

HealthSystems of Mississippi
175 E. Capitol Street
Suite 250, Lockbox 13
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: _____			Phone #: _____			
Age: _____ Sex (<i>M or F</i>): _____						
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						
<input type="checkbox"/> Initial Request (Precertification)			<input type="checkbox"/> Concurrent			
Service Dates: From: _____ Th _____ ru: _____			Treatment Authorization # (TAN) (<i>If applicable</i>): _____			
Service Level: <input type="checkbox"/> RN <input type="checkbox"/> LPN			Last Date Certified (<i>If applicable</i>): _____			
HCPCS Code: _____						
Proposed Schedule: (<i>Hours/day</i>)						
S	M	T	W	T	F	S

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

<input type="checkbox"/> Oriented	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Agitated	<input type="checkbox"/> Depressed
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Comatose	<input type="checkbox"/> Other (Describe): _____	

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:

Beneficiary Name: _____

Medicaid #: _____

Please answer the following questions:		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Does the parent/caregiver have a reasonable plan for an emergency situation? (Power and equipment backup for those with a life support device)
<input type="checkbox"/>	<input type="checkbox"/>	Does the parent/caregiver have a working telephone?
<input type="checkbox"/>	<input type="checkbox"/>	Does the parent/caregiver have transportation available?
<input type="checkbox"/>	<input type="checkbox"/>	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?

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

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

Beneficiary Name: _____

Medicaid #: _____