***Department of* Human Services**
Monroe County, New York

Adam J. Bello
County Executive

Thalia Wright
Commissioner

VERIFICATION OF PREGNANCY STATEMENT

PLEASE RETURN TO:

DATE: PHONE: FAX:

WORKER: TEAM
ADDRESS:

CASENAME: CASE NO.:BA0
ADDRESS:

PATIENT'S NAME:

Dear Doctor:

Temporary Assistance clients are entitled to an additional allowance during pregnancy. Regulations require a physician's statement to verify the pregnancy. It is also necessary that we determine if there are factors related to the pregnancy that curtail the patient's ability to be employed, participate in a training program, or care for her family.

This Agency would appreciate your assistance by providing the following information:

1 The above patient is pregnant. Her expected date of delivery is_____.

2 Limitations:

a. CURRENT: _____

_____

b. FUTURE: _____

_____

PROJECTED ONSET: _____

c. FOLLOWING DELIVERY: _____

_____

EXPECTED DURATION: _____

Doctor's Signature_____Date_____

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