



PROJECT OPEN HAND HOMEBOUND/CRITICALLY ILL PROGRAM

730 Polk Street
San Francisco, CA 94109
415-447-2326
415-447-2492 fax

1921 San Pablo Avenue
Oakland, CA 94612
510-622-0221
510-452-1061 fax

CERTIFICATION FOR SERVICES

(To be completed by Primary Care Provider)

Client Name: _____ Date: _____

I certify that my patient meets the following criteria (eligible clients must meet criteria in BOTH boxes):

Homebound Patient Who Cannot Prepare Meals
(leaves home **only** for essential appointments and services)

AND

Acute Status
(recovering from recent surgery, trauma or injury, or acute exacerbation of a chronic medical condition)

OR

Terminal Condition
(prognosis 6 months or less)

Not Homebound **None of the above conditions**

NOTE: Re-certification is required in 3 months for acute diagnoses and in 6 months for terminal diagnoses.

Signature of Physician/Nurse Practitioner/PA or RN ONLY

Phone _____

*Office stamp required here
Printed Name of Physician/Nurse Practitioner/PA or RN*

Date _____

CLIENT CONSENT TO RELEASE INFORMATION

***All certificates are subject to verification from your physician/nurse practitioner.
Fraudulent documentation will cause termination of services.***

I hereby authorize my physician/nurse practitioner to release information regarding my medical condition to Project Open Hand for purposes verifying my eligibility.

Client Signature

Date

Printed Name of Client

Date of Birth

Health Care Provider to Complete

for the Primary Diagnosis that Makes the Client Eligible for the Program

Surgery Type: _____ Date: _____

Hospitalization Type: _____ Date: _____

Trauma/Injury Type: _____ Date: _____

Cancer Type: _____

Cardiac Disease

- Recent MI
- CHF
- Other

Type: _____

Respiratory Condition

- COPD
- Asthma
- Other

Type: _____

Endocrine Disorder

- DM
- Other

Type: _____

Renal/Urologic Condition

- ESRD
- Other

Type: _____

GI/Liver Disease

- ESLD
- Hepatitis
- Pancreatitis
- Other

Type: _____

Rheumatologic Disorder

- SLE
- Sarcoid
- Other

Type: _____

Infectious Disease

Type: _____

Other

Type: _____

Neurological Disorder

- Stroke
- MS
- Parkinson's
- Other

Type: _____