Healthcare Provider Statement of Necessary Care for a FANF Household Member

Name: FANF recipient or applicant	**RID # and/or Case # (if known)**

Authorized healthcare provider:	**Please return via mail or fax to:**
Name:	Medical Exemption Unit Bureau of Family Assistance, DHHS 129 Pleasant Street, Brown Building Concord, NH 03301-3857
Address:	
Phone:	**Fax:** (603) 271-4637

You are receiving this form because you are a healthcare provider for:

Household member (patient)

The Financial Assistance to Needy Families (FANF) program requires individuals to participate for a minimum of 20 to 30 hours per week in activities that help prepare them for self-sustaining, unsubsidized employment.

The FANF recipient named at the top of this form reports that your patient is a member of the household who requires the FANF recipient to be at home to provide care, and that this care partially or completely limits the FANF recipient's ability to participate in education, training, and other work-related activities. We need your professional assessment to help us determine if this FANF recipient has the ability to participate in preparatory and work-related activities.

Who qualifies as a household member? A household member must live in the same house as the FANF recipient and be either a relative of the FANF recipient or a member of the FANF assistance group.

Only the following currently licensed healthcare providers are authorized to complete and sign this form: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Alcohol and Drug Counselors (Master LADCs only), Psychologists (board certified), Pastoral Psychotherapists, Independent Clinical Social Workers, Clinical Mental Health Counselors, and Marriage and Family Therapists.

Your patient should provide you with a signed *Authorization for Release of Protected Health Information for FANF Financial Assistance* (BFA Form 752A) providing permission for you to release the information in this form (BFA Form 752HH) to DHHS. Please fax or mail this completed form (BFA Form 752HH) directly to the Medical Exemption Unit using the contact information above.

If you have any questions, please call the Medical Exemption Unit at (603) 271-9511, option 2.

Preparatory and Work-Related Activities

There are many preparatory and work-related activities offered to individuals in the FANF work program. Individuals can participate in activities adapted to meet his or her needs and abilities. Activities include:

- **Barrier resolution**: This may include counseling or other services designed to minimize or resolve a personal issue or other barriers to employment.
- **Education or training:** This may include basic or adult education, ESL, or other education or training programs that promote employability.
- **Work-related activities:** This may include paid or unpaid work, or structured, supervised work activities that provide the individual the opportunity to experience and acquire the general workplace behaviors, attitudes, skills, and knowledge necessary to obtain and retain paid work.

Once completed, this form is valid for up to 6 months.

Necessary Patient Care

(Complete if treating a FANF recipient's household member.)

Only the following currently licensed healthcare providers are authorized to complete and sign this form—**please check the corresponding box to indicate your profession:**

- ☐ Physician
- ☐ Physician Assistant
- ☐ APRN
- ☐ Psychologist (board certified)
- ☐ Clinical Mental Health Counselor
- ☐ Pastoral Psychotherapist
- ☐ Independent Clinical Social Worker
- ☐ Alcohol and Drug Counselor (MLADC only)
- ☐ Marriage and Family Therapist

Your patient lives with a FANF recipient who has indicated an inability to participate in required preparatory and work-related activities due to his or her need to be in the home to care for your patient. To help us determine if the FANF recipient is eligible for this type of exemption, please provide the following information:

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Patient (household member)

______________________________ ______________________________

FANF recipient (needed to care for patient) **Relationship to patient**

How does the patient's condition limit his or her activities? ______________________________

In a 24-hour period, how many hours of care are needed for your patient?		0 to 1	1 to 3	3 to 6	6+
☐	Daily living skills, such as bathing, feeding, dressing				
☐	Administration of medications				
☐	Observing/monitoring behavior/medical conditions				
☐	Other				

Indicate any medical, school, therapy, or other appointments that require a caretaker to accompany your patient:

Number of appointments: ______________ **Frequency:** ______________

1. **Does the patient's condition require someone to be at home to provide/assist with daily care?** ☐ Yes ☐ No
2. **Is the FANF recipient named above the only appropriate household member to provide the necessary care for your patient?** ☐ Yes ☐ No
3. **If the patient is a minor, are there functional limitations that prevent your patient from attending childcare or before- or after-school programs?** ☐ Yes ☐ No

   If yes, explain: ______________________________
4. **Are any accommodations needed for the FANF recipient's participation relating to the patient?** ☐ Yes ☐ No

   If yes, explain: ______________________________
5. **With the above-noted accommodations in place (if any), how many hours per week is the FANF applicant/ recipient available to participate in preparatory or work-related activities?**

   ☐ 31 or more hours ☐ 26 to 30 hours ☐ 21 to 25 hours ☐ 20 hours ☐ 1 to 19 hours ☐ None
6. **How long will your patient need this level of care (in months)?** ______________________________

______________________________ ______________ ______________

Authorized healthcare provider signature **Date** **Phone**

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Authorized healthcare provider printed name (with credentials)

Payment of any separate charge for completing this form is the responsibility of the patient.