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/disabled relative **SIGNATURE of Elder/Disabled Relative**

PLAN YEAR 2025-2026

DOCTORS FORM

Dear Physician,

The form on the back pertains to a benefit available to 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 Local 2 members.

Please complete the form on the flip side of this page. 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.

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

We appreciate your time and cooperation,

Louise K. Rush

Louise K. Rush
Director

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PLAN YEAR 2025-2026

DOCTORS FORM

THIS PAGE IS TO BE COMPLETED BY THE PHYSICIAN ONLY …… PLEASE PRINT CLEARLY

Patient Name: _____

Patient Address: _____

Patient Phone: _____

Patient Diagnosis: _____

_____

PHYSICIAN: Please Attach Business Card

DOCTORS PLEASE COMPLETE

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:** _____

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