PHYSICIAN CERTIFICATION OF MEDICATION DEPENDENCY FOR THE DISABILITY ASSISTANCE PROGRAM

IDENTIFYING INFORMATION: To be completed by caseworker

Assistance Group No.	DOB	Sex	County Name		
Client Name *(Last, First, MI)*			County Address		
Client Address			City		Zip
			Caseworker/Case Manager		Telephone No.
City	Zip	SSN			

STATEMENT OF MEDICAL CONDITION: MUST be completed by treating physician

Please describe your patient's chronic medical condition(s):

Date of first onset of this condition(s):

Please list all medications prescribed by you for this patient to control the above listed chronic medical conditions and the prescription history of each for the previous 6 months:

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

Medication _____ Prescription History _____

STATEMENT OF CERTIFICATION: To be completed by treating physician

A medication-dependent person is one who is undergoing treatment for a chronic medical condition which requires the continuous prescription of the medication listed above for a long-term, indefinite period of time. The loss of access to the listed medications would result in a significant risk of a medical emergency and loss of employability for at least 9 months.

_____ is my patient and my signature below certifies that based upon this definition of medication dependency:

☐ (s)he is a medication dependent person.
☐ (s)he is NOT a medication dependent person.

I hereby certify under penalty of law that the above information is a true and accurate description of my patient's medical condition at this time to the best of my knowledge. I understand that I will have my provider agreement with the Ohio Department of Job and Family Services revoked and/or be reported to the State Medical Board and/or be prosecuted for perjury should I knowingly make false or misleading statements or provide altered or false documentation that results in my patient being inappropriately determined to be eligible for the Disability Assistance program as a medication dependent person.

Physician Signature	Date	Medical Provider No.	
Physician Name *(please print)*	Specialty		
Address			
City	State	Zip	Telephone No.