South Carolina Department of Social Services

MEDICAL RELEASE/PHYSICIAN'S STATEMENT

Section I – To Be Completed by Staff

Name of Patient:	Date of Birth:	Last 4 Digits of Patient's Social Security Number:
Case Name:	Case No.:	County:
DSS Employee Name:	Telephone No.:	Fax No.:
DSS Office Mailing Address:		

Section II – To Be Completed by Physician

The patient named above has applied for benefits with our agency. Federal and state regulations require that persons receiving benefits work or participate in activities to prepare them for work, when possible. This patient claims a disability. When individuals claim a disability, we must determine their functional level to identify appropriate activities. Please complete this form, after completion, you may give it to the patient or mail it to DSS at the address listed in Section I.

Part A – Personal Disability

What is the patient's prognosis?

- ☐ The disability is permanent.
- ☐ The disability is not permanent but is expected to last **more** than 90 days. Length of disability _____
- ☐ The disability is not permanent but is expected to last **less** than 90 days. Length ofdisability _____

To what extent is the individual able to work, or participate in activities to prepare for work? Please indicate **one** of the following:

- ☐ The individual is able to work, or participate in activities to prepare for work, **without restrictions:**
  - ☐ Full-time (40 hours/week)
  - ☐ Part-time at _____ hours/week
- ☐ The individual is able to work, or participate in activities to prepare for work, **with restrictions: (Please complete Parts B and C)**
  - ☐ Full-time (40 hours/week)
  - ☐ Part-time at _____ hours/week
- ☐ The individual is pregnant. ☐ Yes ☐ No If yes, when is EDC? _____
  If the individual is pregnant, are there medical limitations or disabilities which may prevent the patient from working (full-time or part-time) or attending school or training? ☐ Yes ☐ No
- ☐ The individual is unable to work, or participate in activities to prepare for work: **(Please complete Part C)**

Part B – Activity Restrictions

What can this individual do now? Check the appropriate boxes that are applicable during a workday:

Maximum hours per workday:	**2**	**4**	**6**	**8**	**Other**
Sitting	☐	☐	☐	☐	_____
Standing	☐	☐	☐	☐	_____
Walking	☐	☐	☐	☐	_____
Climbing Stairs/ladders	☐	☐	☐	☐	_____
Kneeling/Squatting	☐	☐	☐	☐	_____
Bending/Stooping	☐	☐	☐	☐	_____
Pushing/Pulling	☐	☐	☐	☐	_____
Keyboarding	☐	☐	☐	☐	_____
Lifting/Carrying	☐	☐	☐	☐	_____
Other (please describe)	☐	☐	☐	☐	_____

The individual may not lift/carry objects more than _____ lbs. for more than _____ hours per day.

Any other remarks, recommendations or restrictions? _____

Part C – Diagnosis

Primary disabling diagnosis:	Secondary disabling diagnosis:
Comments:	
Name of Physician: (Please type or print)	Physician's Signature: Date:
Office Address: (Street or P.O. Box, City, State, ZIP)	Telephone Number: (Include Area Code)

Section III – To Be Completed by Client

Patient's Name: _____

DSS is requesting verification of the medical condition that limits your participation in the Supplemental Nutrition Assistance Program (SNAP) work requirements and/or Temporary Assistance for Needy Families (TANF) work program. When you sign this authorization, you are giving DSS permission to contact your doctors, medical facilities, or other health care providers to request copies of your health information as indicated below. You do not have to sign this form to be eligible for SNAP/TANF. However, you must sign this form if you want to be eligible for an exemption from the SNAP work requirements and/or TANF work program.

I authorize _____
Doctor, Medical Facilities, or other Health Care Providers

to complete DSS Form 1247, Medical Release/Physician's Statement, and release the information to DSS for purposes of verifying the medical condition that affects my participation in the SNAP/TANF programs.

Applicant/Receipient or Personal Representative's Signature: _____

Date: _____

If you are signing for the applicant/recipient, please describe your authority to act on behalf of the applicant/recipient:

NOTE: If the person requesting the release of case information cannot sign his/her name, two witnesses to his/her mark (X) must sign below:

Witness _____ **Date** _____

Witness _____ **Date** _____

NOTICE TO CLIENT

DSS, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties, it may no longer be protected by privacy regulations. You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.

PURPOSE AND INSTRUCTIONS FOR THE DSS FORM 1247

Purpose

The DSS Form 1247 is used to determine the disability, and the length of disability of a TANF individual who claims to be disabled. This form is used to verify if a TANF individual is a Challenging Adults through Rehabilitation, Education and Services (CARES) client. This form is also used to verify if a SNAP individual is medically certified as physically or mentally unfit for employment in order to meet an exception to the Able Bodied Adults Without Dependents (ABAWD) work requirement, or an exemption from the SNAP work requirements.

Instructions

Section I of this form should be completed by the DSS employee, providing the identifying information of the Applicant/Recipient (A/R).

Section II should be completed by a physician or qualified medical professional. When the form is received by DSS, it should be scanned into SCOSA.

Section III of this form should be completed by the A/R, authorizing the physician or qualified medical professional to complete the form and release the information to DSS.

NOTE: Section III should be completed by the A/R before Section II is completed by a physician or qualified medical professional.