(COUNTY LETTERHEAD)

Date:

PATIENT'S INFORMATION (County Completes This Section)	
PATIENT NAME:	PATIENT DATE OF BIRTH:
CLIENT INDEX NUMBER (CIN):	

Dear Dr. _____

Please complete and return the statement below to the county by _____ regarding your patient listed above so that we can determine his\her eligibility for Medi-Cal. Please use the postage paid pre-addressed envelope. You may also return it by fax or email as indicated below. Your patient has given authorization to release this information to us. Please see attached patient authorization.

County Worker Signature: _____ Date: _____

County Worker Printed Name: _____

Phone Number: _____ Fax Number: _____

County Worker Email: _____

Doctor's Verification for Home and Community Based Services Under Spousal Impoverishment Provisions

DOCTOR'S INFORMATION	
DOCTOR'S PRINTED NAME:	DATE:
TELEPHONE:	EMAIL:
Based on my examination, my patient, _____, will likely require nursing facility level of care for at least 30 consecutive days unless he/she receives in-home care and support services that will permit him/her to reside safely at home. My patient first began needing these services at a nursing facility level of care on _____, and has continued to need these services since that date.	
I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Doctor's Verification is true and correct. DOCTOR'S SIGNATURE:	

(COUNTY LETTERHEAD)

Date:

Patient Authorization

I, _____ authorize doctor _____

to release the medical information on this form to _____ County for the purpose of establishing my eligibility for Medi-Cal.

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits under this program may not be possible if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNED: _____ DATE: _____

If not signed by the patient who is the subject of this disclosure, specify basis for authority to sign:

☐ Parent of Minor ☐ Guardian ☐ Spouse ☐ Authorized Representative

Explain relationship to the patient and why the patient is unable to sign: _____

_____

WITNESS: I know the person signing this form or am satisfied of this person's identity:
(Required for "X", illegible, or foreign character signatures)

Witness signature: _____ Date: _____

Street Address: _____ City/Zip Code: _____

This general and special authorization to disclose information has been developed to comply with the provisions regarding disclosure of medical and other information under: The Health Insurance Portability and Accountability Act, Section 262(a), 42 U.S.C, Section 1320d-1320d-8 (45 CFR Part 164); 42 U.S.C., Section 290dd-2 (42 CFR Part 2); 38 U.S.C., Section 7332; 20 U.S.C., Section 1232g (34 CFR Parts 99 and 300); and state law, including Civil Code, Section 56.10(b), Welfare and Institutions Code, Section 10850 and 14100.2 and Civil Code, Sections 1798-1798.78.