



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: _____