**SAMPLE LETTER OF MEDICAL NECESSITY**

**[Office Letterhead]**

**[Date]**

**RE: [Patient Name] [DOB]**

To Whom It May Concern:

I am writing in support of my patient **[Patient Name]**’s appeal involving **[state issue, e.g.: “the reduction of his/her/their personal assistance services (PAS) from X to Y hours per week” or “the denial of his/her/their request for ### hours of personal assistance services (PAS) per week”]**. I have been **[Patient’s] [primary care physician/specific specialist]** since [**Date or Length of time]**. For the reasons explained below, it is my opinion that at least **[number]** hours per week of personal assistance services (PAS) is medically necessary for **[Patient].**

**[Patient]** is a **[age]-**year-old with **[list all relevant diagnoses, including past diagnoses, such as stroke, TBI, etc. as well as surgeries that still affect Patient. Include dementia diagnoses.]**. **[Patient]** wishes to remain in the community and avoid nursing home placement.

**[Patient]** has extensive health and functional needs related to **[her/his/their] [multiple]** medical conditions. These conditions result in **[describe all the effects of the medical conditions emphasizing those that effect safety and the ability to perform ADLs and IADLs. E.g., swelling and pain in lower extremities which causes impaired balance, and unsteady gait; impulsiveness and forgetfulness related to dementia. If Patient is prone to falls or has had recent falls, describe those. If Patient has dementia or cognitive impairments, note that and how they affect patient and any concerns relative to safety and self-care. If Patient uses assistive devices for ambulating, indicate that as well as what type of assistance with that device the Patient may need if they cannot safely use it on their own. E.g., Patient uses a walker for mobility within their home, but because of the unsteadiness caused by lower extremity swelling they require supervision /direct assistance with the walker to prevent falls.]**

**[Patient]** is unable to **[describe activities such as transferring, walking, toileting, cooking, bathing, grooming, medication management eating, shopping, traveling outside the home, cleaning. Laundry, etc.]** without assistance. **[Where possible connect the need for assistance with the ADL/IADL. E.g., Patient needs assistance with medication management because of the memory deficits associated with dementia. Without assistance Patient is likely to miss taking critical medications or take more than is prescribed. Patient has been known to have medication compliance problems in the past and this has caused \_\_\_\_]**

**[If Patient’s condition is deteriorating or has deteriorated, please describe.]**

**[If hours are need for supervision for safety, include a detailed paragraph on what the safety concerns are, giving examples. E.g., Safety is of particular concern. Last year when Patient was alone, they left an empty pot on a lit stove / they fell while trying to walk on their own and was sent to the ER / etc. It is therefore my medical opinion that [Patient] receive at least [Requested amount] of personal assistance services so that they are able to remain safely in the community and avoid the risk of [explain potential harm].**

**[If assistance is needed with toileting [including related to changing incontinence supplies, or getting to the bathroom to use the toilet:]** Patient also needs at least **[#]** of hours of personal assistance services because **[her/his/their]** toileting needs are unpredictable and cannot be scheduled. If **[Patient]** is unattended, **[she/he/they]** will not be able to use the toilet when needed resulting in soiling themselves, which, if also not addressed, is likely to lead to **[share relevant impact: skin breakdown, urinary tract infections.** **If there is a history of UTI include that information].** Alternatively, Patient will attempt to use the toilet, which **[she/he/they]** cannot safely **[walk to/use]** without assistance.

**[Use language from one or more of the following paragraphs. ]**

(1) The requested PAS hours will [or are reasonably expected to] reduce or ameliorate the physical, mental or developmental effects of **[Patient’s]** illness, condition, or disability in the following ways **[explain any ways you feel the existing/requested PAS hours keep or will keep Patient from experiencing unnecessary health problems or conditions. Some examples might include preventing injuries from falls, preventing specific worsening symptoms by ensuring adherence to medications, maintaining nutrition].**

(2) The requested PAS hours will **[or are reasonably expected to]** prevent the onset of illness, condition or disability**. [Explain how the hours will prevent specific illnesses, conditions or disabilities.]**

[3] The requested PAS hours will assist **[Patient]** to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age. **[Explain how the PAS hours will help achieve or maintain functional capacity. For example, if PAS assists with performing prescribed exercises explain how the exercises will help the person maintain their current level of walking or lifting]**

[4] The requested PAS hours will also allow **[Patient]** to continue to have access to the benefits of community living and continue to live in the setting of **[his/her/their]** choice. With in-home aides, **[Patient]** can live where **[she/he/they]** wants and perform those activities **[she/he/they]** would otherwise be unable to do because of **[her/his/their] [medical conditions]**.

**[If hours are being reduced:]** Reducing **[Patient’s]** PAS hours from **[X]** to only **[Y]** would endanger [Patient’s] health and safety and threaten **[her/his/their]** ability to continue living independently in the community. Without the prescribed PAS hours, Patient would be at increased risk of **[LIST AND EXPLAIN any complications you think might occur if Patient does not have adequate care at home. Examples might include: bedsores or infections (from not receiving incontinence care), unnecessary injuries from falling, dehydration, malnutrition, and unnecessary hospitalization.]** In addition **[IF APPLICABLE, list any other ways you feel a reduction hours might undermine Patient’s ability to stay in the community, as opposed to a nursing home].**

For these reasons, I believe it is medically necessary for **[Patient]** to **[continue to]** have **[#]** hours of PAS. If you have questions or require additional information, please contact my office at **[INSERT PREFERRED CONTACT INFORMATION]**

Sincerely

**[SIGNATURE]**