

**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?

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

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

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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:

- |  |   |       |    |
|--|---|-------|----|
| <input type="checkbox"/> Full-time employment          | - | Yes   | No |
| <input type="checkbox"/> Part-time employment          | - | Yes - | No |
| <input type="checkbox"/> Volunteer activity            | - | Yes   | No |
| <input type="checkbox"/> Light community service       | - | Yes   | No |
| <input type="checkbox"/> Adult Literacy/GED            | - | Yes   | No |
| <input type="checkbox"/> Short-term technical training | - | Yes   | No |

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

Date to return for re-examination:

Additional comments:

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Medical Professional's Name: \_\_\_\_\_  
(Please print)

Date: \_\_\_\_\_

Medical Professional's Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_