CHILD NEED FOR CARE MEDICAL DOCUMENTATION

CONFIDENTIAL

Please return completed form to:

Name: ____________________

Office: ____________________

____

____

Phone: ____________________

Fax: ____________________

Email ____________________

Name of Person Needing Care: ____________________

Age of Person Needing Care: ____________________

Case Name: ____________________

Case Number: ____________________

DCF is trying to determine if the presence of ____________________ is required 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 appreciate and thank you for your assistance.

Sincerely,

____________________ ____________________
DCF Staff Date

RELEASE OF INFORMATION

I, ____________________ (Name of Customer), hereby authorize ____________________ (Name of Provider), to provide the Department for Children and Families with information regarding my child's physical and/or mental conditions as requested on this 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 used only in the administration of DCF programs.

____________________ ____________________
Signature of Customer, Guardian, or Conservator Date

CONFIDENTIAL

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/Condition: ______________________

4. Can this Diagnosis/Condition be controlled with the following? Please mark all that apply.

_____ Medication _____ Surgery _____ Treatment

Please indicate the amount of recovery time after surgery or treatment, if applicable:

____

SECTION TWO

5. Does the medically determined condition of the child require more than standard level of care for a child of this age?

Yes ______ **No** ______

If yes, indicate what kind of care is needed:

____

____

Who is qualified to provide this care?

___ Parent
___ School
___ Child Care Provider
___ Other:

______________________ *Number of hours per day required outside of the standard level of care for a child of this age:*

___ 1-6
___ 6-12
___ 12-24

SECTION THREE

______________________ ______________________

Medical Provider's Signature **Date**

______________________ ______________________

Medical Provider's Printed Name & Title **Phone Number**

CONFIDENTIAL