CERTIFICATION OF MEDICAL STATUS
Chronic and Acute Medical Assistance (CAMA)

PURPOSE: This form documents the current and ongoing medical status of the patient identified below for the purpose of qualifying for CAMA benefits. It does not constitute as a finding of disability. It must be completed by the patient's physician, physician assistant or nurse practitioner who has diagnosed the patient and sent directly to the Division of Public Assistance (DPA) caseworker shown below.

PATIENT IDENTIFICATION: SSN _____-_____-_____ Date of Birth: _____

Last Name (print):_____First:_____Middle: _____

PROVIDER CERTIFICATION: (Must be completed by a physician, physician assistant, or advanced nurse practitioner)

_____ Based upon my medical evaluation, I have diagnosed the patient listed above with the chronic medical condition(s) indicated below and I certify that the patient is in need of ongoing treatment including prescription drugs, chemotherapy or radiation for this condition(s):

____ Cancer patient requiring chemotherapy
____ Terminally ill (see definition on reverse side)
Diagnosis_____
____ Chronic diabetes or diabetes insipidus
____ Chronic seizure disorder
____ Chronic mental illness (see definition on reverse side)
____ Chronic hypertension

_____ I certify that I have examined the patient named above and this patient does NOT require prescription drugs, chemotherapy or radiation for their chronic condition or illness.

Provider Name: (print) _____

Title:_____Specialty:_____

Address:_____

Phone:_____Fax: _____

Signature:_____Date: _____

Please mail or fax this form to the DPA caseworker indicated below. DPA will not accept this form directly from the patient unless it is sealed in the medical provider's business envelope. Completed form is valid for 90 days.

NOTE TO HEALTH CARE PROVIDERS ABOUT DISCLOSURES OF PROTECTED HEALTH INFORMATION TO THE DIVISION OF PUBLIC ASSISTANCE:

The Division of Public Assistance encourages the use of patient authorization to release protected health information and will attempt to provide a HIPAA-compliant authorization signed by the patient to accompany this request for information. However, please be aware that if an authorization to release information does not accompany this request for information, or if you are unable to obtain an authorization from your patient, HIPAA regulation - 45 CFR §164.512(d) specifically permits disclosures of protected health information to government benefit programs for which health information is relevant to beneficiary eligibility without the patient's authorization.

If you have questions concerning disclosures of protected health information, please contact the Department of Health and Social Services Privacy Official at (907) 465-2150.

RETURN COMPLETED FORM TO THE FOLLOWING DPA CASEWORKER:

Name: _____

Division of Public Assistance

_____

_____

Phone: _____ Fax: _____

DEFINITIONS
Chronic and Acute Medical Assistance (CAMA)

The following definitions are offered as guidance in making a medical determination of whether the individual listed on the reverse side of this form presents "chronic mental illness" or is "terminally ill." These definitions are only guidelines and are not intended to replace your professional medical judgment in a specific case. These definitions do generally reflect the conditions for which the CAMA program is intended:

Chronic Mental Illness: An individual with "chronic mental illness" suffers from a very serious mental illness and exhibits significant deficiencies in functioning. A chronic mental illness is more than a severe emotional disturbance, and is marked by the presence of (1) a psychosis of some kind, (2) a mental disorder that is marked by a loss of contact with reality, and (3) by a deterioration in personality and social functioning. A determination of chronic mental illness means that the individual shows involvement generally consistent with the following Medicaid definition of "chronically mentally ill adult" in 7 AAC 43.1990(10):

"chronically mentally ill adult" means an individual 21* years of age or older

(1) who has been diagnosed as having a schizophrenic, major affective, or paranoid disorder, or other severe mental disorder with a documented history of persistent psychotic symptoms not caused by substance abuse; **and**

(2) whose role functioning is impaired in at least two of the following three ways:

(A) inability to function independently in the role of worker, student, or homemaker;

(B) inability to engage independently in personal care or community living activities; or

(C) inability to exhibit appropriate social behavior, resulting in intervention by the mental health system or judicial system.

**For the purposes of CAMA, this definition may also be used for 19 and 20 year olds.*

Terminally Ill: Reference Medicare and Medicaid definition used for hospice care: "terminally ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (42 C.F.R. 418.3)

PRIOR AUTHORIZATION: This form does not constitute prior authorization of benefits.
Outpatient Chemotherapy/Radiation Therapy: If the patient listed on this form is in need of outpatient chemotherapy/radiation therapy, prior authorization must be secured from the First Health Services Corporation. See the Alaska Medical Claims Payment System Provider Billing Manual for instructions.