South Carolina Department of Social Services

MEDICAL RELEASE/PHYSICIAN'S STATEMENT: REQUIRED IN-HOME

Section I – To Be Completed by DSS Staff

Name of Patient:	Date of Birth:	Caregiver's Name:
Address:		Case No.:
Office Address:		DSS Employee's Name: Telephone No.: Fax No.:

Section II – To Be Completed by Physician

The person caring for 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. This person claims they are needed in the home to provide care for this disabled family member. Please complete Parts A and B below. After you complete the form, you may give it to the patient or caregiver; or mail or fax it to DSS address listed in Section I.

Part A – Caring For A Disabled Family Member

To what extent is the caregiver needed in the home to care for this patient? Please check **one** of the following:

The patient's disability:

- ☐ Is permanent.
- ☐ Is not permanent and is expected to last more than 6 months.
- ☐ Is not permanent and is expected to last 6 months or less.

The caregiver is needed in the home:

- ☐ Full-time (24 hours) ☐ 16-23 hours
- ☐ 10-15 hours ☐ Less than 5 hours

Part B – Diagnosis

Primary Disabling Diagnosis	Secondary Disabling Diagnosis

Comments: ______________________________

Name of Physician: (Please type or print)

Physician's Signature:______________________________Date: ______________________

Physician's Address: (Street or P.O. Box, City, State, Zip)	Telephone No.: (Include Area Code)

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Section III – To Be Completed by Patient

Patient's Name: ________________________________

The applicant/caregiver is requesting an exemption from the work requirements in the Supplemental Nutrition Assistance Program (SNAP) and/or an exemption from participating in the Temporary Assistance for Needy Families (TANF) work program because he/she is needed in the home due to your disabling illness or injury. When you sign this authorization, you are giving the South Carolina Department of Social Services (DSS) permission to contact your doctors, medical facilities or other Health Care Providers to request copies of your health information as indicated below. You must sign this form if you want the individual to be eligible for an exemption from the SNAP work requirements or an exemption from the TANF work program.

I authorize ____

Doctor, Medical Facilities or Other Health Care Providers

to complete DSS Form 1247A, Medical Release/Physician's Statement, and release the information to my caregiver (listed) or DSS for purposes of verifying that the individual is needed in the home due to my disabling illness or injury, and therefore, cannot participate fully in the SNAP work requirements or TANF work program.

____________________________________ ____________________________________

Patient or Personal Representative's Signature Date

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

____

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 PATIENT

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.

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INSTRUCTIONS FOR DSS FORM 1247A

Purpose:

The DSS 1247A is used to verify when a TANF applicant/recipient (A/R) is required in the home to provide care for a disabled family member living in the home, or when the SNAP A/R is responsible for the care of an incapacitated person.

Instructions:

Section I of this form should be completed by the DSS employee, providing the identifying information of the A/R and DSS employee who is requesting the verification.

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 patient, 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 patient before Section II is completed by a physician or qualified medical professional.