Medical Request for Long Term Care
To be completed by Medical Doctor only. Please type or print clearly.

Mason County Law Enforcement Officer & Firefighter Disability Board
411 North 5th Street, Shelton, WA 98584
360-427-9670 ext. 747

The Mason County LEOFF 1 Disability Board may provide approval of reimbursement for the reasonable expenses incurred by a LEOFF 1 member needing the services of a nursing home, assisted living facility or in-home health care. The level of care must be determined to be medically necessary by a medical doctor.

MEDICAL REQUEST FOR:

☐ Nursing Home Care
☐ Assisted Living Care
☐ In-Home Health Care

Medical Report for: ___________________________________________________________

1. Name, address, phone number & email address of attending physician:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. The following are the dates on which the patient was examined relative to his/her present condition, including the most recent examination:

__________________________________________________________________________
__________________________________________________________________________

3. The following is a summary of the relevant medical, functional, neurological history of this patient, as known to me:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
4. The following are my findings as to the medical condition of this patient, including diagnosis and prognosis:

__________________________________________________________________
__________________________________________________________________

5. Please check one: ☐ Nursing Home Facility ☐ Assisted Living Facility ☐ In-Home Care is necessary due to the diagnosis in item #4: _____ Yes _____ No

6. Is the patient able to perform the following Activities of Daily Living (ADL’s):
   - Bathing _____ Yes _____ No
   - Dressing _____ Yes _____ No
   - Feeding _____ Yes _____ No
   - Toileting _____ Yes _____ No
   - Transferring _____ Yes _____ No
   - Continence _____ Yes _____ No
   - Cognitive Impairment _____ Yes _____ No
   - Other _____ Yes _____ No
   (Describe other, i.e., self-medicate, etc.)
   ___________________________________________________________________
   ___________________________________________________________________

7. The following are my opinions on the specific medical and other assistance this patient needs:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

8. I have also met, or spoken with, the following individuals regarding this patient:

__________________________________________________________________

9. The following is my opinion regarding the estimated length of time this patient will require the above requested care:

__________________________________________________________________
FOR IN-HOME CARE ONLY:

10. The following are my recommendations as to the specific number of hours and days per week the paid services of a caregiver are required for in-home care:

________________________________________________________________

________________________________________________________________

Date of completion of form: ________________________________

Signature: ____________________________________________

Typed or printed name: ________________________________________

Address___________________________________   Phone ______________________

E-mail ____________________________________