**Grays Harbor County**
LEOFF I Disability Board
Request for Long Term Care Medical Report

The Grays Harbor County Disability Board requires this form to be completed by the attending physician when the member is requesting long term care, whether in-home care, assisted living, group home care, or confinement in a nursing home or similar facility or a hospital extended care facility.

Name of Member _____ Phone _____
Current Address _____

Does the member have Long Term Care Insurance? [] yes [] no

Name of Contact (Power of Attorney or Family Member)
_____ Phone (s) _____

Name of Attending Physician _____
Address _____ Phone _____

MEDICAL INFORMATION (to be completed by physician)

Dates on which the patient was examined relative to his/her present condition, including the most recent: _____

Please summarize the relevant medical, mental, functional, neurological history of this member as it is known to you.
_____
_____
_____
_____
_____
_____
_____

Please list your findings as to the medical condition of this member, including diagnosis and prognosis.
_____
_____
_____
_____
_____
_____
_____
_____

In your opinion, please mark the service(s) necessary for this member:

[] Nursing Home [] In-Home Health Care [] Group Home Care [] Hospital Extended Facility [] Assisted Living Facility
Other care or comments _____

Is the member able to perform the following Activities of Daily Living (ADLs)?

| | | |
|---|---|---|
| Bathing | [] yes | [] no |
| Dressing | [] yes | [] no |
| Feeding | [] yes | [] no |
| Toileting | [] yes | [] no |
| Transferring | [] yes | [] no |
| Incontinent | [] yes | [] no |
| Cognitive Impairment | [] yes | [] no |
| Other _____ | [] yes | [] no |

Is the member able to dispense his/her medications without help? [] yes [] no

Please list any specific medical or other assistance this patients needs and who would be qualified to perform that assistance. (For example, a M.D., RN, LPN, C.N.A., a family member or other person.)

Need: Who qualified?

_____

_____

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_____

Your opinion regarding the estimated length of time this patient will require the care you are prescribing:

_____

_____

_____

_____

Physician signature _____Date this form was completed_____

*Please return form to:*

*Grays Harbor County L.E.O.F.F. I Disability Board*
*310 W. Spruce, Ste 100, Montesano, WA 98563*
*Voice Mail (360) 249-5496 -- FAX (888) 231-8655*
*Email: dragland@co.grays-harbor.wa.us*