

| What is a 90-day certification?  |  |
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| <p>This form is to certify that your need for assistance with activities of daily living is expected to last 90 days or longer to determine your eligibility for WA Cares Fund benefits.</p>   |  |
| How to complete this form:   | How to submit this form:   |
| <p>Complete the applicant information section. Provide your full name and WA Cares Identification number.</p> <p>Have your healthcare provider complete and sign the certification.</p> <p>All sections are required. Incomplete forms may delay your eligibility determination.</p> | <p><b>Upload:</b> Upload your completed, signed form to your online WA Cares account. If you do not have an online WA Cares account, you can create one by visiting: <a href="http://www.wacaresfund.gov">www.wacaresfund.gov</a>.</p> <p><b>Mail to:</b><br/>           DSHS<br/>           The WA Cares Fund<br/>           PO Box 45612<br/>           Olympia, WA 98504-5612</p> |
| Questions about this form:   | Language assistance is available:  |
| <p>Contact WA Cares for assistance:<br/> <b>Call:</b> 844-CARE4WA (844-227-3492)<br/> <b>Visit:</b> <a href="http://www.wacaresfund.wa.gov">www.wacaresfund.wa.gov</a></p>   | <ul style="list-style-type: none"> <li>• Language interpreter services</li> <li>• Sign Language Services</li> <li>• Braille</li> <li>• TTY/TDD users dial 1-800-833-6384</li> </ul>  |

WA Cares has determined the individual listed below needs assistance with at least three activities of daily living. This form is to certify that the individual's need for assistance is expected to last 90 days or longer to determine their eligibility for WA Cares benefits.

All sections are required. Incomplete forms may delay eligibility determination.

## Applicant Information

Provide the following information for the person applying for WA Cares Fund benefits.

|               |                               |           |
|---------------|-------------------------------|-----------|
| First Name    | Middle Initial                | Last Name |
| Date of Birth | WA Cares ID number (if known) |           |

## Healthcare Provider Certification

This form must be completed and signed by a licensed healthcare provider. Answers should be based on knowledge, experience, and examination of the person listed above.

**Does the individual have a chronic condition or prognosis impacting activities of daily living that is likely to last 90 days or longer?**  Yes  No

**Briefly describe the health condition:**

If the condition is expected to improve, give estimated dates. Terms such as "unknown" or "indeterminate" will not be sufficient to determine eligibility for benefits.

**Start Date:**                      **End date:**

## Healthcare Provider Attestation

|                 |                           |                              |
|-----------------|---------------------------|------------------------------|
| Full Name       | Title                     |                              |
| License Number  | State                     | Type of Practice / Specialty |
| Business Name   | Phone (include area code) |                              |
| Email Address   |                           |                              |
| Mailing address | City                      | State      Zip Code          |

## Healthcare Provider Information

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's need for assistance is expected to last 90 days or longer, and that I am a licensed health care provider authorized to certify their condition.

|           |               |
|-----------|---------------|
| Signature | Date of Birth |
|-----------|---------------|