HealthSystems of Mississippi
175 E. Capitol Street
Suite 250, Lockbox 13
Jackson, MS 39201

HealthSystems of Mississippi Medicaid Home Health Care Certification Request Form

I. BENEFICIARY INFORMATION

PATIENT'S INFORMATION	K-BABY -CHECK BOX AND COMPLETE BELOW:
Patient/Baby Name: ______________________________ Medicaid #: ________________________________ Date of Birth: ___/____/____ Age:_____Sex: ____ (M or F)	☐ K-Baby - ***Check Here and complete the following:*** Mother's Name:_________________________ Mother's Date of Birth: ___________________

II. HOME HEALTH AGENCY INFORMATION

Agency Name : ______________________________________ MS Medicaid Provider #: _____________

Address: ______________________________________

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III. CONTACT INFORMATION FOR THIS REQUEST

AGENCY CONTACT	PRIMARY PHYSICIAN INFORMATION
Request Date: _______________________ Contact/Requester: Telephone #:(_____) ______ -________ Ext.______ Fax #: (_____) ______ -_________	Name: ______________________________________ Medicaid Billing No. OR MS License #:____________ Phone #: (_____) ______ -_________ Ext._________ Date of Last Appointment with Beneficiary: ________ Date of Next Scheduled Appointment:______________

IV. REQUEST TYPE - Select one

☐ **Admission Review** – ***Attach Copy Of Initial Nursing Assessment, last Visit Notes and Plan Of Care***

Dates of:

Assessment Visit:_____/_____/____

Next Planned Visit: ____/____/_____

☐ No Additional Visits Planned

☐ **Continued Stay****

Existing Certification #: _______________________

Last Service Date Authorized: _____/______/______

Date of Next Planned Visit: ______/_______/______

Include all required copies. See form completion instructions.

*** If patient seen on "emergency" basis prior to certification by HSM, also provide information about the emergency.*

☐ **Retrospective Review**

☐ Patient's Medicaid eligibility became effective retroactively during admission or after discharge.

ICN (If applicable): ____

Complete this form and attach a copy of the medical record, including all nurses, PT & ST notes.

Beneficiary Name: ______________________________ Medicaid #: ______________________________

V. MEDICAL INFORMATION	
DIAGNOSES FOR THIS ADMISSION	ICD-9-CM CODES
1.	
2.	
3.	

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 concurrent 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. *Attach all required copies as described in form completion instructions*

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NOTE: Please attach copy of physician's written and signed or verbal order for home health services. Orders are to include specified discipline(s), frequency of discipline(s), specific services to be performed by discipline(s) and length of need for services. If visits are required in support of infusion or enteral therapy, physician order specifying the drug or product, route and frequency of administration must be included. (Signed orders must be on file for QM audit).

List Medical Equipment Used By Patient (if any): ______________________________

Primary Caregiver/Relation to Patient:

____

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Care provided by other sources: *Describe care provided by sources other than HHA (paid or unpaid?). Include frequency and dates/days, if applicable.*

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Homebound Status: *Describe, when applicable: patient absences from home, anticipated date of outpatient service - MD office/rehab etc. Describe activity status, mobility, distance ambulated (i.e., number of feet)*

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Please List ADL's For Which Assistance is Required: ______________________________

Functional Limitations: (*Please Check Below if Applicable to this Patient)*

☐ Contractures ☐ Mobility deficit ☐ Paralysis/Hemiparesis ☐ Bowel/bladder incontinence
☐ Hearing deficit ☐ Speech deficit ☐ Limited Endurance ☐ Other (specify below)
☐ Legally blind ☐ Amputation ☐ Dyspnea with minimal exertion ______________________________

Mental Status: ☐ Oriented ☐ Forgetful ☐ Agitated ☐ Depressed ☐ Disoriented ☐ Comatose
☐ Other (describe) ______________________________

Home Environment: ***Describe home environment; address whether home is safe, accessible and can accommodate home plan of care (or can be modified).*** ______________________________

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Beneficiary Name: ____ Medicaid #:____

Patient/caregiver capabilities and compliance with care:

Patient: ☐ Patient/caregiver has sufficient alertness, physical ability and agrees to learn necessary techniques

Concurrent Request: **a.** ☐ Patient/caregiver is capable of learning techniques and is generally compliant with Plan of Care

b. ☐ Patient/caregiver is not capable of/willing to learn necessary techniques, is not compliant with Plan of Care

Discipline	Skilled Interventions Planned	Time Span (Dates) From	To	Frequency of Visits	Total # Visits Requested
HHSK	☐ Bowel/bladder management ☐ Cardiorespiratory management ☐ Clinical Assessment ☐ Diabetes Teaching (new Dx.) ☐ End stage disease/symptom management ☐ Infusion therapy ☐ Management and evaluation of care plan ☐ Nutritional support/tube feedings/enteral therapy ☐ Ostomy management ☐ Pain Management ☐ Periodic reassessment ☐ Psychiatric evaluation/therapy ☐ TPN ☐ Urinary catheter care ☐ Venipuncture (only with other qualifying service or with skilled assessment/lab values management) ☐ Wound management ☐ Other (describe)____________________	___/___/___	___/___/___		
		Goals/Objectives:			
HHPT	☐ PT evaluation ☐ Therapeutic exercises ☐ Gait training ☐ Treatments (List) ____________________ ☐ Other (describe) ____________________	From: ____/____/___	To: ____/____/___	Frequency of Visits	Total # Visits Requested
		Goals/Objectives:			
HHST	☐ ST Evaluation ☐ Treatment of swallowing disorders ☐ Therapy/training for voice/communication disorders	From: ____/____/___	To: ____/____/___	Frequency of Visits	Total # Visits Requested
		Goals/Objectives:			
HHAD	☐ Personal care ☐ Assistance with rehab therapy services ☐ Other (list) ____________________	From: ____/____/___	To: ____/____/____	Frequency of Visits	Total # Visits Requested

Name and Signature of Nurse or RN Case Manager: ____

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