Santa Clara County Social Services Agency

**DOCTOR VERIFICATION**

Mailing Date:

Case Name:

Case Number:

RE: CalWORKs Employment Services Participation for

  *(WTW Client)*

**PATIENT AUTHORIZATION:** This information is needed by the county welfare department to determine my caretaker’s eligibility for exemption from participating in CalWORKs Employment Services.I authorize the release to the Social Services Agency of any medical information which is necessary to assess eligibility for my caretaker, including information related to drug/alcohol abuse or psychiatric conditions. I may revoke this authorization at any time, except for information that has already been given to the welfare department. This authorization is valid for one year from the date it is signed by me. This information will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had this form read to me). I know I can get a completed copy of this form if I ask for it.

Patient’s Signature: ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(If under 18, parent/guardian must sign)*

Relationship to Patient:

**Dear Health Care Provider:**

Please complete the following questions and return as quickly as possible. Your cooperation is greatly appreciated and will help determine eligibility of the patient’s caretaker to participate in the CalWORKs Employment Services Program.

*(Worker Signature/Worker Number) (Telephone Number)*

District Office Address:

 **TO BE COMPLETED BY HEALTH CARE PROVIDER**

|  |  |
| --- | --- |
|  1. | Does , because of his/her medical/psychiatric condition,*(Patient/Client)*require care and supervision in the home? [ ]  Yes **or** [ ]  No**If YES**, is care needed: [ ]  Full-Time **or**  [ ]  Part-Time  |
| 2. | If **Yes,** how long is the care and supervision needed?  *(Specify Dates)* |
| 3. | **If Part-Time** care is needed, what length of time is needed daily?  *(Specify Daily Time Period)* |

Additional Comments: \_

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The patient was last seen by me on A follow-up appointment is scheduled on

 *(Provider’s Name/Title - Please Print) (Hospital/Clinic Name)*

*(Signature of Provider or Authorized Representative) (Telephone Number) (Date)*

Scan CWES: F-7 SCD 1782 - 10/17