

STATE OF MICHIGAN
Department of Health and Human Services

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

ADULT SERVICES MEDICAL NEEDS CERTIFICATION
(New 9-25)

INSTRUCTIONS: To be completed by a physician (M.D. or D.O.), physician assistant, nurse practitioner, occupational therapist, physical therapist, or clinical nurse specialist.

Note to medical provider: This form must be completed, signed, and dated by an enrolled Medicaid provider who holds one of the professional licenses listed above.

SECTION 1 – To be filled out with Patient Information

Patient's Name

Patient's Birth Date

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's or Representative's Signature

Printed Name

Signature Date

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SECTION 2 – FOR DEPARTMENTAL USE ONLY

1. Case Name

2. Log Number

3. Recipient ID Number

4. Adult Services Worker Name

5. Worker Email Address

6. Worker Phone Number

7. County

8. Return Fax Number

SECTION 3 – Medical Provider to fill out

A Date Patient Last Seen

B Diagnosis(es) or ICD Code(s) for this patient

C Is the condition chronic and ongoing? Yes No

D If Box C is No, when will the medical condition be resolved? Give date and details.

E Is the patient nonambulatory? Yes No

If yes, explain.

F Does the patient use or need adaptive equipment? (Walker, wheelchair, cane, lift chair, bath bench, grab bars, etc.) Yes No

Include details

G Do you certify the patient has a medical need for assistance with any of the personal care services such as bathing, dressing, eating, grooming, mobility, toileting, transferring? Yes No

Select YES or NO. By selecting YES, you are indicating the patient requires hands-on assistance with one of the listed tasks below.

H Select any Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) services needed.

<input type="checkbox"/> Bathing	<input type="checkbox"/> Grooming	<input type="checkbox"/> Transferring	<input type="checkbox"/> Medication
<input type="checkbox"/> Dressing	<input type="checkbox"/> Mobility	<input type="checkbox"/> Housework	<input type="checkbox"/> Meal Preparation
<input type="checkbox"/> Eating	<input type="checkbox"/> Toileting	<input type="checkbox"/> Laundry	<input type="checkbox"/> Shopping for Foods/Meds

Select any Complex Care services needed:

<input type="checkbox"/> Bowel Program	<input type="checkbox"/> Eating/Feeding Assistance	<input type="checkbox"/> Specialized Skin Care
<input type="checkbox"/> Catheters or Leg Bags	<input type="checkbox"/> Peritoneal Dialysis	<input type="checkbox"/> Suctioning
<input type="checkbox"/> Colostomy Care	<input type="checkbox"/> Range of Motion Exercises	<input type="checkbox"/> Wound Care
<input type="checkbox"/> Other		

I Is the patient's spouse or parent (if patient is a minor) physically unable to provide some or all of the patient's personal care needs? Yes No

If yes, explain.

J Any additional information

SECTION 4

National Provider Identifier (NPI) Number (must be individual's NPI Number, not a group number)

Are you a Medicaid enrolled provider?

Yes No

Medicaid Provider ID Number

Name and Title (Print or type)

Telephone Number

Medicaid Enrolled Provider Signature

Signature Date

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The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: Federal 45 CFR of 233.20, CFR 440.10, and CFR 440.20.

COMPLETION: Voluntary. **PENALTY:** Benefits may be affected.