**STATEMENT OF PHYSICIAN**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the physician of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient),

affirm that I have examined the Patient and determined that a need exists for continuing personal care services for the Patient. I believe that such continuing personal care services are necessary in order for the Patient to continue living at home and to avoid their entry into a nursing facility.

Signed: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_