State of Kansas
Department for Children and Families
Economic & Employment Services

ES-4310
10/08

NEED FOR CARE
MEDICAL DOCUMENTATION

Case Name: ______________________________

Case Number: ______________________________

Name of person needing care: ____________________

Age of person needing care: ________

Agency Use Only
Case Manager:
Telephone #:
Fax #:
Return Address:

DCF is trying to determine if ______________________ can provide self care.

A release of information follows below. Please complete and return this form to the case manager at the address listed above by _______________ .

We appreciate and thank you for your assistance.

Sincerely,

____ ____________

DCF Human Service Specialist **Date**

RELEASE OF INFORMATION

I, ________________________, hereby authorize ___________________________
(Name of Provider)
to provide the Department for Children and Families with information regarding my physical and/or mental conditions as requested on this letter. I release the above-named provider form 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**

Case Number: ______________________________

Please respond to the following questions:

Diagnosis:

Is this condition (please mark all that apply):

- __ **Permanent?**
- __ **Temporary? Please indicate duration:**
- __ **Controllable with medication? Comment:**
- __ **Correctable with surgery? Comment:**

Can this patient provide self care?

- __ **Yes**
- __ **No (if no, what kind of care is needed?)**

Who is qualified to provide this care?

Number of hours required for care per day:

- __ **1-6**
- __ **6-12**
- __ **12-24**

____ ________

Medical Provider Signature **Date**

____

Please Print Medical Provider's name and credentials (MD, OS etc…)

____

Telephone number