ADULT NEED FOR CARE MEDICAL DOCUMENTATION

CONFIDENTIAL

Name of Person Needing Care:	Please return completed form to: Name:
Age of Person Needing Care:	Office:
Case Name:	Phone:
Case Number:	Fax: Email
DCF is trying to determine if the presence	
at home because	has a medically determined condition
that does not permit self-care. A release of	information follows below. Please complete and
return this form by . We a	ppreciate and thank you for your assistance.
DCF Staff	Date
RELEASE (OF INFORMATION
	hereby authorize
(Name of Customer)	(Name of Provider)
to provide the Department for Children a	and Families with information regarding my physical
and/or mental conditions as requested on the	nis letter. I release the above-named provider from any
and all liability in reference to the release	of the medical information provided in this release. I
understand that this information will be use	ed only in the administration of DCF programs.
Signature of Customer, Guardian, or Conse	ervator Date

Case Name:	Case Number:
Person Needing Care:	
SECTION ONE	
1. Medical/Mental Diagnosis/Condition	of Person Needing Care:
2. Date of Onset:	
3. Anticipated Duration of the Diagnosis	s/Condition:
Medication	rolled with the following? Please mark all that apply. Surgery Treatment ry time after surgery or treatment, if applicable:
SECTION TWO 5. Does the medically determined condit Yes No If yes, indicate what kind of care is new	reded:
Who is qualified to provide this care? Spouse Other Family Member Home Health Aide Other: Number of hours per day required out 1-6 6-12 12-24	
SECTION THREE	
Medical Provider's Signature	Date
Medical Provider's Printed Name	& Title Phone Number