STATEMENT OF REQUIRED CARETAKER SERVICES

Case Name:   Individual Name: 

To the Health Care Professional:

is receiving assistance from the Department for Community Based Services (DCBS). They have [He/she has] reported the need to care for a family member who lives in the home and is mentally or physically incapable of self-care and no alternative care arrangements are available. Your assistance is needed to determine if the caretaker services provided for are required. Attached is an Informed Consent and Release of Information and records form signed by . Thank you.

How many days per week is _____________________ needed to provide the care? _____________________

How long will care be needed? _________________________________________________________________

[Can this care be provided by another source such as a home health care worker, Hospice, or a nurse? □ Yes □ No]

_________________________________________  __________________________________________
Printed Name of Health Care Professional  Telephone Number

_________________________________________  __________________________________________
Signature of Health Care Professional  Date

If you have questions, please contact DCBS at 1-855-306-8959.

Please return this form by ___________ to: __________________________________________

_________________________________________
Fax: ________________________________