Personal Assistance Services (PAS) Program

MEDICAL/PHYSICAL DIAGNOSIS FORM

The application process for the PAS program requires an applicant to submit a written statement from a licensed physician, physician assistant or registered nurse certifying the applicant's need for essential personal care. Completion of this form will assist the below named applicant to apply for the PAS program which will assist with home and community-based services providing support for this individual to remain in the community. Please provide the information below and return this form to our office, or provide to the applicant to return to the office with the completed CBC Program Application. The information provided will be used only in conjunction with the official duties of this department and will be considered confidential.

Applicant/Recipient Name:

SSN:

Please list the applicant/recipient's diagnosis that constitutes a physical disability as per NAC 427A:

Please check the level of functional limitation for each Activity of Daily Living of the applicant/recipient:

Bathing: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Dressing: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Grooming: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Toileting: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Eating: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Mobility: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Transfers: Independent ☐ Stand By Assist ☐ Moderate Assist ☐ Max Assist ☐

Other/Comments:

Physician's Name:

Phone:

Physician's Signature: Date: