

MUNICIPALITY OF WESTBROOK  
GENERAL ASSISTANCE  
426 BRIDGE ST.  
WESTBROOK, ME 04092  
207 854-0676 FAX: 1-877-722-3057

Doctor's Statement

State regulations require that persons receiving assistance work or participate in activities to prepare them for work unless they are physically or mentally incapable of working. Any information you provide is confidential by Maine State Statutes.

The person named below has applied for General Assistance from the City of Westbrook.

Name: \_\_\_\_\_

I, \_\_\_\_\_ hereby give my consent to the City of Westbrook General Assistance, 426 Bridge St., Westbrook, ME to receive any and all medical information from the named health provider.

TO: \_\_\_\_\_ DATE: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CLIENT ADDRESS \_\_\_\_\_

**This client of the GENERAL ASSISTANCE PROGRAM has stated they are presently disabled.**

**In order to determine the eligibility of the above-named client to receive the assistance he/she is requesting, we require the following information:**

1. Nature and extent of the illness, disability or injury: \_\_\_\_\_

2. In your opinion is the client able to:	<u>YES</u>	<u>YES</u> (WITH LIMITATIONS)	<u>NO</u>
(a) work at a regular job/employment? How many hours per week? _____	_____	_____	_____
(b) seek work/do job searches?	_____	_____	_____
(c) attend school or classes?	_____	_____	_____
(d) do city workfare?	_____	_____	_____

IF **YES WITH LIMITATIONS**, please state limitations, i.e. light duty, limited hours/days, restrictions on lifting, movement, standing, etc.

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

3. If disabled, length of time he/she will be unable to work or perform items under #2 above: \_\_\_\_\_

If unknown at this time, give date of next evaluation: \_\_\_\_\_

4. If disabled, in your opinion, would this client benefit from the services of the Dept. of Vocational Rehabilitation for retraining or education?

\_\_\_\_\_

5. In your opinion, is this client so disabled that he/she should apply for disability benefits? \_\_\_\_\_

6. Does this illness or condition require medication? \_\_\_\_\_

If so, please specify: \_\_\_\_\_

7. If client is not considered permanently disabled, what can this client do to help themselves become work-ready?

\_\_\_\_\_

8. Date you last evaluated this patient for this disability \_\_\_\_\_

9. Additional information/comments, if any: \_\_\_\_\_

\_\_\_\_\_

Doctor's Name (please print): \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Dated: \_\_\_\_\_

Agency: \_\_\_\_\_

**Any information you provide is confidential by Maine State Statute. We thank you for your cooperation. The information may be returned via the client or faxed to 1-877-722-3057 or mailed to: Westbrook Community Center, 426 Bridge St., Westbrook, ME 04092 Attn: General Assistance**