



Statement of Incapacity

The use or disclosure of information will be limited to purposes directly connected with the administration of programs of the Department of Family Services (DFS). I hereby give permission for any person having information relating to my physical/mental/employability status to give such information to DFS.

Name of Patient (Printed) _____ Last 4 digits of SSN: _____

Address of Patient _____

Signature of Patient _____ Date: _____

The person named above has applied for or is receiving assistance from DFS. Information required to determine eligibility is listed below, select any that are applicable to the patient:

- ☐ Unable to work currently
- ☐ Able to work with limitations/restrictions
- ☐ Able to work in any capacity

Remarks by physician:

Printed Name of Physician or Psychologist

Licensed Physician or Psychologist Signature

Address

Telephone Number

Date

City, State, Zip

E-mail Address