MINISTRY OF DEFENSE
Families, Commemoration
and Heritage Department

STATE OF ISRAEL

The fields marked with * are required.	
Date	
File Number	

Explanation for receiving payment for a personal caregiver by another – bereaved families permanently residing overseas

To exercise your rights as mentioned, you should carefully read this explanation sheet.

The documents you shall issue

Functioning form

Attached hereto is the functioning form and the instructions page directed to the treating doctor (family doctor).

The family/geriatric doctor shall fill out this form in legible handwriting, including details of the medical diagnosis, if possible, in Hebrew too, age of the eligible person, and date the form was filled out.

Fill out and sign the waiver of medical confidentiality and authorization to receive and provide information (the form is attached hereto).

Confirmation of employment of a caregiver

Attached hereto is confirmation of employment of a caregiver.

State the full personal particulars as mentioned in the I.D. card.

Guarantee of social rights form

The guarantee of social rights form is attached hereto

Sign the aforesaid form (if the eligible party is unable to sign, his power of attorney shall sign the form)

Please take care to fill out all the particulars requested, including the necessary signatures, and attach original documents, in order to make it possible to handle your request as soon as possible.

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To: Training Doctor	
Date	
File Number	
Responsible representation	

Re: Filling out the form for determining nursing aid or institutional arrangement

To: Treating Doctor

Attached hereto is the form that we use for determining our participation in assisting another person or institutional arrangement for bereaved families handled by the Ministry of Defense.

We request to fill out the form with full attention, taking care to:

1. Surname, first name, and age of the applicant
2. State the medical diagnosis; if possible also in Hebrew translation
3. Mark X next to just one disability in each section (in accordance with the eligible person's status)
4. If a mistake in the form is made and corrected, please sign next to the correction
5. Please sign in the place designated for the doctor's signature, including the stamp
6. Sign the applicant on a waiver of confidentiality at the bottom of the form

Thank you in advance for your cooperation.

Sincereny,

_____

Signature

MINISTRY OF DEFENSE
Families, Commemoration
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STATE OF ISRAEL

To:

Ministry of Defense

Families, Commemoration, and Heritage Department

Waiver of confidentiality and authorization to obtain and send information

Declaration

I, the undersigned, _____hereby agree and grant the Ministry of Defense - Families, Commemoration, and Heritage Branch and/or any of its employees and/or any other person/entity acting on behalf of the Ministry of Defense - Families, Commemoration, and Heritage Branch to:

Provide to _____ (hereinafter: "the person requesting the information") information or document of any kind about me in the possession of the Ministry of Defense, *inter alia*, information about my social, rehabilitation, mental, and medical status, and information about the rights, compensation, benefits, and other payments to which I am/was eligible from the Ministry of Defense - Families, Commemoration, and Heritage Branch. I hereby permit the Ministry of Defense - Families, Commemoration, and Heritage Branch and/or any of its employees to provide the person requesting the information any document, certificate, assessment, report, or opinion in the possession of the Ministry of Defense - Families, Commemoration, and Heritage Branch with respect to my social, rehabilitation, mental, and health status and/or with respect to the rights, compensation, benefits, and other payment to which I am/was eligible from the Ministry of Defense - Families, Commemoration, and Heritage Branch.

Obtain from _____ (hereinafter: "the provider of the information") information or document of any kind, *inter alia*, information about my social, rehabilitation, mental, and medical status, and any information about the rights to which I am/was about me the provider of the information.

I hereby release and exempt the Ministry of Defense - Families, Commemoration, and Heritage Branch and/or any of its employees and/or any other person/entity acting on behalf of the Ministry of Defense - Families, Commemoration, and Heritage Branch and the provider of the information from any duty to keep the information confidential pursuant to the Protection of Privacy law, 5741-1981, and by virtue of any law or agreement, I shall have claim or suit of any kind against you with respect to the provision of said information.

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Declaration of address abroad

First Name *	Last Name *	Israeli ID number *

Date _____

☐ I certify the signing of the document digitally

_____

Signature

(In cases the form is submitted manually)

MINISTRY OF DEFENSE
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Guarantee of social rights

I, the undersigned, _____, file no. _____, request to receive, at my choice, the assistance to another due to the medical condition as an additional benefit to compensation.

I am aware that I employ a caregiver and that I hear the full liability as a lawful employer with respect to employee-employer relations.

In this matter, I am responsible for ensuring the rights of the caregiver and his/her insurance at the National Insurance Institute and to for him/her and for him/her the full social rights (health insurance, vacation, health allotment, illness, compensation, etc.) accruing to him/her by law.

I declare that payment of the aid that I receive to help another as an additional benefit to compensation is intended in full solely for this purpose.

Date _____

☐ I certify the signing of the document digitally

_____

Signature

(In cases the form is submitted manually)