Clear Form

Minnesota Department of **Human Services**

DHS-7096-ENG 5-15

Long-Term Services and Supports

Request for Physician Certification of Level of Care

Instructions to physician

Please answer the questions on this page and sign as indicated. Your certification of this person's level of care is required to determine this person's service eligibility for public programs to support this person in his/her home and community.

Physician certification

I am the primary physician of the named individual and certify that:

NAME OF PERSON	DOB

1. Has a need for skilled assessment and intervention multiple times during a 24-hour period to maintain health and prevent deterioration of his/her health status and
2. Has, due to his/her health condition, both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes and
3. Requires a 24-hour plan of care, including a back-up plan, to reasonably assure health and safety in the community and
4. Would, without the provision of services through the Community Alternative Care Program, require frequent or continuous care provided in a hospital.

Prognosis – optional (select one)

- ◯ Poor – little or no recovery is expected and/or further decline is imminent
- ◯ Guarded – minimal improvement is expected, decline is possible
- ◯ Fair – partial recovery is expected
- ◯ Good – marked improvement
- ◯ Excellent
- ◯ Choose not to respond

PHYSICIAN SIGNATURE	DATE

PHYSICIAN COMMENTS