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|  | **Physician Certification For  Home Maintenance Allowance (HMA)** | | | |
| CLIENT NAME | | STARTING DATE | | ACES CLIENT ID NUMBER |
| **PHYSICIAN:** The following information is needed to allow the client to be eligible for the Home Maintenance Allowance (HMA). The HMA will allow some of the client’s income (to the 100% Federal Poverty Level maximum) to be set aside for up to six (6) months to maintain or support the client’s transition to a community residence while they are receiving services in a nursing facility or Medicaid Medical Institution.  Your cooperation is sincerely appreciated. | | | | |
| Please Check One:  Upon review of the above-named person’s health status, I believe they will likely return to their community home within six (6) months from the date above.  Upon review of the above-named person’s health status, I believe they are **NOT LIKELY** to return to a community home within six (6) months from the date above. | | | | |
| PHYSICIAN’S SIGNATURE | | | DATE | |

**DSHS 14-456 (REV. 07/2025)**