Georgia Department of Human Services
Division of Family and Children Services

MEDICAL STATEMENT

TO:

RE. Client's name:

Case number:

Worker ID:

The above-named person has applied for or is receiving:

☐ Temporary Assistance for Needy Families (TANF) ☐ Food Stamps.

To needy families, while simultaneously working to transition TANF applicants/recipients into work, self-sufficiency and off government assistance. TANF is a time-limited program and Mr. /Ms. has already received TANF for of 48 months. We need to know his/her current medical condition and the anticipated date of recovery in order to determine his/her placement in an appropriate work-related activity.

Authorization to release medical information signed by the TANF/Food Stamp participant is included below:

Authorization for Release of Medical Information
(To be completed by the TANF/Food Stamp applicant/recipient)

I, hereby authorize to furnish to the Division of Family & Children Services the requested information about my medical condition, including my ability to participate in suitable work activities and my capability for current/future employability.

Date Signature or Mark

If signed by an 'X', person who witnesses the mark sign

Signature of Witness
Date

The section below is to be completed by the medical professional:

Date of most recent examination: _____

Diagnosis of present condition: _____

_____

_____

Expected duration of illness: _____

Prognosis (please be specific):

What are the specific instructions that the patient has been told to follow?

When do you estimate the patient will be able to participate in work related activity (ies)?

What accommodations, if any, can we put in place that would enable the patient to participate in work related activities at this time?

Please indicate if any of the following activities are appropriate for this individual. **If accommodations are needed, please specify in the space provided above.** Check all applicable boxes:

☐ Full-time employment	Yes	No
☐ Part-time employment	Yes	No
☐ Volunteer activity	Yes	No
☐ Light community service	Yes	No
☐ Adult Literacy/GED	Yes	No
☐ Short-term technical training	Yes	No

Does the patient need a full-time caretaker? ☐ Yes ☐ No

Date to return for re-examination:

Additional comments:

Medical Professional's Name: _____ Date: _____
(Please print)

Medical Professional's Signature: Phone Number:

Address: