Washington State Health Care Authority

Licensed Health Professional Certification of Potentially Disabling Condition

1 Patient information

Check the application you are using this form for:

☐ Acute Care Hospital Application

☐ LTSS Presumptive Eligibility Application

Date of Admit (for hospital use)

Last name | First name | MI | Date of birth | Client ID (if known)

Address | City | State | ZIP code

2 Provider information

Licensed health provider name | Phone number

Address | City | State | ZIP code

Contact name | Fax number | Email address

3 Potentially disabling condition

A potentially disabling condition means the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death; or has lasted or can be expected to last for a continuous period of not less than twelve months.
Describe how the patient's condition meets the criteria of a potentially disabling condition as described above:

4 Licensed Health Professional* Certification

In signing below, I certify that the condition for which treatment was provided to the above named patient on the date(s) specified (check only one box):

☐ Meets the definition of a potentially disabling condition

☐ Does not meet the definition of a potentially disabling condition as described above

Signature of Health Professional | License #

Print full name

Provider/Facility name | Date

*See WAC 388-449-0010 for acceptable medical sources.

HCA 19-0054 (8/24)

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Licensed Health Professional Certification of Potentially Disabling Condition Instructions

This form is completed by a licensed health professional to corroborate a disabling condition for an individual who will discharge on long-term services a

1. Date of Admit—provide date of client's most recent hospital admission

2. Patient Information—complete all patient demographic information. Include the individual's DSHS client identifier, if known

3. Provider Information—complete all hospital demographic information, including contact information for hospital personnel working on the discharge

4. Potentially Disabling Condition—provide details of the patient's potentially disabling condition including details of impairments that significantly limit a patient's ability to work, such as:
    - lack of mobility, hearing, seeing or speaking issues,
    - impaired ability to understand or carry out basic instructions,
    - impaired judgement,
    - impaired ability to respond appropriately to work situations,
    - impaired ability to deal with changes, etc.

For more information regarding impairments that can be used to determine a disability refer to WACs 388-449-0020 and 388-449-0030.

5. Licensed Health Professional Certification—indicate whether the patient meets the definition of a potentially disabling condition. The licensed health professional must then sign, and provide licensing and facility information. For information regarding who qualifies as a licensed health professional, please refer to WAC 388-449-0010.

6. Fax or mail the completed form to:
    - 1-855-635-8305, or
    - DSHS – Home and Community Services
    - PO Box 45826 Olympia WA 98504-5826