HealthSystems of Mississippi
175 E. Capitol Street
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Jackson, MS 39201

HealthSystems of Mississippi
Private Duty Nursing
PDN Agency Plan of Care Form

BENEFICIARY INFORMATION

BENEFICIARY'S INFORMATION	PARENT'S INFORMATION
Beneficiary Name: ______	Parent or Caregiver Name: ______
Mississippi Medicaid #: ______	Address: ______
Date of Birth: ______	______
Age: ______ Sex *(M or F):* ______	Phone #: ______

PDN AGENCY INFORMATION	AGENCY CONTACT INFORMATION
Agency Name: ______	Request Date: ______
Mississippi Medicaid Provider #: ______	Contact/Requester: ______
Address: ______	Phone #: ______ Ext. ______
______	Fax #: ______
______	

PRIMARY PHYSICIAN INFORMATION

Name: ______	Date Last Beneficiary Appointment: ______
Mississippi Medicaid Provider #: ______	Date Next Beneficiary Appointment: ______
Phone: ______ Ext. ______	

REQUEST TYPE - Select one

☐ Initial Request (Precertification) ☐ Continued Stay

Service Dates: From: ______ Thru: ______	Treatment Authorization # (TAN) *(If applicable):* ______
Service Level: ☐ RN ☐ LPN	Last Date Certified *(If applicable)*: ______
HCPCS Code: ______	

Proposed Schedule: *(Hours/day)*

S	M	T	W	T	F	S

Beneficiary Name: ____ Medicaid #:_______________________

MEDICAL INFORMATION

DIAGNOSIS (ES)	ICD-9-CM CODES
1.	
2.	
3.	
4.	

HOSPITALIZATION INFORMATION ***(If applicable)***

Hospital Name:

Hospital Admit Date: **Hospital Discharge Date:**

List skilled services to be provided by nurse: (Include the skilled teaching to be provided to the parent / caregiver.)

Nurse's Summary: *Record findings from nursing assessment. Include ventilator setting (mode, 02, tidal volume, PEEP, PIP, high and low alarm limits); treatments (dressing changes, suctioning, nebulizations, trach/G tube care, CPT); gastrointestinal feeding (name, amount, frequency, bolus or continuous, * please indicate if feedings are supplemental); current medications (name, dosage, frequency, route) and vital signs.* ***If this is a continued stay request, you may attach monthly summary(ies) covering prior certification period in place of completing this section.***

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 w/ minimal exertion	

Mental Status (*Please Check Below if Applicable to this Patient)*

☐ Oriented	☐ Forgetful	☐ Agitated	☐ Depressed
☐ Disoriented	☐ Comatose	☐ Other (Describe):	

Beneficiary Name: ____ Medicaid #:______________________

List reason(s) beneficiary is considered homebound. ______________________________

____

____

List ADL's for which assistance is required: ______________________________

____

____

Goals: ______________________________

____

____

Identify all other home care services currently being provided: (*Case Management, Physical Therapy, Speech Therapy, Occupational Therapy, Respite, Hospice, Respiratory Therapy, Home Health, personal care attendant, etc. to include hours, days, and times services are being provided*): ______________________________

____

____

Medical Equipment / Supplies Used By Patient	

Onsite home evaluation date:

Home Environment: *(Describe home environment; address whether home is safe, accessible and can accommodate the plan of care in the home):*

____

____

____

____

____

Please describe the plan for reducing and/or discontinuing PDN services: ______________________________

____

____

____

If applicable, please describe plan to transition beneficiary to most appropriate setting when PDN criteria are no longer met:

____

____

Please answer the following questions:

Yes	No	
☐	☐	Does the parent/caregiver have a reasonable plan for an emergency situation? (Power and equipment backup for those with a life support device)
☐	☐	Does the parent/caregiver have a working telephone?
☐	☐	Does the parent/caregiver have transportation available?
☐	☐	Is the beneficiary's home environment conducive to appropriate growth and development for the beneficiary's age group and conducive to the provision of appropriate medical care?

Beneficiary Name: ____ Medicaid #:_______________________

Agency RN Attestation, Signature and Date

I certify that the private duty nursing services requested on this form are those exact items ordered and certified by the ordering physician, and that these exact private duty nursing services will be delivered to the beneficiary specified on this form. A private duty nursing agency who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

____ ________________________________

Signature of Agency RN **Date**

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