Medicaid Personal Attendant Services

Practitioner's Statement of Medical Need

Program Description: Primary Home Care (PHC) and Community Attendant Services (CAS) are Medicaid programs administered by the Texas Department of Aging and Disability Services (DADS). PHC and CAS provide ***non-technical attendant services*** to eligible individuals who have a medical condition resulting in a functional limitation in performing personal care. Attendants help individuals with activities of daily living, such as bathing, grooming, meal preparation and housekeeping. Attendants are trained and supervised by non-medical personnel.

A diagnosis of only mental illness, intellectual disability, or both, does not meet the criteria for medical need. The individual is not eligible if there is no other medical diagnosis.

Part I. Individual Information - To be completed by the provider/employer.

Individual Name (Last, First, MIddle)		Individual No.
Individual Address		
Provider/Employer Name	Supervisor	Area Code and Telephone No.
Provider/Employer Address		

Part II. Provider's Statement

I certify that I have verified with the US Department of Health and Human Service Office of Inspector General and the Texas Health and Human Services Commission Office of Inspector General that the practitioner is not excluded from participation in Medicare or Medicaid.

Provider/CDSA Representative's Name (please type or print) _____ **Signature - Provider/CDSA Representative** _____ Date _____

Part III. Practitioner's Statement and Certifications

Please Check All Functional Limitations Related To Medical Diagnoses

☐ Bedfast	☐ Behavior/Emotional Problems	☐ Falls Easily	☐ Cognitive Impairment	☐ Contractures
☐ Dizziness	☐ Difficulty Swallowing	☐ Limited Range of Motion	☐ Hearing Impairment	☐ Incontinence
☐ Pain	☐ Limited Dexterity	☐ Spasticity	☐ Nausea	☐ Hearing Impairment
☐ Paralysis	☐ Shortness of Breath	☐ Chairbound	☐ Tremors	☐ Numbness
☐ Vision Impairment	☐ Blackouts	☐ General Weakness	☐ Unable to Stand for Long	

☐ Other: _____

Statement of Medical Need

I hereby certify this individual has been evaluated within the past 12 months and was found to have a medical need resulting in a functional limitation; **OR**

I hereby certify I have ongoing knowledge of this individual, have reviewed the individual's medical record within the past 12 months and the individual has a medical need resulting in a functional limitation.

If the medical need is temporary, I anticipate the need will end on _____

I also certify that I am not an owner, partner or member of the service provider requesting completion of the Practitioner's Statement of Medical Need.

Signature - Practitioner _____ **Date** _____

Practitioner's Name (please type or print)	☐ MD ☐ DO ☐ APN ☐ PA	License or NPI No.	State	Military or VA ☐ Yes
Practitioner's Address (Street, City, State, ZIP Code)				Area Code and Telephone No.