RYAN WHITE PROGRAM
LETTER OF MEDICAL NECESSITY FOR HOME DELIVERED MEALS
(PHYSICIAN CERTIFICATION)

As the primary physician for _____________________, CIS # ___________________, it is my professional opinion that he/she qualifies for home delivered meals assistance because he/she meets the conditions required for this service (as indicated below).

I hereby certify that:

1. This patient has the following diagnosis (check one):

☐ AIDS

☐ HIV+ symptomatic, with the following condition that makes home delivered meals necessary: (please specify condition and check one of the following: __________________________________)

_____ Temporary condition (specify time period ____)

_____ Permanent condition

AND

2. This patient meets the following Project AIDS Care (PAC) Waiver condition for home delivered meals (check as appropriate):

☐ The patient is homebound*; functionally impaired**; and no other person in the patient's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation.

☐ A therapeutic diet is authorized for this patient that can only be implemented through home delivered meals.

AND

3. This patient requires _________ home delivered meals per day, from the date of my signature, for a period of (check one):

(# of meals)

☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS

Definitions - * *Homebound: The individual is confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals.*

** *Functionally impaired: The patient has difficulty performing one or more activities of daily living such as bathing, dressing, walking, getting to the toilet, or eating. The functionally impaired person may not be capable of preparing meals.*

Sincerely,

________________________________	________________________________
Physician's Signature	Date
________________________________	________________________________
Physician's Name (please print)	Physician's Florida Medical License Number
________________________________	(______)__________________________
Agency/Clinic/Practice Name	Physician's Telephone Number
________________________________	________________________________
Agency/Clinic/Practice Street Address	Agency/Clinic/Practice City, State, Zip

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider. **Rev. 3/1/09**