INCAPACITY TO WORK – EMPLOYABILITY ASSESSMENT FORM

An individual with a physical or mental disability which temporarily or permanently precludes him or her from gainful employment to the extent of being incapable of self-support, may be eligible for General Assistance (GA). Prior to assistance being granted, this form must be completed to aide in the determination and document the disability.

SECTION I – Must be completed by applicant / recipient for public assistance

NAME:	BIRTHDATE:	SOCIAL SECURITY NO:
ADDRESS:	TELEPHONE NUMBER:	
CITY:	STATE:	ZIP CODE:

BRIEFLY EXPLAIN WHY YOU BELIEVE YOU CANNOT WORK:

I HEREBY AUTHORIZE ALL MEDICAL PROVIDERS TO RELEASE ANY MEDICAL INFORMATION THAT IS RELATED TO MY EMPLOYABILITY TO THE GENERAL ASSISTANCE OFFICE OF JACKSON COUNTY. THE INFORMATION OBTAINED WILL BE USED ONLY FOR PURPOSES RELATED TO AN ASSESSMENT OF MY ABILITY TO WORK AND MY ELIGIBILITY FOR PUBLIC ASSISTANCE.

X _____ _____ _____

Signature of applicant/recipient Printed Name Date

After you have completed this section, arrange for an appointment with a licensed physician (medical doctor, doctor of osteopathy, physician's assistant, certified registered nurse practitioner, or psychologist. General Assistance benefits cannot be authorized for you until the fully-completed form is returned to the County General Assistance Office.

MEDICAL PROVIDER: RETURN DIRECTLY TO THE GENERAL ASSISTANCE OFFICE

JACKSON COUNTY GENERAL ASSISTANCE
201 W. PLATT STREET
MAQUOKETA, IA 52060
PHONE: 563-652-1710 ~ FAX: 563-652-1797

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SECTION II – To be completed by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist.

The information on this form will be used by the Jackson County General Assistance Office, to assess your patient's qualification for GA benefits based on his or her inability to work. Please complete this section based on your evaluation of the patient's statement in Section I and your examination of the patient. Complete the following only if you have examined the person and consider yourself able to determine such ability to or incapacity from work.

EMPLOYABILITY (check only one)

☐ **PERMANENTLY DISABLED** – Has physical or mental disability which permanently precludes gainful employment.
☐ **TEMPORARILY DISABLED** – Is currently disabled due to a temporary condition as a result of an injury or acute condition and the disability temporarily precludes any gainful employment. Temporary disability began _____ and is expected to last until _____
☐ **EMPLOYABLE** – The patient's physical and/or mental condition is such that he or she can work.

EXAMINIATION RESULTS – * Complete only if permanent or temporary disability exists

Primary Diagnosis:

ASSESSMENT BASED UPON – Check all that apply

☐ Physical Examination

☐ Review of Medical Records

☐ Clinical History

☐ Appropriate tests and diagnostic procedures

☐ Other (Specify) _____

_____

As a licensed medical provider, I certify that the above information is true and correct to the bse of my professional knowledge. I further certify that my diagnosis and assessment are based solely on the patient's condition as determined by my examination.

MEDICAL PROVIDER:	TELEPHONE NO:
ADDRESS:	

_____ _____

Signature Date

MEDICAL PROVIDER: RETURN DIRECTLY TO THE GENERAL ASSISTANCE OFFICE – FAX 563-652-1797