ADA COUNTY
INDIGENT SERVICES

Office (208) 287-7960
Fax (208) 287-7969
252 E. Front Street, Suite 199
Boise ID 83702

PHYSICIAN'S MEDICAL STATEMENT

DATE: _____ DEPUTY CLERK: _____

PHYSICIAN'S NAME: _____

PATIENT NAME: _____

DOB: _____ SSN: _____

THE INFORMATION REQUESTED BELOW IS REQUIRED TO ESTABLISH ELIGIBILITY FOR NON MEDICAL INDIGENCY ASSISTANCE AND MUST BE SUBMITTED BY: _____

WHAT IS THE PATIENT'S DISABILITY? _____

_____

DATE OF ONSET OF DISABILITY: _____

HOW LONG DO YOU EXPECT THIS DISABILITY TO LAST? _____

_____

IS PATIENT CONSIDERED TO BE DISABLED PURSUANT TO THE SOCIAL SECURITY REQUIREMENT OF *'A PERSON MUST BE UNABLE TO DO ANY SUBSTANTIAL GAINFUL WORK DUE TO A MEDICAL CONDITION WHICH HAS LASTED OR EXPECTED TO LAST FOR AT LEAST TWELVE (12) MONTHS IN A ROW'*? YES ☐ NO ☐

WHEN CAN PATIENT RETURN TO USUAL ACTIVITY AND/ OR EMPLOYMENT: _____

_____

_____
Name and title of person completing form

_____ _____ _____
Physician's signature **Date** **Telephone**

MEDICAL RELEASE OF INFORMATION

I hereby authorize Ada County and any medical provider to release and share any information, including medical records relating to my care or coverage. I acknowledge that some information pertaining to treatment I have received may include material that is protected under Federal Law. Specific authorization is given to release Drug/Alcohol abuse, Mental Health, and HIV information which are under Federally Protected Status. I authorize any health provider to release information to Ada County and understand I am waiving the confidentiality of such records for the limited purpose of this application only.

_____ _____
Signature Date