



# 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

### 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](mailto:lrush@local2benefits.org).

We appreciate your time and cooperation,

Louise K. Rush  
Director





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**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+  
M      O      N      T      H      S

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: \_\_\_\_\_

