

Terminal Illness Certification

FAX MEMO from _____

Name of facility

I certify that _____ is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course

Customer Name _____
Customer DOB: _____
Customer SS# _____
Terminal Illness Diagnosis: _____

Attending Physician

Signature

Printed Name: _____

Address: _____

Phone #: _____

FAX #: _____

Proposed Nursing Facility

Facility Name

Address: _____

City: _____ Zip _____

ADMIT DATE _____

Phone #: _____

FAX #: _____

NOTE: The nursing facility, hospital, or hospice provider must send appropriate documentation with this Fax for a determination letter to be generated. The determination letter along with this documentation must then be retained in the person's chart in place of a CARE Certificate /Proof of PASRR. **Fax this completed form and appropriate documentation**

to: CARE-KDADS 785-291-3427

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