NOTICE OF FORM CHANGE NO. 03-097

DATE 8/4/03

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE

SOC 425 (7/03) Physician's Certification of Medical Necessity

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☐ Revised	DATE OF FORM 7/03	REPLACES	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted

REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval

☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:

Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY

☒ Use until exhausted
☐ Destroy

USE NEW FORM

☐ When supply available in DSS Warehouse
☒ Use new form effective immediately.

USE FORM IN ACCORDANCE WITH

☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Due to low usage, this form will now be a Master Only form. Printed stock will no longer be available from the CDSS Warehouse.

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic

PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY

DATE:

This form must be completed to determine Personal Care Services Program eligibility and annually for recertification.

After completion, return this form to the agency address indicated below.

PATIENT'S NAME	DATE OF BIRTH	CASE NUMBER

Dear Doctor:

The Personal Care Services Program provides assistance through In-Home Supportive Services, to those eligible individuals who are limited in their ability to care for themselves and would be unable to remain safely in their own homes without this service.

Your patient has requested help with one or more of the following personal care services: assistance with ambulation; bathing; oral hygiene; grooming; dressing; care and assistance with prosthetic devices; bowel, bladder and menstrual care; repositioning, skin care, range of motion exercises and transfers; feeding and assurance of adequate fluid intake; respiration; or assistance with self-administration of medications.

Your examination of this patient may be reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met, or through Medi-Care.

AGENCY	SERVICE WORKER	SERVICE WORKER NUMBER
AGENCY ADDRESS (Street, City, Zip)		PHONE ( )
SERVICE WORKER'S SIGNATURE		DATE

PATIENT AUTHORIZATION

By signing this form, I hereby authorize the release of information, including information regarding alcoholism, drug abuse, mental illness or HIV infection, pertaining to my medical necessity for personal care services to the above named agency.

PATIENT'S SIGNATURE (Or Authorized Representative)	DATE

FOR PHYSICIAN'S USE ONLY

PHYSICIAN'S NAME	PHONE ( )
OFFICE ADDRESS (Street, City, Zip)	
DIAGNOSIS	DATE LAST SEEN BY PHYSICIAN
PROGNOSIS (If Known)	

I recommend one or more of the above listed personal care services for this patient in order to prevent out-of-home placement. ☐ Yes ☐ No

PHYSICIAN'S SIGNATURE	PROVIDER NUMBER	DATE