PIKE TOWNSHIP GOVERNMENT
TRUSTEE
ANNETTE M. JOHNSON
5665 Lafayette Road, Suite C, Indianapolis, IN 46254
(317)291-5801 Office

MEDICAL STATEMENT

Client name: ___________________________ **Case number:** ____________________

Address: ____

Last four (4) of Social Security number: ______________________________________

The client listed above has applied for Township Emergency Assistance with the PIKE Township Trustee's office. Eligibility standards for assistance require all able-bodied persons to be working or seeking employment. State law gives Trustee's the ability to investigate the situation of persons requesting Township Assistance. The above named client has told our office of an inability to work because of a physical, mental or emotional problem. Please help us verify the information given to us by completing the
form below.

Please fax (317) 388-7385 back or email bsmith@pikefire.com and/or abarragan@pikefire.com to help facilitate the request for assistance from our office. Thank you.

Name of examining physician: ____

Name of Office, Hospital or Clinic: ____________________ **Date of last exam:** ___________

Physician address and Phone Number:

____

PHYSICAN'S SIGNATURE: ____

In regards to the ability to work, as outlined above, I have examined the client and have given the following diagnosis:

The client is; check all that apply.

_______ABLE TO WORK _______UNABLE TO WORK

_______ ABLE TO WORK WITH RESTRICTIONS (as indicated);

____

POSSIBLE RELEASE DATE FOR RESTRICTIONS: ____________

________ FULLY DISABLED DATE OF DISABILITY: ________

DISCLOSURE STATEMENT

I give permission for all of the above information to be released to Pike Township Trustee's Office for the purposes of assessing my application for assistance. I understand that the information that they gather is confidential and will be used only for the purposes of investigating my application for assistance, and will not be re-disclosed to any other entity. Please cooperate fully with the Trustee's Office to help expedite this process. This authorization is valid for a period of 180 days from the date below. I understand I may revoke this authorization by notifying the parties in writing, but that revoking authorization will have impact upon actions already taken in compliance with this form. I understand that if I refuse to sign this authorization, my request for assistance might be affected:

Client's Signature: ____________________________________ **Date:** ______________________