

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)	<input type="checkbox"/> K-Baby - <i>Check Here and complete the following:</i> Mother's Name: _____ Mother's Date of Birth: _____

II. HOME HEALTH AGENCY INFORMATION

Agency Name : _____ MS Medicaid Provider #: _____
 Address: _____

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

<input type="checkbox"/> Precertification – <i>Attach Copy Of Initial Nursing Assessment Visit Notes And Plan Of Care</i> Dates of: Assessment Visit: ___/___/___ Next Planned Visit: ___/___/___ <input type="checkbox"/> No Additional Visits Planned	<input type="checkbox"/> Emergency ** Dates of: Assessment Visit: ___/___/___ Next Planned Visit: ___/___/___ <input type="checkbox"/> No Additional Visits Planned
<input type="checkbox"/> Concurrent ** Existing Certification #: _____ Last Service Date Authorized: ___/___/___ Date of Next Planned Visit: ___/___/___ <i>Include all required copies. See form completion instructions.</i> <small>** If patient seen on "emergency" basis prior to concurrent certification by HSM, also provide information about the emergency.</small>	<i>Indicate the reason(s) for emergency services:</i> <input type="checkbox"/> Request for emergency services received from doctor's office <input type="checkbox"/> Delay of service would lengthen patient's hospital stay Other (describe): _____ _____

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*

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:

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

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)*

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

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Mobility deficit | <input type="checkbox"/> Paralysis/Hemiparesis | <input type="checkbox"/> Bowel/bladder incontinence |
| <input type="checkbox"/> Hearing deficit | <input type="checkbox"/> Speech deficit | <input type="checkbox"/> Limited Endurance | <input type="checkbox"/> Other (specify below) |
| <input type="checkbox"/> Legally blind | <input type="checkbox"/> Amputation | <input type="checkbox"/> 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).* _____