

**Instructions For Completing
HealthSystems of Mississippi Medicaid
Home Health Care Certification Request Form**

Section I Beneficiary Information

1. **Patient Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the patient's birth.
4. **Age** - Enter the age of the patient at the time service is to be rendered.
5. **Sex** - Indicate the sex of the patient.
6. **K-Baby** - Indicate if the patient is a K-baby.
7. **Mother's Name** - Enter the full name of the K baby's mother.
8. **Mother's Date of Birth** - Enter the month, date, and year of the mother's birth.

Section II Home Health Agency Information

1. **Agency Name** - Enter the name of the agency that will provide the care.
2. **Medicaid #** - Enter the agency's HSM assigned Pseudo-Provider number, if applicable. This number is assigned based upon a request from the agency to identify specific branches for autofax purposes. **It is to be used for requesting HSM certification only.** It is composed of the agency's Mississippi Medicaid (Billing) Provider number with an alphabet added to the end. Pseudo-numbers are not to be used for billing for services rendered. If a Pseudo-Provider number has not been assigned by HSM, enter the agency's Mississippi Medicaid (Billing) Provider Number.
3. **Address** - Enter the home health agency's complete mailing address or post office box, including city, state, and zip code.

Section III Contact Information for this Request

Agency Contact

1. **Request Date** - Record the date of the request.
2. **Agency Contact Person/Requester** - Enter the name of the individual who is primary contact at the Home Health Agency for this case.
3. **Telephone #** - Enter the contact person's telephone number, including area code and extension.
4. **Agency Fax #** - Enter the agency contact's fax number (if changed since previous request), including area code.

Primary Physician

5. **Name** - Enter the first and last name of the physician who is ordering the home health care.
6. **Mississippi Medicaid Billing Number or Medical License Number** - Enter the ordering physician's Mississippi Medicaid billing number **or** Mississippi medical license number.
7. **Telephone #** - Enter the physician's telephone number, including area code and extension.
8. **Date of Last Appointment** - Record the date of the patient's last visit to the primary physician.
9. **Date of Next Appointment** - Record the date of the patient's next scheduled visit to the primary physician.

Section IV Request Type

1. **Admission Review** - If the request is for admission, insert the following:
 - A. **Date of Assessment Visit** - Enter the date of initial assessment visit provided to patient.
 - B. **Date of Next Planned Visit** - Enter date of the next scheduled visit to provide home health service to patient.

NOTE: Attach a copy of the initial nursing assessment, last visit notes, plan of care and physician's orders for home, infusion, and/or enteral therapy.

2. **Continued Stay** - If the request is for continued stay review (certification for continuing services), complete the following:
 - A. **Existing Certification #** - Enter existing certification number.
 - B. **Date of Last Service Authorized** - Enter the date of last service authorized.
 - C. **Date of Next Planned Visit** - Enter the date of the next scheduled home health visit.

NOTE: Attach a copy of the most recent case conference/progress notes, clinical notes from the last visit prior to the (current) request for continued stay review certification and physician's orders for home, infusion, and/or enteral care.

4. **Retrospective** - Check box for retrospective review and complete the following, if applicable:
 - A. **ICN** - Internal Control Number

NOTE: A copy of the patient's home health medical record must be attached to this request form.

Section V. Medical Information

1. **Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K-baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
3. **Diagnoses/ICD-9-CM Codes** - Enter the patient's primary diagnosis and secondary diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.
4. **Clinical Summary** - Record information that describes why the patient requires home health care, including the following: patient's physical, cognitive, nutritional status (weight, height, ideal body weight), if skin breakdown, describe wound bed and size, amount and character of drainage, treatment & preventive measures and decubitus stage, if applicable. Include a record of vital signs, physical findings and pertinent lab results for the conditions requiring home care. If continued stay request, give update of clinical condition, new diagnoses, and progress towards achievement of goals since date of last request. Describe reasons why patient remains homebound.

NOTE: Attach a copy of the required medical record parts for each type of review request (Precertification, Emergency, or Continued stay) as above, Section IV.

5. **Equipment Used** - List any medical equipment the patient is currently using, if any.
6. **Primary Caregiver/Relation to Patient** - List the primary caregiver(s) and their relation to the patient. List any alternate caregivers that could assist with the patient's plan of care.
7. **Care Provided by Other Sources** - Describe any additional home care being provided by sources other than the home health agency requesting service certification. Include relationship of caregiver to patient (i.e., mother, sitter, church member, etc.) and type of service provided.
8. **Homebound Status** - Describe, as applicable, the patient's absences from home and anticipated date of outpatient service (MD office, rehab etc.). Describe activity status, mobility (i.e., distance ambulating).
9. **ADL's for which Assistance is Required** - List all ADL's the patient requires assistance to accomplish.
10. **Functional Limitations** - Describe any functional limitations the patient has requiring physical assistance.

Check the box(es) that describe all the patient's current functional limitations. If other, specify.

11. **Mental Status** - Check the box(es) that best describe the patient's current mental status. If other, specify.
12. **Home Environment** - Describe home environment, addressing whether home is safe, accessible and whether it can be modified to accommodate home plan of care, if applicable.
13. **Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K-baby, list baby's name.
14. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
15. **Orders for Services** - Attach a copy of the physician's order (signed or verbal) for home health. If visits are requested in support of infusion or enteral therapy, physician orders specifying the drug or product, route and frequency of administration must be included.
16. **Patient/Caregiver Capabilities and Compliance** – For patients, check box if patient and/or caregiver has sufficient cognitive and physical ability to learn necessary information or techniques, and agree to assist in the plan of care. For continued stay review, check the box that best describes the patient/caregiver: a) patient/caregiver is capable of learning necessary techniques and is generally compliant with the plan of care, **or** b) patient/caregiver is not capable of/willing to learn necessary techniques and/or is not compliant with the plan of care.
17. **Visits Requested** - Specify the home care disciplines needed, the time span and number of visits requested per week and measurable objectives for each discipline requested.
18. **RN Name and Signature** - Enter the name and signature of the nurse or RN Case Manager.