Revised Medical Request for Home Care Form (M-11q)

The Medical Insurance and Community Services Administration’s Home Care Services Program (HCSP) is introducing a revised Medical Request for Home Care form M-11q. The revised form has been approved by the NYSDOH, and it should be used to request personal care Level I/II. The form is effective immediately. The HCSP will continue to accept the current M-11q form until April 1, 2010. The changes to the current form are listed below:

1. Three sections of the M11Q have been eliminated ("Impairment," "Mental Status," and "Identification of Service Needs"). These three sections are covered in more depth and with more specificity in the Nurse’s Assessment (form 27R).

2. The following two questions have been added to Section D of the revised form.
   A. "Based on the medical condition, do you recommend the provision of services to assist with personal care and/or light housekeeping tasks?"
   B. "Please indicate contributing factors and any other information that may be pertinent to the patient’s need for assistance with personal care tasks?"

3. The Additional Comments section has been moved to section G.

Providers can obtain a copy of the revised M11q (10/09) form by calling the HCSP at (212) 896-5713. Providers are encouraged to reproduce the form for their use.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF
## MEDICAL REQUEST FOR HOME CARE

**GSS District Office**

**Attn: Case Load No.**

RETURN COMPLETED FORM TO:

**Address**

**Boro**

**Date Returned/Received by GSS**

**FOR GSS USE ONLY**

<table>
<thead>
<tr>
<th>PATIENT'S NAME</th>
<th>BIRTHDATE</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>MEDICAID NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME ADDRESS (No. &amp; Street)</td>
<td>BORO</td>
<td>ZIP CODE</td>
<td>TELEPHONE NO.</td>
</tr>
<tr>
<td>Hospital/Clinic Chart No.</td>
<td>Contact Person</td>
<td>Contact Tel. No.</td>
<td></td>
</tr>
</tbody>
</table>

**II. MEDICAL STATUS**

**PATIENT'S MEDICAL RELEASE:** I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA Dept. of Social Services in connection with my request for home care.

**DATE:**

**SIGNATURE(X):**

**How long have you treated the patient?**

**Date of this examination:**

**Place of this Examination:**

**Date of next examination:**

### A. CURRENT CONDITION

**DATE OF ONSET**

Check(✓) prognosis of each

<table>
<thead>
<tr>
<th>1. PRIMARY DIAGNOSIS/ ICD CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. SECONDARY DIAGNOSIS/ ICD CODE</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
</tbody>
</table>

### B. HOSPITAL INFORMATION

- CURRENTLY IN:
  - (Hospital Name)

**ADMISSION DATE:**

**EXPECTED DATE OF DISCHARGE:**

### C. MEDICATION

<table>
<thead>
<tr>
<th>DOSAGE</th>
<th>ORAL OR PARENTERAL</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>6.</td>
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<tr>
<td>7.</td>
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</tbody>
</table>

**INDICATE PATIENT'S ABILITY TO TAKE MEDICATION:** (*)

1. [ ] can self-administer
2. [ ] needs reminding
3. [ ] needs supervision
4. [ ] needs help with preparation
5. [ ] needs administration

(*) If patient CANNOT self-administer medication

(a) can he/she be trained to self-administer medication? [ ] Yes [ ] No If No, indicate why not:

(b) What arrangements have been made for the administration of medications?
D. MEDICAL TREATMENT

Does the patient receive any of the following medical treatment? Indicate medical treatment currently received: (✓)

1. Decubitus Care
2. Dressings: Sterile Simple
3. Bed bound care (turning, exercising, positioning)
4. Ambulation exercise
5. ROM/Therapeutic exercise
6. Enema
7. Colostomy care
8. Ostomy care
9. Oxygen administration
10. Catheter care
11. Tube irrigation
12. Monitor vital signs
13. Tube feedings
14. Inhalation therapy
15. Suctioning
16. Speech/hearing/therapy
17. Occupational therapy
18. Rehabilitation therapy
19. Indicate any special dietary needs
20. Other

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

\__________________________________________________________________________
\__________________________________________________________________________

Based on the medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Please indicate contributing factors (e.g. limited range of motion, muscular motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care services tasks.

\__________________________________________________________________________
\__________________________________________________________________________

Can patient direct a home care worker? ☐ Yes ☐ No If No, explain below.

\__________________________________________________________________________

E. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

<table>
<thead>
<tr>
<th>Cane</th>
<th>Crutches</th>
<th>Walker</th>
<th>Wheelchair</th>
<th>Hospital Bed</th>
<th>Side Rails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has</td>
<td>Needs</td>
<td>Ordered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedpan/Urinal</td>
<td>Commode</td>
<td>Diapers</td>
<td>Hoyer Lift</td>
<td>Dressings</td>
<td>Respiratory Aids</td>
</tr>
</tbody>
</table>

If any needed equipment was not ordered, what other plans have been made to meet this need?

\__________________________________________________________________________
\__________________________________________________________________________

Revised 10/09
F. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, Hospice, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program?

<table>
<thead>
<tr>
<th>Identify AGENCY</th>
<th>SERVICE</th>
<th>STATUS OF SERVICE</th>
<th>REFERRAL DATE</th>
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G. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care. If necessary, please attach an additional sheet(s) explaining the patient's condition in greater detail.

<table>
<thead>
<tr>
<th>Signature of Person Completing Additional Comments Section</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
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</table>

PHYSICIAN'S CERTIFICATION

I, THE UNDERSIGNED PHYSICIAN, CERTIFY THAT THIS PATIENT CAN BE CARED FOR AT HOME, AND THAT I HAVE ACCURATELY DESCRIBED HIS OR HER MEDICAL CONDITION, NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PART 515, 516, 517, AND 518 OF TITLE 18 NYCCR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM, PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES WHEN MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

(Print) Physician's Name ___________________________ Specialty ___________________________ Physician's Signature ___________________________

Intern ______ Resident ______

SIGNATURE DATE MUST BE WITHIN THIRTY DAYS AFTER MEDICAL EXAM OF PATIENT.

Date Form Completed ___________________________ Registry No. ___________________________ Telephone No. ___________________________ Hospital Contact Person ___________________________ Telephone No./ E-mail ___________________________

Indicate where form was completed:

Hospital/Clinic/Inst. Name ___________________________ Address ___________________________ Telephone No. / E-mail ___________________________

If Nurse/social worker/other person assisted in completing this form:

Name ___________________________ Title ___________________________ Address ___________________________ Telephone No. / E-mail ___________________________