City Of Biddeford

General Assistance
205 Main Street, Biddeford ME 04005
Phone: (207) 284-9514 Fax: (207) 571-0675

Primary Care Medical Form

Name: _____ Date of Birth: _____

Physician's Name: _____

Address: _____

I authorize the release of the following medical information to the City of Biddeford:

Signature: _____ Date: _____

State regulations require that persons receiving assistance work or participate in activities to prepare them for work unless they are physically or mentally incapable of working.

Below to be completed and signed by a licensed physician ONLY:

Specific Medical Problem(s)—please be as detailed as possible: _____
_____
_____

Date individual was seen for medical condition(s): _____ Next appointment: _____

To what extent is the individual able to work or participate in activities to prepare for work **(CIRCLE ONE)?**

I am unable to make a determination. Reason: _____

The individual is able to work or participate in activities to prepare for work **without restrictions**:
Full time (40 hours/week) Part time at _____ hours/week

The individual is able to work or participate in activities to prepare for work **with restrictions:**
Full time (40 hours/week) Part time at _____ hours/week

Please list restrictions (i.e. sitting, standing, walking, climbing stairs/ladders, kneeling/squatting, bending, pushing/pulling, lifting/carrying): _____

The individual may participate in education/training programs:
Yes No

The individual is **unable** to work or participate in activities to prepare for work at all:
The disability is permanent The disability is not permanent and is expected to last _____ months

Definition of **Disability** under the Social Security Administration Standards: An individual who has a **medically documented physical and/or mental health condition** when prevents him/her from performing **any type of work for at least one year.** Would you advise this person to apply for permanent Social Security Disability benefits? Yes No

Would you recommend any form of rehabilitation for this individual (circle one)?
Vocational Rehabilitation Substance Abuse Mental Health Other _____

Signature _____ Date _____
(Licensed Physician)