New Jersey Department of Human Services

PHYSICIAN CERTIFICATION

Name (Last, First)	Sex ☐ Male ☐ Female	Medicaid No.
Home Street Address		Telephone Number
City, State, Zip Code		Veteran Status ☐ Yes ☐ 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 an intellectual or developmental disability or a related condition? ☐ 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