



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 2019 -2020

ELDER & DISABLED RELATIVE QUALIFICATION

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.

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

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
Director



**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

PLAN YEAR 2019 - 2020

ELDER & DISABLED RELATIVE QUALIFICATION

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

Patient Name: _____

Patient Address: _____

Patient Phone: _____

Patient Diagnosis: _____

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: _____

PHYSICIAN: Please Attach Business Card