Permitted Health Care Resident

FOR INTERNAL USE ONLY
NOT TO BE PRODUCED TO THIRD PARTIES WITHOUT WRITTEN CONSENT OF THE PATIENT IDENTIFIED BELOW OR FOLLOWING PROPER SUBPOENA OF CONSUMER'S PERSONAL RECORDS UNDER CODE OF CIVIL PROCEDURE SECTION 1985.3

DOCTOR'S CONFIDENTIAL CERTIFICATION LETTER

TO: Tri-Palm Unified Owners Association, A Community for Senior Citizens (55 years and older)
32-851 Desert Moon Drive, Thousand Palms, CA 92276
Telephone: (760) 343-5256 Fax: (760) 343-1828

I hereby declare, under penalty of perjury, that the following statements are true and correct, to the best of my knowledge:

1) ____ is my patient, whose address is

________________________________, Thousand Palms, CA 92276;

2) I am a duly licensed physician in the State of California and my medical license number

is #____.

3) Doctor's Name, business address and phone number are as follows:

____

____

____

4) I am aware that my patient has asked to have a full-time, live-in caregiver.

5) I hereby certify that my patient is a person who <u>requires</u> live-in care for necessary daily activities or medical treatment or both.

6) This care requires substantial assistance with (check all that apply):

Necessary daily activities: ❑ Walking; ❑ Help getting in/out of bed; ❑ Dressing
❑ Personal hygiene (bathing/toilet); ❑ Dressing; ❑ Meals preparation/eating;
❑ Cannot drive;

❑ Other ____

Medical treatment: ❑ Oxygen; ❑ Medications; ❑ Medical equipment; ❑ Doctors appointments;

❑ Other ____

Full time (24/7) care required: (check one)

( ) Short Term (1-6 mos) - ( ) Long Term (1-4 yrs) - ( ) Palliative

I understand that this information is solely for the internal use of Tri-Palm Unified Owners Association, that it will be kept confidential and will be provided only to authorized representatives of Tri-Palm Unified Owners Association, who periodically verify and reevaluate eligibility of residents to maintain the Senior Housing status of the community in which my patient resides.

I also understand that, if there is any dispute regarding the above issues, I may be called to testify under oath about these matters, in a deposition in Court or in another proceeding.

I declare, under penalty of perjury under the laws of the State of California that the foregoing statements are true and correct.

Executed at ______________________________, California, on ____________________

Signature: ____
Physician's Signature

(Rev.Apr. 2016)

TPUOA

Tri Palm Unified Owners Association

Permitted Caregivers Registration Form

Property Owner: ______________________________ Date: ___________

Address: ____________________________________ Lot #: ___________

____

Qualified Senior Resident: ____

Owner: Full-time______ Part-time ________ Renter: Full-time __ Part-time____

♦♦

Doctor's Information:

Name:___________________________ Phone #:_____________________

Address:____

Current Doctor's Certification letter on file: Yes _____ No ______ N/R _______

Caregiving Assistance requirement: ___________________________________

____

Short Term: (Number of Months) _____ Long Term:_______ Terminal:________

NOTE: IF APPROVED IT WILL BE FOR THE APPROVED UNDERAGE CAREGIVER ONLY AND NO ONE ELSE (FAMILY, FRIENDS ETC.).

♦♦

Caregiver Information: Birthdate: ___________________

Caregiver Name:______________________ ID#: ____________________

Relationship: Family member: _______________ Other: ______________

US Citizen: Yes ☐ No ☐ If No, US Work Permit #: __________________

Qualifications/Certification(s):_____________________________________

♦♦

Internal Use Only: (4-year permit) Expiration

Senior Housing Committee approval: Yes:____ No:____ Date: ______________

(Rev. June 2018)