STATEMENT PURPOSE

Adult Family Type Care is a plan for 24-hour care in a family setting for 1-4 dependent adults. It is not a medical facility. Only persons who, by reason of age, physical or mental limitation, are in need of assistance with the basic activities of daily living, can be cared for in adult residential care settings.

The information solicited on this medical evaluation will aid in determining the suitability of the individual as an ADULT FAMILY TYPE HOME operator. It will be used by the Local Department of Social Services and the Office of Children and Family Services, which are responsible for supervision and certification of Family Type Homes for Adults.

LDSS-3239 (Rev. 12/2006)

MEDICAL EVALUATION (Operator)

NAME:		
ADDRESS:		
SEX ☐ M ☐ F	DATE OF BIRTH:	EXAMINATION DATE"

SECTION **I: MEDICAL HISTORY**

RECENT SURGERY *(TYPE OF PROCEDURE AND DATE):*	RECENT ACUTE ILLNESS *(TYPE AND DATE):*
CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS:	ACTIVITY RESTRICTIONS:

SECTION **II: EVALUATION**

In your opinion is the individual physically and mentally capable of providing the dependent adults living in the home with adequate care and services.

☐ Yes ☐ No *(Please fully describe.):*

PHYSICIAN'S NAME AND ADDRESS (TYPE OR PRINT):	PHYSICIAN'S SIGNATURE:	DATE:
	X	