

City of Portland  
Health & Human Services Department, Social Services Division  
PRIMARY CARE MEDICAL FORM

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

\_\_\_\_\_ (Client name), \_\_\_\_\_ (DOB) has applied to this office for assistance. We ask your cooperation in providing information regarding his/her medical condition as this data is part of eligibility determination.

\_\_\_\_\_  
Financial Eligibility Specialist

I authorize the release of medical information to the City of Portland. \_\_\_\_\_

Client Signature

**TO BE COMPLETED BY PHYSICIAN'S OFFICE:** Please print

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**SPECIFIC** Medical Problem(s) – Please be as detailed as possible:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date this person was seen for medical condition(s): \_\_\_\_\_ Next Appointment Date: \_\_\_\_\_

**IS THIS PERSON ABLE TO DO ANY TYPE OF WORK?** (Please circle ONE) **Yes** **No**

**\* Workfare is a requirement for receiving assistance. An eligible person who is medically capable of work may be required to perform work for the City. Job assignments include clerical, housekeeping, laundry, maintenance and other duties.**

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

**YES**, are there any work/Workfare\* restrictions? \_\_\_\_\_

If **NO**, please give reason for inability to do any type of work: \_\_\_\_\_

If **NO**, would you advise this person to apply for permanent Social Security Disability benefits? **Yes** **No**

Definition of **DISABILITY** under the Social Security Administration Standards:

An individual who has a **medically documented physical and/or mental health condition** which prevents him/her from performing **any type of work for at least one year**.

If this individual has a **temporary disability**, what is the anticipated duration of recovery before patient achieves maximum medical improvement? \_\_\_\_\_ 1 Week \_\_\_\_\_ 1 Month \_\_\_\_\_ 3 Months

What medication(s), if any, is this individual taking that would interfere with job performance? Please include possible side effects. \_\_\_\_\_

Would you recommend any form of rehabilitation for this individual? (Please circle ONE) **Yes** **No**

Please specify: \_\_\_\_\_ Substance Abuse \_\_\_\_\_ Vocational Rehabilitation \_\_\_\_\_ Mental Heal \_\_\_\_\_ Other (\_\_\_\_\_)

Medical Provider's Signature: \_\_\_\_\_ Agency/Facility Name: \_\_\_\_\_

Social Services Division – 196 Lancaster Street, Portland, ME 04101 – (207-775-7911)

\*Workfare questions please call 775-6315 ext. 231

**PLEASE RETURN COMPLETED FORM VIA FAX TO THE FOLLOWING NUMBER: 207-775-7917**