STATE OF WISCONSIN
DEPARTMENT OF CHILDREN AND FAMILIES
Division of Family and Economic Security

MAS

NEED TO CARE FOR DISABLED FAMILY MEMBER

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m) Wisconsin Statutes].

Case Name	Case Number
Name of Incapacitated/Disabled Family Member	Date of Birth
Nature of Incapacitation/Disability	

Extent of Personal Care Required (e.g., daily care needs, behavior patterns, need for supervision, therapeutic needs, etc.)

Can care be provided in a child or adult facility? (please check) ☐ YES ☐ NO
If no, why not?

This restriction remains in effect until _____/_____/_____ or until the patient is re-evaluated on _____/_____/_____.

Medical Provider or Agency Name	Telephone ( )		
Address	City	State	Zip Code
Title	Signature		Date Signed

RETAIN COMPLETED FORM IN CASE RECORD

DWSP-10786 (R. 01/2009)