To: Nikki Haley

My name is Angela Dorsey
I have been fight with
Rheumatoid Arthits. Since Jan 3, 2013
I am perment disabled, I apply
for Disability on Aug 27-2013
threw Social Security. I have
been fight with this battle.
I have a lawyer to repeat
my case. I haven't worked in
2 years. Because I can not
worked any more due to my
illness. I have 2 childrun and
it is hard to provide for them.
I don't have any money come in.
I have worked all my life
as a single mom. Until I
got sick, I have been fight
with Social Security. I have
gave my lawyer so much infomation
from my doctor about my illness
and medical records. I just wanted
to no. if you could help me

in any kind way. I Don't no what else to do. this was my last choice

thanks
Angela Dang

South Carolina Department of Social Services

MEDICAL RELEASE/PHYSICIAN'S STATEMENT

Section I – To Be Completed by Staff

Name of Patient: Angela Dorsey	Date of Birth: Jan 24, 1973	Social Security Number: XXX-XX-247-25-3873
Case Name:	Case No.:	County: Select County ...
Casemanager's Name:	Telephone No.:	Fax No.:
DSS Office Address/Mail:		

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 functioning 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 in Section I.

Part A – Personal Disability

What is the patient's prognosis?

a. ☒ The disability is permanent.
b. ☐ The disability is not permanent but is expected to last **more** than 90 days. Length of disability _____.
c. ☐ The disability is not permanent but is expected to last **less** than 90 days. Length of disability _____.

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:**
a. ☐ Full time (40 hours/week)
b. ☐ 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)**
a. ☐ Full time (40 hours/week)
b. ☐ 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	☐	☐	☐	☐	30 min - 1 hr, but gets stiff
Standing	☐	☐	☐	☐	"
Walking	☐	☐	☐	☐	"
Climbing Stairs/ladders	☐	☐	☐	☐	unable to climb stairs
Kneeling/Squatting	☐	☐	☐	☐	minimal
Bending/Stooping	☐	☐	☐	☐	minimal
Pushing/Pulling	☐	☐	☐	☐	minimal
Keyboarding	☐	☐	☐	☐	minimal
Lifting/Carrying	☐	☐	☐	☐	minimal
Other (please describe)	☐	☐	☐	☐	

The individual may not lift/carry objects more than 5 lbs. for more than <1 hours per day.

Any other remarks, recommendations or restrictions? would also refer to functional capacity exam by physical therapist

DSS Form 1247 (DEC 08) Edition of MAY 08 is obsolete.

Section II, Continued – To Be Completed by Physician

Part C – Diagnosis

Primary disabling diagnosis:	Secondary disabling diagnosis:
Rheumatoid Arthritis	polyarthralgia

Comments:

Name of Physician: (Please type or print)	Signature – Physician:	Date:
Amanda Haltiwanger, FNP	AH FNP	09/08/15
Office Address: (Street or P.O. Box, City, State, ZIP)	**Telephone Number:** (Include Area Code)	
100 N. Wheeler St Prosperity SC 29127	(803) 364-4857	

Section III – To Be Completed by Client

Patient's Name: [illegible]

SCDSS is requesting verification of the medical condition that limits your participation in the Family Independence (FI) Program. When you sign this authorization, you are giving SCDSS 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 TANF. However, you must sign this form if you want to be eligible for an exemption from the FI program.

I authorize/ Lovelace Family Medicine

Doctor, Medical Facilities, or other Health Care Providers

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

The authorization expires on: _____

X [signature] _____ Sept 8- 2015

Client or Personal Representative's Signature **Date**

If you are signing for the client, please describe your authority to act for the client:

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

SCDSS, 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.