COLORADO
Department of Health Care Policy & Financing

Home Maintenance Allowance Physician Statement Form

This form is a required part of the verification process for a member applying for the Health First Colorado (Colorado's Medicaid Program) Home Maintenance Allowance benefit. This form must be signed by a licensed medical professional.

Member Information			
First Name:		MI:	Last Name:
DOB:	Medicaid ID#:		Nursing Facility Admission Date:

Verification:

☐ It is medically reasonable to believe that the member will return to the community from a Nursing Facility within six (6) months.

Treating Licensed Medical Professional Information		
Name:		
Name of Practice:		
Practice Address:		
City:	State:	Zip:
Phone:		

Attestation:

☐ I attest that the information provided above is accurate and true to the best of my knowledge.

Signature of Licensed Medical Professional Verifying this Information	
Signature:	Date:

Person Completing this Form	
Name:	
Title:	Date: