Ohio Department of Medicaid

PHYSICIAN CERTIFICATION

This certification is to be completed and signed by the Medicaid applicant's physician. The information sought by this form is necessary to determine whether the requirements in Ohio Administrative Code 5160: 1-6-06(D)(2)(a) are met: whether the Medicaid applicant's child caregiver provided care to the institutionalized individual which permitted the institutionalized individual to reside at home rather than in a long-term care facility or be enrolled on a Home and Community-Based Services (HCBS) waiver. This form will not be used to determine the amount, duration, or scope of services that the individual needs. This form cannot be used to prescribe treatment of any kind for the individual listed below.

Patient Information

Individual's First Name		Individual's Last Name		
Street Address	City		State	Zip Code
Telephone Number	Date of Birth	Medicaid Recipient ID or Medicaid Case Number		

Patient Diagnoses

List All Below	Date of onset	Type of Care or Services Needed

Other Information

Please provide any other information concerning the patient or patient's child caregiver which may help ODM determine whether the patient's child caregiver prevented the patient from needing institutionalization or home and community-based waiver services:

Physician Information

Name			
Street Address	City	State	Zip Code
Telephone Number	Specialty		

Physician Certification

I certify that I have reviewed sufficient documentation, including the patient's medical records, to enable me to complete this form. I certify that the information on this form and any information on any attached documents that I provide are true and accurate to the best of my knowledge.	
Physician's Printed Name	License Number
Physician's Signature	Date