TEXAS
Department of Aging
and Disability Services

_____
Date

Physician Name and Address

Applicant/Individual Name: _____

Date of Birth: _____

Your patient, named above, is applying for services through a Department of Aging and Disability Services (DADS) community program funded by Medicaid.

Federal regulations require that an individual's physician certify the need for home and community-based services under the supervision of an MD/DO. To provide this certification, sign the attached Physician Signature Page. By signing this page, you are attesting to the need for community-based services as an *alternative* to nursing facility care for this individual.

Return the attached Physician Signature Page as soon as possible in the enclosed self-addressed postage-paid envelope or fax to the number listed below. A delay in returning the Physician Signature Page will delay determining your patient's eligibility for services.

If you have any questions, please contact me.

Thank you for your assistance.

MDCP Nurse, Address, Area Code and Telephone Number, and Fax Number: