Attachment 1

SAMPLE Physician Certification

Name _____ Date _____

Address _____

City, State, Zip _____

Soc. Sec. No. _____ Date of Birth _____

Applicant signature _____ Date: _____

The individual listed above has applied to receive Medical Assistance funded services which may be delivered in a home and community-based setting or in a nursing facility. In order to receive these services, the individual requires a prescription/order for these services. Please complete the following information and return (fax) this form to the address below:

I certify that the above named person requires the support provided through Home and Community-Based Services or a Nursing Facility ____ Yes ____ No

Check appropriate length of care required.
Long-term (Over 180 days) _____ Short-term (180 days or less) _____

Physician signature _____ Date: _____

Printed Physician Name _____ License Number _____

Physician Phone _____ Fax _____

Date signed _____

THANK YOU!

This form replaces the MA-51 for Medical Assistance Services provided by:

Area Agency on Aging