DSS Mailing Address:
________________________________
________________________________

Case Number:____________________
Worker:_________________________
Date Notice Sent:________________

DSS Street Address:
________________________________
________________________________

Client Name:____________________
Address: _______________________

**North Carolina Food and Nutrition Services**
**Department of Social Services (DSS) Medical Report**

Please complete this form for the above patient/client. The information you provide will be used by the county Department of Social Services (DSS) to assist in determining eligibility for the Food and Nutrition Services (FNS) (known as Food Stamps) program. The purpose of this request is to provide verification of their medical condition and/or participation in your program.

You or the patient/client should return this form to DSS, **due date** ______/________/__________.

**Patient/client authorization**
I hereby authorize any physician, hospital, or clinic who has treated/ treating, or examined me to give DSS information about my present or past condition of health.
**Signature** ________________________________ **Date** ______/________/__________

Please answer one or more of the following questions in the box below. Please sign and date this form including your profession or position in the agency.**

1. Is the patient/client pregnant? ___ Yes ___No ___Unknown If yes, due date ______/_______/_______
2. Is the patient/client a participant in a drug or alcohol treatment or rehabilitation program?
   ___ Yes ___No If yes, duration of program ___________________
3. Please select all the medical conditions that may apply to limiting their ability to work 20 hours per week or more. ___ mental and/or physical condition ___ alcohol, and or/ drug dependence?
4. Please indicate below how long the medical condition will limit their ability to engage in work.
   ___temporary ___permanent ___ less than 30 days ___more than 30 days
   ___ more than 6 months ___ more than 12 months/or indefinite ___ Other (specify)___________

___________________________ Name (please print)
___________________________ **Title/Profession****
______/______/______ **Date Form Signed**

___________________________ Signature
___________________________ **Address**
___________________________ **Phone**

** This form may be signed by **any** medical personnel, including physician, physician's assistant, nurse, nurse practitioner, a designated representative at a physician's office, or any other appropriate medical personnel. For purposes of verifying an individual's participation in a rehab program (question #2), any representative of the organization operating the program may sign.