



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III
Governor

Bureau for Children and Families
Office of Children and Family Policy
Division of Children and Adult Services
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Martha Yeager Walker
Secretary

ADULT FAMILY CARE/ADULT EMERGENCY SHELTER CARE PROGRAM
Physician's Letter

Applicant's Name: _____ Address: _____

Dear Physician:

The above named individual has applied to become/is currently an Adult Family Care/Adult Emergency Shelter Care provider for the Department of Health and Human Resources. If approved, one to three elderly, blind or disabled adults may be placed in their home. Please complete the following information for the individual named and return it to the following address within ten (10) days. Questions regarding this form may be directed to the Adult Services supervisor at the telephone number indicated below.

West Virginia Department of Health and Human Resources

Telephone #: _____

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|----|---|-----|--------------------------|----|--------------------------|
| 1. | I certify that I have examined the individual named above and that, to the best of my knowledge, he/she is free of communicable diseases'. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. | I certify that he/she is physically and mentally able to care for adults placed in their home by the Department of Health and Human Resources'. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Limitations: (please specify) _____

(Signature)

(Physician's name-please type/print)

(Date completed)