STATE OF MICHIGAN
Department of Health and Human Services

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

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.

☐ Bathing ☐ Grooming ☐ Transferring ☐ Medication
☐ Dressing ☐ Mobility ☐ Housework ☐ Meal Preparation
☐ Eating ☐ Toileting ☐ Laundry ☐ Shopping for Foods/Meds

Select any Complex Care services needed:

☐ Bowel Program ☐ Eating/Feeding Assistance ☐ Specialized Skin Care
☐ Catheters or Leg Bags ☐ Peritoneal Dialysis ☐ Suctioning
☐ Colostomy Care ☐ Range of Motion Exercises ☐ Wound Care
☐ 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

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.