Annette M. Johnson
Pike Township Trustee
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Indianapolis, IN 46254

Ph# (317) 291-5801
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MEDICAL VERIFICATION

Physician: ______________________ Physician Address: ______________________

Date: ______________________ Physician Phone Number: ______________________

The below named person has applied for assistance from our office. In order for us to grant said assistance, we must verify his/her present medical status, as the applicant has stated that his/her situation is related to his/her medical condition.

Thank you for your assistance in this matter.

Doctor, please release any and all information requested below concerning my mental and physical condition to the Pike Township Trustee Office for the purpose if verifying my need for Emergency Assistance.

Case #: ______________________

______________________ Clients Name (printed)

______________________ Clients Signature

______________________ Date of Birth

______________________ SS #

The above named patient:
- ________ is presently under my care.
- ________ was under my care, but was released ______________
- ________ was seen by me on a consultation basis
- ________ is not a patient
- ________ other, ______________________

Diagnosis: ____

____

Is patient considered to be disabled? ________ Yes ________ No

Is disability ________ Partial ________ Total
________ Temporary ________ Permanent

If partial, what type of work is patient prohibited from doing? ______________________

____

If temporary, what is the anticipated date of release to return to work? ______________________

____

Physicians Signature ______________________ Date: ______________________

CONSENT TO THE DISCLOSURE OF INFORMATION TO THE TOWNSHIP TRUSTEE

I, ______________________________, Case Number ________________, residing at __________________
____, Indiana, consent to the disclosure of the following information to ______________________________, the investigator of township assistance for ____________________________ Township ______________________ County, Indiana:

Information that will verify my:

1. Countable income.
2. Countable assets.
3. Wasted resources.
4. Relatives capable of providing assistance.
5. Past or present employment.
6. Pending claims or causes of action.
7. A medical condition if relevant to work or workfare requirements.
8. Any other information required by law.

This information may be used only in connection with:

(1) My township assistance application from PIKE Township MARION County, IN.

(2) My application for public assistance from the Division of Family and Children county offices and the Office of Medicaid Policy and Planning.

(3) Others (if any).

Signature of Applicant	Signature of Other Adult	Signature of Other Adult
Date Signed	Date Signed	Date Signed

This consent form expires 180 days after the date of signing.

ACKNOWLEDGMENT AND PLEDGE OF CONFIDENTIALITY BY THE TOWNSHIP

The undersigned township trustee or employee acknowledges that he/she may, in the course of employment, have access to certain personal information and that such information is to be treated as confidential, and is to be released and exchanged only with agencies related to the undersigned employment by the township in reviewing and investigating this application or as otherwise provided by law.

Trustee or Employee	Date Signed