Verification of Incapacity

Jasper County General Assistance
315 W. 3rd St. N., Suite 200
Newton Iowa 50208
641-791-2609 Fax 641-787-1302

Eligibility for County Assistance is contingent on the individual's seeking work or written proof from a medical provider that the individual's current condition would prevent them from seeking any type of employment. "A refusal or failure to actively seek employment or refusal or failure to accept reasonable employment offered shall disqualify the individual from assistance." If the individual is unable to work, the form below must be filled out and returned to the General Assistance office prior to approval for assistance.

Name of Patient_____ Birth date_____

Address_____

*****PATIENT'S CONSENT TO RELEASE OF INFORMATION*****

I do hereby authorize the release to Jasper County General Assistance the results of any examination including clinical, laboratory or hospital records pertaining to my condition. I also hereby forever release and discharge General Assistance, and the Medical representative, physician or hospital representative signing this form from any liability for divulging such information whether such information is deemed confidential or not.

_____/_____
Patient's signature Date

This authorization expires 60 days after the date of signature

This information is to be released to:

Connie McQuiston, Director
Jasper County General Assistance
315 W. 3rd St. N., Suite 200
Newton Iowa 50208
641-791-2609

To:_____

XXXXX The section below must be completed by Physician XXXXX

1. DIAGNOSIS_____

2. TREATMENT:

   a. HAS THE PATIENT BEEN UNDER SUPERVISION? YES☐ NO☐

   b. WHAT IS THE PROBABLE DURATION OF TREATMENT?_____

   c. WHEN SHOULD THE PATIENT BE RE-EXAMINED?_____

   d. IS CONDITION:

      TEMPORARY☐ PROGRESSIVE☐ PERMANENT☐

   e. WHAT TYPE OF TREATMENT IS BEING GIVEN?

      _____

3. WORK CAPACITY: ABLE TO SEEK **ANY** TYPE OF WORK?

   YES☐ NO☐

MUST INDICATE DATE ABLE TO RETURN TO WORK OR DATE ABLE TO SEEK WORK: _____

4. COMMENTS: _____

PHYSICIAN SIGNATURE: _____

ADDRESS_____