DEPARTMENT OF VETERANS AFFAIRS

(Veteran's Name) (VA File Number)

VA Helpless Child Certification Form*

I, _____ certify that my patient, _____ became
(Physician's Name) (Helpless Child's Name)

permanently incapable of self-support ***prior to reaching age 18***, due to his/her diagnosis

of _____.
(Diagnosis)

Please complete the following:

This certification is based on

1) I have treated the patient prior to the age of 18: YES NO

2) **If NO**: I have reviewed the patient's treatment records for the time period when he/she reached age 18: YES NO

3) **If NO**: state the reason(s) and basis(es) for your medical opinion. (Please Note: it is not sufficient to base your opinion on a self-report, by the patient, that he/she was incapable of self-support prior to/since the age of 18): _____

_____

_____

(Printed Name of Physician) (Signature of Physician) (Date Signed)

*To be completed by Medical or Mental Health Professional