WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355

MEDICAL REQUEST FOR HOME HEALTH CARE

This form to be completed by the LEOFF I member's health care provider and mailed directly to member's employer/employer retired from prior to the commencement of any home health care.

Patient: _____ Patient's SSN: _____
Employer/Retired from: _____
Health Care Provider: _____
Health Care Provider Address: _____
Health Care Provider Phone: _____

State the medical necessity and the estimated length of time during which home health care will be required and the type of care required (medical, daily living, and/or other).

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Provide the Board with a description of work to be performed by the home health care provider. This description is to be as detailed as possible.

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_____ _____
Signature of Member's Health Care Provider Date

WCLIB #9