

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 section 1 or 2 or both, as appropriate):

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

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Continence |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Transferring |

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
- Facility 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
- Registered Nurse
- Licensed Social Worker in the State of Indiana

Signature

Printed Name

Date

Address

This certification is valid for one year.