State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner

John R. Guhl
Director

MEDICAID COMMUNICATION NO. 09-10 **DATE:** May 1, 2009

TO: County Welfare Agency Directors
ISS Area Supervisors

SUBJECT: Revised PA-4 Form

As you are aware, the New Jersey Department of Health and Senior Services' "Certification of Need for Nursing Care in Facility Other than General Hospital" PA-4 form is a document that is completed by a physician for those Medicaid applicants who are in need of skilled nursing home care or services provided by the Home and Community Based Waiver Programs to Medicaid.

Effective immediately, the revised PA-4 form entitled "Physician Certification (PA-4)" shall be used and will replace all previous versions. Please destroy (recycle) any earlier copies of the PA-4 form.

Attached to this Communication is a copy of the revised Physician Certification (PA-4) along with the instructions for its completion. Questions regarding the use of this form should be directed to Gregory Papazian, Director, Department of Health and Senior Services, Division of Aging and Community Services, at 609-943-5658.

Sincerely,

John R. Guhl
Director

JRG:M
Attachment

c: Jennifer Velez, Commissioner
Department of Human Services

William Ditto, Executive Director
Division of Disability Services

Kevin Martone, Deputy Commissioner
Department of Human Services

Jeanette Page-Hawkins, Director
Division of Family Development

Kenneth W. Ritchey, Assistant Commissioner
Division of Developmental Disabilities

Kimberly S. Rickets, Commissioner
Department of Children and Families

Heather Howard, J.D., Commissioner
Kathleen M. Mason, Assistant Commissioner
Patricia Polansky, Assistant Commissioner
Department of Health and Senior Services

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
PHYSICIAN CERTIFICATION (PA-4)

Name (Last, First)	Sex M ☐ F ☐	Medicaid No.
Home Address and Phone No.		

Date of Birth	Social Security No.	Medicare No.	Veteran Status Yes ☐ No ☐
Primary Contact and Phone No.			

MEDICAL AND CARE NEEDS – TO BE COMPLETED BY PHYSICIAN

1. Diagnosis(es)	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 development 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

Physician Name (Print)	Physician Signature	Date
Address:		Phone Number:

The PA-4 is to be completed by the attending physician for individuals seeking long term care services including Medicaid home and community based program. It is a statement which substantiates the individual's diagnosis and describes their related care needs.

The PA-4 form will be used to assist the assessor in determining whether home and community based long term care services can best meet the needs of the individual.

PA-4 INSTRUCTIONS

Complete the top portion of the PA-4 with the individual's name, address, phone number, date of birth, veteran status, Social Security and Medicaid number.

Include individual's primary contact and phone number.

Medical and Care Needs

1. Provide the individual's primary and secondary diagnosis.

2. Identify all prescribed and PRN medications.

3. Identify all physician ordered therapies or treatments.

4. Describe in detail the individual's physical limitations. Also include whether the individual requires care or assistance with their activities of daily living (ADLs) as a result of these limitations.

5. Describe in detail the individual's emotional or behavioral status and indicate whether counseling or supportive therapy is indicated.

6. Indicate whether individual requires treatment for active tuberculosis.

7. Indicate whether individual requires active or supportive treatment for mental illness.

8. Indicate whether individual requires active or supportive treatment for a developmental disability or mental retardation.

9. Is there reasonable indication that the individual might require hospital or nursing home care within the next 30 days without home and community-based waiver services?

Review all of the completed information for content and accuracy

Print the physician's name, address, and phone number. The physician must sign the PA-4.

Please return the completed form to the County Welfare Agency