

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-6355**

**MEDICAL REQUEST FOR HOME HEALTH CARE**

This form to be completed by the LEOFF I member's health care provider and mailed directly to member's employer/employer retired from prior to the commencement of any home health care.

Patient: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_  
Employer/Retired from: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Health Care Provider Address: \_\_\_\_\_  
Health Care Provider Phone: \_\_\_\_\_

**State the medical necessity and the estimated length of time during which home health care will be required and the type of care required (medical, daily living, and/or other).**

---

---

---

---

---

---

---

---

---

---

**Provide the Board with a description of work to be performed by the home health care provider. This description is to be as detailed as possible.**

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_  
Signature of Member's Health Care Provider

\_\_\_\_\_  
Date