State of Illinois Department of Human Services
Division of Rehabilitation Services
Home Services Program
Physician's Certification

Office Address:_____

_____

Office Fax:_____ Office Phone:_____

To Dr. _____ Re:_____

_____ SS#:_____

_____ DOB:_____

Dear Doctor:

Your patient has requested in-home care assistance from the Home Services Program through the Division of Rehabilitation Services as an alternative to nursing facility placement. We provide the following types of assistance in an individual's home: Personal Assistant, Homemaker Services, Maintenance Home Health, Electronic Home Response, Home Delivered Meals, Adaptive Equipment, Home Modification, Respite and Adult Day Care. An individual can be eligible for any combination of the above services. The attached plan of care reflects your patient's choice of services within the scope of the Home Services Program.

We are required by the rules governing our program to have medical documentation of disabilities and your concurrence that in-home care is necessary for the above individual to safely remain in his/her home. Please complete the following and return by fax or by mail at your convenience. Feel free to contact any Home Services Program staff member should you have any questions or concerns.

_____ APPROPRIATE for the Home Services Program. Without services, customer is at risk of nursing facility placement.

_____ INAPPROPRIATE for the Home Services Program. This patient has the necessary skills and /or resources to live independently in his/her home.

_____ INAPPROPRIATE for the Home Services Program. This patient requires nursing facility placement.

Please list ALL KNOWN disabilities or health impairments which affect the patient's activities of daily living.

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_____ _____
Physician's Signature Date

_____ _____
Signature of DRS/HSP Reviewing Staff Date