Local 2/Hospitality Industry
Child & Elder
Care Plan
209 Golden Gate Avenue, San Francisco, CA 94102 • 415/864-0506
ChildElderPlan@local2benefits.org • www.local2benefits.org

Name of Local 2 member : _____

PLEASE PRINT

Phone Number of Local 2 member: _____

Name and signature of ELDER OR DISABLED relative below is authorization for their physician to provide a medical diagnosis to the Child & Elder Care Plan.

_____ _____

PRINTED Name of Elder or Disabled Relative **SIGNATURE of Elder or Disabled Relative**

PLAN YEAR 2016-2017

ELDER & DISABLED RELATIVE QUALIFICATION

Dear Physician:

The form on the back pertains to a benefit available for Local 2 members who are hotel and restaurant workers in San Francisco. This benefit reimburses costs associated with the caregiving of an elderly or disabled relative of a Local 2 member.

Please complete the form, on the flip side of this letter, within two weeks of receiving it. The information you provide will help us determine whether the elder or disabled relative's physical and/or mental condition fits our criteria for reimbursement.

Please help us keep this information confidential by inserting this form in one of your office envelopes and then sealing the envelope. The Local 2 member can then deliver it to us.

If you have any questions, please call 415.864.8770 x720 or email me at lrush@local2benefits.org.

We appreciate your time and cooperation.

Louise K. Rush

Louise K. Rush
Director

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PLAN YEAR 2016-2017

ELDER & DISABLED RELATIVE QUALIFICATION

DOCTORS - PLEASE COMPLETE and PRINT CLEARLY

Patient Name: _____

Patient Address: _____

Patient Diagnosis: _____

_____

1. **In your opinion, does your patient have a disabling medical condition that requires the services of a caregiver to assist with daily activities such as bathing, dressing, walking, and/or cooking?**

0	1	2	3	4	5
INDEPENDENT	NEEDS SUPERVISION		NEEDS ASSISTANCE		DEPENDENT

2. **In your opinion, does your patient need the services of a caregiver for:**

0	1	3	6	12	18+
	MONTHS				

3. **Your patient has significant need for a caregiver due to one or more of the following conditions:**

___ bed bound _____severe dementia _____restricted physical mobility _____none

Date of patient's last visit: _____

Name of Physician: _____**Lic #:** _____

Signature of Physician: _____**Date:** _____

PHYSICIAN:

Please Attach Business Card