Verification of Incapacity

Case No.: _____
Case Name: _____
SSN: _____
Date: _____
Worker No.: _____

The following information is needed to determine your eligibility for General Relief.

Please return this form by: _____ .

Medical release authorization: I authorize my medical provider to release the following information:

_____ _____
Patient or Representative Signature Date

Health Care Provider: Please answer the questions below.

1. Does the patient have a physical or mental health condition that prevents or substantially reduces their ability to engage in work or training?

   ☐ No (please answer question 9 and sign the form)
   ☐ Yes (please answer the following questions:

2. Onset date: _____

3. Expected duration:
   ☐ Temporary, expect to release patient for work on: _____
   ☐ Permanent

4. Are they able to work? ☐ No, please go to no. 5 ☐ Yes, please answer the following questions:
   Can perform ☐ limited full-time work ☐ limited part-time work

5. Describe how the physical and mental condition reduces their ability to engage in work:

   _____
   _____

6. Is the physical or mental condition primarily due to drug and/or alcohol abuse?
   ☐ Yes ☐ No ☐ Unknown

7. Has the patient submitted a disability insurance application for completion?
   ☐ Yes ☐ No ☐ Unknown

   If yes, date submitted: _____

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8. Is the patient receiving or seeking treatment? ☐ Yes ☐ No ☐ Unknown

9. I recommend a referral for:
   - ☐ Mental Condition
   - ☐ Physical Condition
   - ☐ None

Comments: _____

_____ _____
Signature of Health Care Provider Date

_____
Print Name

_____
Title

_____
Agency

_____
Address

_____
Phone No.

_____
DEA No.