OFS 90L
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02/11 Issue Obsolete

Louisiana Department of Children and Family Services

Request for Verification of the Need for Full Time Care

Date: _____ DCFS Case Name: _____

Patient Name: _____ DCFS Case SSN: _____

Patient SSN: _____ Patient DOB: _____

Dear Dr.: _____:

Persons receiving assistance through the DCFS are subject to a time-limited benefit program and are required to participate in a work/training/education program unless the agency determines there is a reason not to impose these requirements.

The above client states he is needed in the home to provide full-time care for your patient. In order to assist us in making a determination on our client's case, please answer the following questions.

Thank you for your assistance.

_____
DCFS Representative

Does your patient require another person to be in the home full-time due to a disability or illness?
_____ Yes _____ No

If yes, is your patient permanently incapacitated according to the definition below? _____ Yes _____ No

"Permanent Incapacity – The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a period of not less than 12 months."

If the patient is not permanently incapacitated as defined above but requires another person to be in the home full-time because of their illness, please give the length of time the caretaker will be required in the home because of the patient's disability:

_____ months _____ weeks

Diagnosis and Prognosis of Patient: _____

_____

_____

_____

_____ _____
Signature of Medical Professional Telephone Number

_____ _____
Print Name Date