

**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:
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Person Completing this Form

Name:	
Title:	Date:

