State of Hawaii
DEPARTMENT OF HUMAN SERVICES
Social Services Division
Adult & Community Care Services Branch

PLEASE MAIL COMPLETED REPORT TO:

MEDICAL STATEMENT

Consent to Release Information:

PRINT Last Name	First Name	Initial	/ / Birth date

☐ M ☐ F

Address	City	Zip Code

I hereby authorize the evaluating physician, physician assistant, advanced practice registered nurse, or medical facility to release to the Department of Human Services and its designees any information related to my past and present medical care, including substance abuse history and any information related to my HIV/AIDS status. I understand this information shall be used for the sole and limited purpose of determining eligibility for services provided by the Adult and Community Care Services Branch.

Signature of Patient or Legal Guardian of Patient _____ Date

Diagnosis: _____

Medications: (specify) _____

Special Diet: (specify) _____

Medical/Assistive Equipment: (specify) _____

Other Comments: _____

Estimate Date of Onset of Disability: _____ / _____ / _____
Month Date Year

Indicate Date Disability Will End, if known: _____ / _____ / _____
Month Date Year

Probable Duration of Disability: ☐ Temporary: _____ months

☐ More than one year

☐ Permanent

After each function listed below, indicate the individual's capacity by marking an "X" in the appropriate column. Note: "full" capacity means no significant impairment of function. As necessary, provide additional description in space provided under "Other Comments" on page 1.

Functions	CAPACITY			**Functions**	CAPACITY		
	Full	**Partial**	**None**		**Full**	**Partial**	**None**
Standing				Pushing			
Sitting				Pulling			
Kneeling				Upper Limb Mobility: Left Arm			
Bending from waist				Left Hand			
Walking				Right Arm			
Climbing: Legs Only				Right Hand			
Light Lifting: Under 15 lbs.				Reaching Above Shoulder			
Moderate Lifting: 15-44 lbs.				Speech Articulation			
Heavy Lifting: 45 lbs. & over				Operation of Motor Vehicle			

PRINT: Name of Physician, Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)

Signature of Physician, PA, or APRN

Date

Address

City

Zip Code

Telephone Number