CareerSource PASCO | HERNANDO

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Name Of Physician _____ Date _____

Dear Physician, Case #

I, (patient's name) _____, am requesting that the attached Statement of Need for Care form be completed. ***This form or other medical documentation verifying caretaker status must be completed by a physician licensed under Florida Statute Chapters 458 and/or 459.***

- My family member _____ is taking care of me due my illness, injury and/or disability.
- My family member is currently in a workforce program, which prepares families for self-sufficiency. In order to receive cash assistance, recipients are required to participate in countable work activities. Some cash recipients may receive a temporary medical excuse from some or all program requirements while caring for a disabled family member or other good cause reason.
- My family member, as a part of the workforce program, would like to develop a self-sufficiency plan that considers his or her caretaker role. Because he or she is caring for me, the Statement of Need for Care Form needs to be completed.
- The only representative allowed to request the information on the Statement of Need for Care form is the individual requiring care (if adult over the age of 18), the legal guardian for the individual that is requiring care who is under the age of 18 or the legal representative of the individual requiring care.
- The individual requiring care (patient) or the legal guardian of a child under the age of 18 requiring care is the only person allowed to request the completion of the Statement of Need for Care form. Each time a new form is needed, *a new release will be signed.*
- **I have signed a medical release of information. My family member has also signed the rights and responsibilities portion of the form. Both releases are attached.** *The release includes my rights and responsibilities as stated in the Health Insurance Portability and Accountability Act (HIPAA).*

Thank you for taking the time to complete the Statement of Need for Care form. Please forward the completed form to the following career manager; or if you prefer, please give me the form so that I can deliver it to the career manager:

Name: **Phone Number:**
Address: **Fax Number:**

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Welfare Transition Participant Rights and Responsibilities

Part I. To be Completed by WT Program Participant,

*Social Security Number:

Mr./Ms _____(***the WT participant***) has stated that he or she is caring for a family member full or part-time.

Name of the family member requiring care (patient's name) _____.

The WT participant's relationship to the family member in need of care/patient _____.

The family member in need of care ☐ is a household member or ☐ is not a household member of the WT participant.

I provide care for ☐ 1-10 hours a week, ☐ 11-20 hours a week, ☐ 21-30 hours a week, ☐ 31-40 hours a week.
☐ Other (example, I can participate in the program, but drive my family member to appointments three (3) times a week, etc) _____

_____.

☐ I certify that there is no one else to care for or assist my disabled family member.

Rights

- I have agreed to have the statement completed. If I change my mind and want to revoke the process of having the statement completed, **I must submit a request in writing to both the physician and the WT program provider. I must provide the written request to both parties by the close of business (5 p.m.) on _____/_____/_____.**
- I have the right to withdraw my role as a caretaker. I must inform my career manager immediately when the circumstances change so that I can update my self-sufficiency plan.

Responsibilities

- **I understand that the form must be completed by the physician and turned into my career manager by (date)_____ at (time)_____.**
- If I refuse to sign the form or fail to supply the required information by the above date, I **must** participate in the WT program's countable activities for the minimum required hours.
- I must complete the activities as indicated on my self-sufficiency plan. **Refusal to sign the form and failure to participate in countable activities may result in the reduction or cancellation my cash assistance and food stamp benefits.**
- If the form is revoked, I am still responsible for completing the activities I agreed to complete on my self-sufficiency plan.

_____ _____
Signature of WT Participant Date of Signature

_____ _____ _____
Signature of Guardian if under 18 years of age Printed Name of Guardian Date

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Physician Statement

Part III. To be completed by a physician licensed under Florida Statute Chapters 458 and/459.

1. This certifies that (***patient's name***) _____ has a primary diagnosis of _____

_____.

2. The condition is ☐ permanent or ☐ temporary?

3. This individual, (***patient's name***) _____, is required to have ☐ part-time care or ☐ full-time care.

a) Part-time care:

The individual must be cared for during the following hours _____.

☐ The individual needs assistance getting to medical appointments or is requiring assistance during specific planned treatment. Comments: _____

_____

_____.

☐ The part-time care began on or about _____ and may last through _____. Comments: _____

_____.

b) Full-time care:

The need for full-time care began on or about _____ and may last through _____. Comments: _____

_____ _____ (___) _____

Name of Licensed Physician **Signature of Physician** **Telephone Number**

_____

Mailing Address (include city and zip code)

_____ _____

Physician's License Number **Date Form Completed**

PRIVACY ACT STATEMENT

*I understand that I am required by law to provide my social security number(s) or proof that I have applied for a social security number if I do not currently have one to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137). If I do not have a social security number and have not applied for a social security number, I can request help with filing an application. The social security number is used to administer the program, including determining eligibility, attributing the receipt of services, correspondence and participation to my case, as well as for reporting purposes.

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