Texas Department of Aging
and Disability Services

Form 2355
August 2011-E

In-Home and Family Support Program

Physician Statement

Date	
Applicant/Individual Name	Case Manager Name, Address, Area Code and Telephone No.
Address	

The following medical information is needed to determine this individual's eligibility for the In-Home and Family Support Program. The program is intended to assist the individual in order to allow him to reside in his home. **Please complete all items below.** If you have questions, contact the case manager at the address and telephone number above.

I. Diagnoses

Medical Diagnoses (list all health conditions)	Prognosis (include duration if prognosis is not permanent)	Prognosis is Permanent?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

II. Does the applicant/individual have any functional limitations resulting from a diagnosis listed in Section I? ☐ **Yes** ☐ **No**

If Yes, check all substantial limitations that apply.

- ☐ Self-Care
- ☐ Receptive and Expressive Language
- ☐ Learning
- ☐ Mobility
- ☐ Self-Direction
- ☐ Capacity for Independent Living
- ☐ Economic Self-Sufficiency
- ☐ Other (specify): _____

III. _____ Signature – Physician/Physician's Assistant/ Advanced Practice Nurse

_____ Date

_____ Print Name - Physician/Physician's Assistant/ Advanced Practice Nurse

Mailing Address	Area Code and Telephone No.
If the practitioner is a physician's assistant or advanced practice nurse, provide the name of the overseeing physician (type or print):	

Please return this document in the addressed, stamped envelope provided.