HCS 494

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Medical Condition or Health Needs that Impact Ability to Work or Do Other Community Engagement Activities – Request for Condition Approval

Client Name_____ Medicaid Case # (if known) _____ Date _____

This form should be used if you are applying for Medicaid coverage and need to request an exclusion from the community engagement requirement due to a medical condition that is **not currently included in Montana's list of qualifying conditions**. This must be a medical condition that impacts your ability to work or do other community engagement activities. *Please visit **medicaidchanges.mt.gov** for a list of conditions that qualify.*

If you have a condition that is included in Montana's list of approved conditions, fill out Appendix B, Page 4 *(Medical Condition or Health Needs that Impact Ability to Work or Do Other Community Engagement Activities: Provider Attestation Form)*.

You must work with your medical provider to complete this form. This request will be reviewed by DPHHS, and you will receive a notice of your eligibility determination.

Patient Authorization

I authorize the provider named below to complete this form and release it to the Department of Public Health and Human Services to determine my exclusion from the community engagement requirement.

Patient Signature _____ Date _____

Provider Attestation

I, _____ (provider name) attest that the patient named above has a condition that **impairs the patient's ability to do work or other community engagement activities**

Describe the condition(s) (e.g., *ICD-10 or DSM-5 codes)* and how this impacts the above patient's ability to meet the community engagement requirement.

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Provider Certification

I certify that I am a licensed health care provider and that the information on this form is true and correct to the best of my professional knowledge.

Provider name _____ Credentials / title _____

License / NPI # _____ Practice or facility _____

Telephone _____ Address _____

Provider signature _____ Date _____