SENIOR CARE OUTREACH
RESPECT, CARE, AND CONNECTION

**Senior Care Outreach**
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# PHYSICIAN'S STATEMENT OF NEED

## PATIENT INFORMATION

**Name:** _____ **Date of Birth:** _____

**Address:** _____

**TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL** *The individual named above is applying for a charitable grant for non-medical in-home care services (e.g., meal preparation, laundry, sanitation, and safety supervision). To qualify under Arizona QCO guidelines, we require verification of a chronic illness or physical disability.*

### 1. Primary Diagnosis

Please list the primary physical condition(s) or chronic illness(es) affecting the patient:

_____

_____

### 2. Functional Limitations

Does the patient's condition result in significant difficulty or inability to perform the following independently? (Check all that apply)

- [ ] **Nutritional Maintenance:** Preparing healthy meals or managing specialized diets.
- [ ] **Sanitation/Shelter:** Maintaining a clean and safe living environment (laundry, light cleaning).
- [ ] **Personal Hygiene:** Bathing, grooming, or dressing safely.
- [ ] **Mobility/Safety:** Safe movement within the home or preventing falls.
- [ ] **Medical Access:** Transportation to essential medical appointments or pharmacies.

### 3. Physician's Certification

By signing below, I certify that the patient has a **primary diagnosis of a severe physical condition or chronic illness** that may require ongoing intervention and that the services requested are reasonably necessary to meet their basic needs and ensure their safety at home.

**Physician Name (Print):** _____ **License #:** _____

**Signature:** _____ **Date:** _____

**Office Phone:** _____