New Jersey Department of Health
HIV Home Care Program

PHYSICIAN CERTIFICATION AND PLAN OF CARE

Name of Client	Certification Period From: To: *(Recertification every 60 Days)*
Diagnosis(es)	

The service plan developed by the case manager for the above-named client includes the following services (indicated by a check mark) which are covered by the HIV Home Care Program:

CASE MANAGEMENT

- ☐ Case Management: Initial and Monthly

PARAPROFESSIONAL CARE

- ☐ Homemaker/Home Health Aide Services: ________ hours/day ________ days/week
- ☐ Personal Care Attendant: ________ hours/day ________ days/week

PROFESSIONAL CARE

- ☐ Routine Nursing: Number of visits/week ________
- ☐ Occupational Therapy: Evaluation and/or number of visits/week ________
- ☐ Physical Therapy: Evaluation and/or number of visits/week ________
- ☐ Speech Therapy: Evaluation and/or number of visits/week ________
- ☐ Medical Social worker: Evaluation and/or number of visits/week ________

SPECIALIZED CARE

- ☐ Intravenous Drug Therapy and IV Prescription Drugs: Number of days/week ________
  Specific Drugs: ________________________________
- ☐ Respiratory Therapy: Number of visits/week ________
- ☐ Routine Diagnostic/Monitoring Tests: Number of days/week ________
  Specific Test(s): ________________________________

OTHER SERVICES

- ☐ Medical Day Care: Number of days/week ________
- ☐ Durable Medical Equipment, Specifically: ________________________________
  ____

Name of Physician (Print)	
Address	
Signature	Date

If the service plan is medically appropriate and directly related to this client's HIV infection, please sign and return this form to:

Case Manager: ________________________________

Agency Name: ________________________________

Address: ________________________________

____

Telephone No.: ________________________________

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