LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

State Personal Assistance Services (SPAS)
Statement of Medical Status

The purpose of this form is to verify medical information reported by the patient for home and community-based services. Please return the completed form to the patient to be mailed with the application.

I. Patient Information								
Name:				**DOB:**		**Gender:**		
SSN:		**Medicaid #:**			**Medicare #:**			
Street Address:					**Phone #:**			
City:			**State:**			**Zip Code:**		

II. Medical Information (This section **MUST** be completed by the physician)	
Primary Diagnosis:	
Secondary Diagnosis:	

Check all that apply:

The patient has a loss of ☐ Sensory and/or ☐ Motor functions interfering with activities of daily living to the extent that the patient requires non-medical assistance with:

☐ Mobility in Bed ☐ Transfers ☐ Locomotion ☐ Dressing ☐ Eating ☐ Toileting ☐ Bathing

☐ Personal Hygiene ☐ Meal Preparation ☐ Housekeeping ☐ Managing Finances ☐ Phone Use

☐ Shopping ☐ Transportation

Physician's Name:		**Phone:**	
Address:			
Physician's Signature:			