INFORMED CONSENT FOR HEALTH QUESTIONNAIRE

We ask the following questions about your health to find out if you:

(1) need help getting and keeping your benefits,
(2) are not able to work, and
(3) may qualify for disability benefits.

We keep all information about your health confidential. We use it to help you with the General Assistance program requirements.

_____ Please check here if you need help in understanding or filling out this form.

<u>You do not have to answer these questions.</u> However, if you do not answer the questions, we will assume that you do not need help in applying for benefits and can work and take part in employment services. If you can work and do not want to answer these questions, a doctor will need to fill out a form stating that you cannot work.

Please place your initials next to one of the following:

_____ I will answer this questionnaire. I understand my medical information is confidential and used only to help me.

_____ I choose not to answer this questionnaire. I understand that not answering may mean that I will have to work and take part in employment services.

_____ I cannot work. I choose not to answer the questionnaire. I will get my doctor to send a statement that I cannot work.

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Client's Signature Date

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***County Use Only:**

By: __________

Social Worker Signature Date

Form #90-151 (05-27-08)