

**KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES**

**SENIOR CARE ACT**

**PHYSICIAN/RN STATEMENT FOR CUSTOMER DIRECTED ATTENDANT CARE  
(Health Maintenance Activities)**

**PART I: COMPLETED BY THE CUSTOMER OR CASE MANAGER**

Customer Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
SS # \_\_\_\_\_

Person supervising or directing the customer's Medication Setup or Health Maintenance Activities:

Customer

**OR**

Customer's Authorized Representative \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

The customer has been assessed and found eligible for Senior Care Act. The customer or his/her authorized representative has chosen to self-direct Attendant Care services that are classified as Medication Setup or Health Maintenance Activities. Medication Setup and Health Maintenance Activities include the following tasks:

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

Attached you will find a Customer Service Worksheet that addresses the customer's needs and outlines who will assist the customer.

Attached is documentation from the case manager (only check if applicable).

**PART II: COMPLETED BY THE PHYSICIAN OR REGISTERED NURSE**

Please check one:

- I have read the information provided to me and in my judgment the person listed in the box above **is able** to supervise and direct the customer's Medication Setup or Health Maintenance Activities.
- I have read the information provided to me and in my judgment the person listed in the box above **is not able** to supervise and direct the customer's Medication Setup or Health Maintenance Activities for the following reasons:

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

**X** \_\_\_\_\_  
Signature of Customer's Attending Physician or Registered Nurse

**X** \_\_\_\_\_  
Date