TOWN OF CONWAY
P.O. Box 2680 Conway, New Hampshire 03818
(603) 447-3811
www.conwaynh.org

MEDICAL RELEASE AND REPORT

TO THE PHYSICIAN OR CLINIC:

New Hampshire General Assistance laws require able-bodied GA recipients to seek and retain work as a condition of continued assistance. The goal is to provide short term assistance with basic needs of survival while minimizing the amount and duration of assistance.

The person referenced below has indicated an inability to work. Your input on this form will help us decide whether to grant full or partial exemption(s).

Client Name:_____Date of Birth:_____Is this person your ❑Patient ❑Caretaker?

Is the patient homebound? ❑Yes ❑ No If yes, what is the primary cause? ❑Health ❑Financial ❑Mental Health ❑Incarceration ❑Other

If yes, indicate the number of hours the patient requires a caretaker? ___per day; ___per wk.

What is the nature and extent of this individual's current limitations? _____

_____

The individual can work a maximum of #___hours/day, #___days/week; recommended period of modification: __/__/__ to __/__/__.

Is this person disabled? ❑Yes ❑ No Please check all that apply: ❑ Temporarily ❑ Permanently ❑ Partially ❑ Totally

Incapacity begin date:_____Last examination/treated? _____

Expected duration of incapacity? ❑1month or less ❑Up to 3 months ❑1 year or more ❑4 years or more

What is the source of the incapacitation? ❑Illness ❑Injury ❑Accident ❑Pregnancy ❑ Other: _____

Please list name and phone contact for other medical professionals who may have helpful information for disability claims or exemptions.

_____ _____

Print Name **Telephone / Fax**

Please check the appropriate boxes:

	Receives	**Referred**
Disability cash assistance		
Visiting nurses / Hospice		
Home Health Care		
Medically coded with utility company?		
Partners in Parenting		
Addiction Treatment		
Mental Health Treatment		
Case Management Services		
Jen's Friends		
Servicelink		
Medication samples / assistance		
Meals on Wheels		
Other		

_____ _____

Physician Signature **Date**

_____ _____

Print Name **Date**

_____

Phone contact/Attach business card.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing my name below, I authorize the verification and release of the medical information including alcohol, drug or psychiatric information, medical diagnosis, medical history, treatment plan or hospitalization requested above. I understand that the information will be held in the strictest confidence and that it will only be reviewed by, or shared with, authorized Town of Conway staff involved in the administration of the General Assistance Program or as otherwise permitted by State laws or federal regulations. A photocopy of this signed release may be used in place of an original. This release of information expires 12 months from the date indicated by the client below.

_____	_____
Patient Signature	**Date**
_____	_____
Print Name	**Date**

Thank you for taking the time to complete this form.
Please contact the Municipal Welfare Department if you have any questions.