STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR SOCIAL SERVICES

Alex J. Mayer
Cabinet Secretary

Lorie Bragg
Commissioner

# Adult Family Care Physician's Letter

**Applicant's Name**:

**Address**:

Dear **ENTER PHYSICIAN'S NAME:**

The above-named individual has applied to become or is currently an Adult Family Care provider for the State of West Virginia Department of Human Services, Bureau for Social Services. If approved, one to three vulnerable adults may be placed in their home. Please complete the following information for the individual named and return it to the listed address within ten days. Questions regarding this form may be directed to the Adult Family Care homefinder at the telephone number indicated below.

West Virginia Department of Human Services

**ENTER AFC HOMEFINDER NAME**

**ENTER TELEPHONE NUMBER**

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 [ ] No [ ]

I certify that he/she is physically and mentally able to care for adults placed in their home by the Department of Human Services: Yes [ ] No [ ]

Limitations: (please specify)

(Signature)

(Physician's name-please type/print)

(Date completed)

Sincerely,

**HOMEFINDER NAME**
**TITLE**
**ADDRESS**