Clear

STATEMENT OF THE NEED FOR CARE

Caregiver's Name(s): _____

_____

Case Number: _____

Part A: Caregiver's Statement (Caregiver Completes)

Relationship to the Disabled Individual:_____

This certifies that I provide care to (*name*) _____.

I began providing personal care for this disabled individual on _____.
(Date)

Please answer the questions below regarding the disabled individual.

Does the disabled individual reside in your home?..... ☐ Yes ☐ No

Is your physical presence in the home required in order to provide personal care, supervision, or to arrange for services for the disabled individual?..... ☐ Yes ☐ No

Do you have alternative care available for the disabled individual?..... ☐ Yes ☐ No

_____ _____
Print Name *Date*

Part B: Physician's Statement (Physician Completes)

This certifies that *(name)* _____, whose primary diagnosis is (*use ICD-10-CM code*) _____ is ☐ temporarily or ☐ permanently disabled to the extent that personal care is required.

The need for care began on or about _____ and may last through _____.
(Date) *(Date)*

State License #:_____ State License Issued:_____

_____ _____ _____
Signature *Date* *Phone Number*

_____ _____
Print Name *Address, City, State, and Zip Code*

Please return the completed and signed form to the local Department of Children and Families office at:

Eligibility Specialist:_____ Date:_____