ADULT NEED FOR CARE
MEDICAL DOCUMENTATION

CONFIDENTIAL

Name of Person Needing Care: _____

Age of Person Needing Care: _____

Case Name: _____

Case Number: _____

Please return completed form to:

Name: _____

Office: _____

_____

_____

Phone: _____

Fax: _____

Email _____

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, _____, hereby authorize _____,
(Name of Customer) (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 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

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 this person prevent him/her from providing self-care?

Yes _____ No _____

If yes, indicate what kind of care is needed:

_____

_____

Who is qualified to provide this care?

___ Spouse

___ Other Family Member

___ Home Health Aide

___ Other: _____

Number of hours per day required outside of the standard level of care:

___ 1-6

___ 6-12

___ 12-24

SECTION THREE

_____ _____

Medical Provider's Signature **Date**

_____ _____

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