CERTIFICATION OF MEDICAL NECESSITY
FOR MEDICAID ASSISTIVE CARE SERVICES

Form for Assisted Living Facility, Residential Treatment Facility and Adult Family Care Home Residents

Resident Name _____ DOB _____

This is to certify that this recipient is in need of an integrated set of assistive care services on a 24-hour basis, including at least two of the following four service components on a daily basis (check as applicable):

☐ Assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and/or toileting.

☐ Assistance with instrumental activities of daily living, which is defined as individual assistance with shopping for personal items, making telephone calls, managing money, etc.

☐ Health support, which is defined as observing the resident's whereabouts and well-being; reminding the resident of any important tasks; and recording and reporting any significant changes in appearance, behavior, or state of health to the health care provider, designated representative, or case manager.

☐ Assistance with self-administration of medication, which is defined as assistance with or supervision of self-administration of medication as permitted by law.

HEALTH CARE PROVIDER

Facility Name: _____

License Number: _____

Administrators' Signature: _____

Date Signed: _____

CERTIFICATION OF MEDICAL NECESSITY:

Physician/Physician Assistant/
Advanced Registered Nurse Practitioner/
Registered Nurse: _____