State of California – Health and Human Services Agency

California Department of Social Services

CARE OF A HOUSEHOLD MEMBER VERIFICATION

COUNTY OF

Notice Date : _____
Case Name : _____
Case Number : _____
Worker Name : _____
Worker Number : _____
Telephone Number: _____
Address : _____
_____
_____

(Addressee)

Care of a Household Member Verification

Patient/Client Information and Authorization to Release Information			
Name of Patient/Client (Last, First, Middle):	Sex:	Date of Birth:	Last Four Digits of Social Security Number:

I authorize _____ of _____
Name of Provider — Clinic or Medical Group

to release information to the county welfare department from my records on the conditions checked below:

☐ Physical Condition ☐ Mental Condition ☐ Other (Describe): _____

I know this authorization may be used by the county welfare department for up to one year to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the welfare department. This information is needed by the county welfare department to decide the type of work or training activities that I can take part (participate) in, and the CalWORKs services that I need. This information will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had this form read to me) after it was completed. I know I can get a copy of this form if I ask for it.

Statement of Provider

Please verify the patient's illness or incapacity.

Is the patient ill or incapacitated? ☐ Yes ☐ No

Onset Date of Condition: _____.

The condition is: ☐ Chronic ☐ Acute and expected to last until: _____.

Does the patient's condition require someone to be in the home to care for them and help with activities of daily living? ☐ Yes ☐ No

Licensed or Certified Health Care Provider (or Designee)			
Signature of Provider or Provider's Authorized Representative:		Date Signed:	
Print Name and Title/Specialty:		Phone Number:	
Street Address (Mailing Address if Different):	City:	State:	Zip Code: