

# Disability Statement for In-Home Supportive Services



When no other reimbursement source is available the CalVCB may reimburse a victim/claimant for In-Home Supportive Service expenses he/she has paid to a caregiver as a result of a qualifying crime related injury. The victim's physician must submit one of the following documents:

1. A Disability Statement for In-Home Supportive Services; or
2. A letter on the physician's letterhead addressed to the CalVCB that contains the same information in the Disability Statement for In-Home Supportive Services.

Note: Payment for attendant care is limited to a daily maximum of eight hours, not to exceed 40 hours per week and the physician must recertify the need for attendant care in writing at 60-day intervals. If the victim/claimant is permanently disabled, the 60-day recertification by a physician is not necessary.

CalVCB application number

## To be Completed by the Treating Physician

Victim's name

Date of injury *mm/dd/yy*

Was this a crime-related injury?

Yes      No

Diagnosis with codes

Prognosis

The patient has been under my care from \_\_\_\_\_ to \_\_\_\_\_ and seen on a  
weekly      monthly      as-needed basis      or is permanently disabled.

The patient is unable to perform activities of daily living and cannot safely remain in his/her home without assistance:  
Yes      No

The patient requires in-home care from \_\_\_\_\_ to \_\_\_\_\_

The patient requires in-home care \_\_\_\_\_ hours per day, \_\_\_\_\_ days per week.

The patient will require in-home care to assist in the following areas:

Personal care

Meal preparation

Changing bandages and cleaning wounds

Transportation to medical appointments

Housekeeping

Other *Please describe*

Shopping for food

This in-home care may be performed by a family member or other person and does not require professional or licensed medical care.

Yes      No

## Physician Information

Name as shown on license

State license number

Street Address

Telephone number

City

State

Zip

*I certify under penalty of perjury that, based on my examination, this Disability Statement truly describes the patient's disability and the estimated period of disability, if any.*

*I further certify that I am licensed to practice in the state of:*

\_\_\_\_\_  
Physician's signature *Required*

\_\_\_\_\_  
Date signed

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  - b. Protect and defend the rights or property of CalVCB; and,
  - c. Act under exigent circumstances to protect the personal safety of users of CalVCB, or the public.
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11. For additional information regarding privacy, please see CalVCB's Privacy Notice. See <http://victims.ca.gov/privacy.aspx>.
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