Certification of Chronically Ill Individual

I certify that as of the date of this document _____ (patient's name) called "Patient" is a chronically ill individual because Patient (complete 1 or 2 or both as appropriate):

1. Is unable to perform the following activities of daily living (ADLS) (check at least two):

_____ eating _____ bathing _____ toileting _____ dressing

_____ transferring _____ continence

without substantial assistance from another individual and has or will be unable to perform such ADLS without such assistance for a period of at least 90 days due to a loss of functional capacity.

2. Has a severe cognitive impairment requiring substantial supervision to protect Patient from threats to health and safety, and has suffered a deterioration or loss of intellectual capacity that has been measured by (both must be checked):

_____ Clinical Evidence, and _____ Standardized tests that periodically measure improvement in Patient's (i) short-term or long-term memory, (ii) orientation as to people, places or time, and (iii) deductive or abstract reasoning.

I am _____ a physician, _____ a registered nurse, or _____ a licensed social worker in the State of Indiana (check one).

_____ _____

Signature Printed Name

_____ _____

Date Address

This certification is valid for one year.