MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS

HEALTH CERTIFICATION

PARTICIPANT NAME (LAST, FIRST, MI)		DATE OF BIRTH (MONTH/DAY/YEAR)
SOCIAL SECURITY NUMBER (LAST FOUR DIGITS) XXX–XX–___ ___ ___ ___	DCN NUMBER	SEX ☐ MALE ☐ FEMALE

ICD CODE	PRINCIPLE DIAGNOSIS

ICD CODE	OTHER PERTINENT DIAGNOSIS

FUNCTIONAL LIMITATIONS

☐ Amputation
☐ Bowel/Bladder (Incontinence)
☐ Contracture
☐ Hearing
☐ Paralysis
☐ Endurance
☐ Ambulation
☐ Speech
☐ Legally Blind
☐ Dyspnea with Minimal Exertion
☐ Other (specify) _____

PROGNOSIS

☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent

CURRENT TREATMENT PLAN INCLUDING BUT NOT LIMITED TO MEDICATIONS, DME, SUPPLIES, THERAPIES (FREQUENCY AND DURATION)

NAME/SIGNATURE OF PERSON FILLING OUT THE FORM	DATE
ATTENDING/PRESCRIBING PHYSICIAN NAME	ADDRESS
TELEPHONE NUMBER	FAX NUMBER
ATTENDING/PRESCRIBING PHYSICIAN SIGNATURE	DATE