Wyoming LIEAP
Low Income Energy Assistance Program

STATEMENT OF INCAPACITY

The use or disclosure of information will be limited to purposes directly connected with the administration of programs of the Department of Family Services (DFS). I hereby give permission for any person having information relating to my physical/mental/employability status to give such information to DFS.

Name of Patient (Printed) _____Last 4 digits of SSN:_____

Address of Patient_____

Signature of Patient _____ Date: _____

The person named above has applied for or is receiving assistance from DFS. Information required to determine eligibility is listed below, select any that are applicable to the patient:

- ☐ Unable to work at this time
- ☐ Able to work with limitations/restrictions
- ☐ Able to work in any capacity

Remarks by physician:

_____

_____

_____

_____
Printed Name of Physician or Psychologist

_____ _____
Licensed Physician or Psychologist Signature Date

_____ _____
Address City, State, Zip

_____ _____ _____
Telephone Fax E-mail Address (optional)

LIEAP ID: {hhid}

Revised 07/24/2018