



# Department of Health Care Policy and Financing

## Physician Statement of Life Limiting Illness

Client Information	
<b>Full Legal Name</b>	<b>Clients Medicaid ID Number</b>

The above named client is applying to participate in the HOPEFUL Pediatric Hospice Waiver program. As a participant, the client must have a life limiting illness that is attested to by a physician.

Definitions
<ol style="list-style-type: none"> <li>1. <b>Life Limiting Illness</b> means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the client reaches adulthood.</li> <li>2. <b>Adulthood</b> means age 19 years or older.</li> </ol>

Physician Statement and Signature			
As the treating physician of the client listed above, please answer the following questions. <b>Check one box for each question.</b>			
1. Are you this client's primary care physician?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Are you this client's specialist physician?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Does the client have a life limiting illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Life Limiting Illness(print)</b>		<b>Diagnosis Code</b>	
<b>Physician Name (print)</b>	<b>Signature</b>	<b>Date</b>	
<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
( )			
<b>Telephone Number</b>		<b>Specialty/Practice Area</b>	