GRANDPARENTS AND RELATIVE CAREGIVERS RAISING RELATIVES' CHILDREN WITHOUT LEGAL CUSTODY OR GUARDIANSHIP

A DELAWARE LAW FOR THE CHILD IN YOUR CARE

NOW YOU CAN:

AUTHORIZE MEDICAL TREATMENT

Complete the Caregivers' Medical Authorization Affidavit inside and have it notarized!

Some Caregivers' Medical Authorization facts:

- Parents, custodians, or guardians may sign this affidavit allowing a caregiver **with whom the child is living** to give medical treatment authorization for the child.
- In order to complete the affidavit in the absence of parent(s), custodian, or guardian, a caregiver must provide two proofs of their attempts to locate the party responsible for the child.
- At any time a parent, custodian, or guardian can take back their permission allowing the caregiver to authorize medical treatment.
- The Caregivers' Medical Authorization Affidavit is good for up to one year from the date it was notarized.
- A caregiver must present a completed and notarized Caregivers' Medical Authorization Affidavit when seeking medical treatment for the child.

Eligible individuals must successfully complete and have notarized the Caregivers' Medical Authorization Affidavit in order to approve medical treatment for a relative's child.

You can also acquire the Caregivers' Medical Authorization Affidavit from public health clinics, state service centers, and the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) via:

- ➢ the internet: www.DSAAPD.com
- ➢ E-mail to DSAAPDinfo@state.de.us
- ➢ the mail by calling DSAAPD in: New Castle at 255-9390, Newark at 453-3820, Milford at 422-1386 or statewide at 1-800-223-9074.

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF SERVICES FOR AGING AND ADULTS WITH PHYSICAL DISABILITIES

RELATIVE CAREGIVERS' MEDICAL AUTHORIZATION AFFIDAVIT

• This Affidavit may be used when a parent, custodian, or guardian wishes to give a relative caregiver their permission to approve medical treatment for his or her child who is living in the caregiver's home.

OR

• This Affidavit is to be completed when a relative caregiver who is raising a child without legal custody or guardianship is seeking authorization for medical care before seeking that care. The parent(s), custodian, or guardian cannot be located.

In accordance with Delaware Law on Consent for Medical Treatment of Minors (13 Del.C. §707-708 (a)) I swear or affirm that:

1. I, ______________________________ reside at ____ .
   (Name of Relative Caregiver) (Address)

2. I am eighteen years of age or older.

3. ______________________________ , ____________________ resides with me at this address.
   (Name of Child) (Date of Birth)

4. I am______________________________ to the child for whom this Affidavit is being submitted.
   (Your relationship to the child)

   (A relative caregiver is an adult who, by blood, marriage or adoption, is the child's great grandparent, grandparent, step grandparent, great aunt, aunt, step aunt, great uncle, uncle, step uncle, step parent, brother, sister, step brother, step sister, half brother, half sister, niece, nephew, first cousin or first cousin once removed but who does not have legal custody or legal guardianship of the child.)

5. The name of the child's mother, father, legal custodian, or guardian is: ________________________________

6. ***If the parent(s), custodian, or guardian is available*** to sign this affidavit indicating their approval for a relative caregiver to authorize medical treatment for their child who is living with that caregiver, this section must be completed and signed.

   I, (Print your name)__________________________________ , the (Check the appropriate box)

   ❒ parent(s) ❒ custodian ❒ guardian of

   (Print child's name)__________________________________ , a minor who is living with this caregiver and is related to me by blood, adoption, or marriage, give permission for (Print caregiver's name) __________________________________ , to stand in my place regarding approval of medical treatment for this child.

   ____ ___________________________

   Signature of Parent(s), Custodian, or Guardian Date

7. ***If the parent(s), custodian, or guardian cannot be located***, you must complete Section A below as one of the proofs of your efforts to reach the parent(s), custodian, or guardian. In addition, you must also choose one of the Options -- B, C, D, or E. It is required that you complete the described action and write the information your option requests.

Required Section A:

A. I have sent a certified letter/notice to the parent(s), guardian, or custodian at their last known address. This letter/notice informed the parent(s), custodian, or guardian of this child that I intend to act as a caretaker and take medical responsibility for the child. That letter/notice is attached along with the certified mail receipt reporting the letter was not deliverable because the parent(s), custodian, or guardian of the child was not at this location.

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And one of the following options:

B. I, or a person acting in my behalf, (name) ______________________________ visited the last known address of the parent(s), custodian, or guardian. *Describe what was found at that visit. Include the name of the person spoken to; what that person's relationship with the parent(s), custodian, or guardian is; what the contact person said; and any other related information that clarifies the situation.*

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OR

C. I, or a person acting in my behalf, (name) ______________________________ attempted to determine the location of the parent(s), custodian, or guardian by contacting their place of employment, health care providers, or friends. *Describe the results of your inquiry. Include the name of the employers, health care providers, or friends. Tell what was their response to your request for the location of the parent(s), custodian, or guardian.*

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OR

D. I placed a notice in the *News Journal* and the *Delaware State News* informing the parent(s), custodian, or guardian of (child's name) ____________________________________ that I intend to take medical responsibility of the child. Eight days after publication describe what happened. Include the response you received or the lack of response. *Attach a copy of the legal notice, being sure to include the portion of the newspaper with the date the notice was printed.*

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OR

E. Other documents or confirmations that show that the parent(s), custodian, or guardian cannot be found.

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8. ***Signature of the relative caregiver (Required for all affidavits)***

By signing this Relative Caregivers' Medical Authorization Affidavit, I understand that if I am making false statements I am subject to a minimum civil penalty of $1,000. I may also be subject to criminal prosecution.

I, (Print your name)________________________________ , do declare, certify and state under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge.

This, the ________ day of ___________________ , 20 _____.
(Date) (Month) (Year)

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Signature of Relative Caregiver
(*To be signed in the Presence of a Notary Public*)

9. To be completed by the Notary Public:

On this, the ________ day of ____________________ , 20 _____, personally appeared before me, _________________________________ , known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged that he/she executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

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(Printed Name of Notary Public)

____ My commission expires _________________________
NOTARY PUBLIC (Signature) (Date)

This Caregivers' Medical Authorization is valid for one year or less. This Authorization begins on

_________________________________ and will expire on _________________________________ .
(date notarized) (date)