



# City Of Biddeford

General Assistance

205 Main Street, Biddeford ME 04005

Phone: (207) 284-9514

Fax: (207) 571-0675

## Primary Care Medical Form

(THIS FORM MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)

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.

RE \_\_\_\_\_

Date of Birth \_\_\_\_\_

Physician's Name: \_\_\_\_\_

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Date this person 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? Please **circle one**:

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

I am unable to make a determination. Reason: \_\_\_\_\_

Would you recommend any form of rehabilitation for this individual?

Vocational Rehabilitation

Substance Abuse

Mental Health

Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Licensed Physician)