PERSONAL CARE SERVICES PROGRAM
PHYSICIAN CERTIFICATION

This form must be in the PC member's file if the Pre-Admission Screening tool was completed by a PC Agency Registered Nurse in cases where the agency completed PAS mid-authorization.

I have thoroughly reviewed the Pre-Admission Screening (PAS) for

_____completed by _____ on
Patient's Name RN Name

_____. I confirm the findings on the PAS correctly describes the physical and mental
Date

condition(s) of the above-mentioned patient.

I understand my signature on this form and the PAS is certifying the information is complete and accurate. I understand that payment for the services based on the medical information contained on this form will be from Federal and State funds. Should it be proven that the medical information on this form is false, I understand that I may be charged with Medicaid Fraud.

Physician Name Printed (must be MD, DO, Physician's Assistant or Nurse Practitioner)

Physician Signature (must be MD, DO, Physician's Assistant or Nurse Practitioner)

Date