfare with restrictions that contradict what they prove to this office they can do on a daily and weekly basis. We are aware that patients will make legitimate reports of their pains and symptoms in your office but will demonstrate behaviors that contradict the long lasting debilitating effects once out of your office. We expect that if accommodations can be made in a work place and supports exist in the community to help people with disabilities become employed this be taken into consideration.

This office is looking for information that truly reflects the patient/clients medical, psychological and physical condition that is consist with being either so disabled they can not work at all, short periods of time or can work with accommodations and various community supports.

We are aware that some attorney's advice their client not to attempt to work at all as this will affect the amount of the back payment the client and attorney will receive. This is between the client and Attorney.

General Assistance is a program of last resort and designed to be short term and help while clients are looking for work to become self-sufficient. If a client is disabled we ask that this statement reflect that and will expect our clients to spend as much time and effort seeking treatment and resolve as we would them looking for work.

Please sign this to memo and include if your are an MD, PNP, PSY, MSW or other

Signature