MAS

BayLake Consortium

Serving counties of Brown, Door, Marinette, Oconto and Shawano
Phone: 1.888.794.5747 FAX 1.855.293.1822

October 24, 2022

NAME_____ CASE NUMBER_____

Please return this complete form by ___/___/___ to the address below:

CDPU
PO Box 5234
Janesville WI 53547-5234

VERIFICATION OF CLIENT'S ABILITY TO RETURN HOME

I, _____, am requesting a deduction from my countable income, to maintain my home/apartment that I intend to return to upon my release from the institution. I understand that the deduction cannot be allowed for more than six months. I understand that my ability to return home must be verified by a physician, before the expense(s) can be allowed as a deduction to my liability to the institution.

SIGNATURE _____ **DATE** _____
(CLIENT AND/OR AUTHORIZED REP)

TO BE COMPLETED **ONLY** BY A PHYSICIAN

The client, listed above, is indicating that is it reasonable to expect they will return to their home within the next six months. A physician's statement is required in support of this claim. Please complete the information below and include a description of the current diagnosis and prognosis for the client.

Diagnosis/condition_____
_____

Prognosis_____
_____

( ) **CANNOT** be reasonably expected to return home within six months.

( ) **CAN** be reasonably expected to return home within six months.

PHYSICIAN NAME (PLEASE PRINT) _____

PHYSICIAN SIGNATURE_____ **DATE**_____