

**New Jersey Department of Health and Senior Services
PHYSICIAN CERTIFICATION**

Name (Last, First)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Medicaid No.
Home Street Address		Telephone Number	
City, State, Zip Code		Veteran Status <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth	Social Security Number		Medicare Number
Primary Contact Name		Primary Contact Telephone No.	

MEDICAL AND CARE NEEDS – TO BE COMPLETED BY PHYSICIAN

1. Primary Diagnosis: _____
 Additional Diagnoses: _____

2. Medications: _____

3. Treatment/Therapies/Surgeries: _____

4. Does patient have any physical limitations? Yes No If Yes, describe:

 Please describe any related care needs:

5. Does patient have any emotional or behavioral problems? Yes No If Yes, describe:

 Is counseling or support required? Yes No If Yes, explain:

6. Does patient require treatment for active tuberculosis? Yes No

7. Does patient require treatment for any mental illness? Yes No

8. Does patient have symptoms or a diagnosis of mental retardation or a developmental disability? Yes No

9. Is there a reasonable indication that patient might need hospital or nursing home care within 30 days without home and community-based services? Yes No

I certify to the above-named individual's diagnosis and related care needs.

Name of Physician (Print)	Signature	Date
Address		Telephone Number