PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

COMPLETE ALL ITEMS ***"INCOMPLETE FORMS MUST BE RETURNED TO PHYSICIAN"***

1. Patient Identifying Information

Patient Name:_____ CIN:_____

Patient Address:_____ d/o/b:_____Sex_____

_____ Patient Telephone #:_____

_____ Patient Medicare #:_____

Contact Person:_____

Contact Phone #:_____

If currently hospitalized

Name of Hospital:_____ Date of Admission:_____ Anticipated date of Discharge:_____

To Above address? ☐ Yes ☐ No If No explain)_____

2. General Information:

DATE OF EXAMINATION::_____ Place of Exam:_____

Physician's Name: _____ License #:_____Telephone #:_____

Physician's Address_____City_____State_____Zip Code_____

If the examination was conducted by a Physician's Assistant, specialist's Assistant, or Nurse Practitioner, Identify:

Name:_____Profession:_____License #_____

3. Medical Findings

NOTE: Indicate N/A if an item does not apply to this patient or Unk if the requested information is unknown to the physician signing this form

For the condition(s) requiring personal care: Height:_____ Weight:_____

Primary Diagnosis:_____ICD-10-CM Code_____

Secondary Diagnosis:_____ ICD-10-CM Code_____

Describe the patient's current medical/physical condition:_____

_____

Is the patient's condition stable? ☐ Yes ☐ No

Is patient appropriate for Hospice care? ☐ Yes ☐ No

Describe the current treatment plan and therapeutic goals including the prognosis for recovery:_____

_____

Describe any prohibited activities or functional limitations:_____

_____

_____

Is the patient self directing? ☐ Yes ☐ No

Is the patient able to summon help by any means? ☐ Yes ☐ No

If no, explain:_____

Is the patient able to ambulate independently? ☐ Yes ☐ No With devices? ☐ Yes ☐ No

Other Assistance? ☐ Yes ☐ No Describe Device or Assistance: _____

Patient's Name _____

Is patient continent of bowel? ☐ Yes ☐ No Is patient continent of bladder? ☐ Yes ☐ No

Catheter/Colostomy Needs:_____

List all current medications (prescriptions and OTC) and note dosage and frequency and any special instructions (attach additional sheet if necessary):_____

_____

Can the patient self administer medications? ☐ Yes ☐ No

If the patient requires a modified diet or has other special nutritional or dietary needs, describe:_____

_____

Please indicate any task, treatments or therapies currently received or required by the patient:_____

_____

Does the patient require assistance with or provision of skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc)?

☐ Yes ☐ No If yes, please indicate specifics:_____

_____

Based on the medical condition, do you recommend the provision of service to assist with skilled tasks, personal care and/or light housekeeping tasks? ☐ Yes ☐ No

Contributing factors:

Describe contributing factors including but not limited to the social, family, home or medical (e.g. muscular/motor impairments, poor range of motion, decreased stamina, etc.) situation that may affect the patients ability to function, or may affect the need for home care or that may affect the patient's need for assistance with skilled tasks, personal care tasks and/or light housekeeping. Please include any other information that may be pertinent to the need for assistance with home care services.

_____

_____

IT IS MY OPINION THT THIS PATIENT CAN BE CARED FOR AT HOME. 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 PHYSICIANS'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AS PARTS 515, 516, 517 AND 518 OF TITLE 18 NYCRR 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 SERVCES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDTION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature:_____ **Date:**_____

Please note, NYS Department of Health requires that a Physician's Order for Personal Care/CDPAP Services be signed and dated by a New York State Medicaid enrolled physician.

SIGN AND RETURN COMPLETED FORM WITHIN 30 CALENDAR DAYS OF EXAMINATION TO:

NASSAU COUNTY DEPARTMENT OF SOCIAL SERVICES
ATTENTION: MEDICAL SERVICES
60 CHARLES LINDBERGH BLVD.
UNIONDALE, NEW YORK 11553
FAX NO: (516) 227-7449

(SEE INSTRUCTIONS ON REVERSE)

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES INSTRUCTIONS

COMPLETE ALL ITEMS. *(Attach additional sheets, if necessary).* INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN. INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT.

1. Patient Identifying Information

- **Patient Name.** Enter the patient's name.
- **CIN.** Found on the patient's Medical Assistance ID card.
- **Date of Birth.** Enter the patient's date of birth.
- **Sex.** Enter the patient's gender.
- **Address and telephone number.** Enter the patient's address and telephone number.
- **Medicare #.** Enter the patient's Medicare number if available.
- **If currently hospitalized.** If the patient is hospitalized at the time of completion of the physician's order, indicate the name of the hospital, date of admission, and anticipated date of discharge.
- **Discharge to above address.** If the patient is to be discharged to an address other than the address listed above please explain.
- **General Information**

Physician's Name, License #, Address, Telephone. Enter information for the physician signing the order. Enter either the physician's license number as issued by the New York State Department of Education or the provider billing number issued by the New York State Department of Health Medicaid Management Information System.

- **Examination conducted by other than a physician.** If patient was examined, and the order form completed by a physician's assistant, specialist's assistant, or nurse practitioner, complete the required information.
- **Place of Examination.** Indicate the location (office, clinic, home, etc) of the examination of the patient.
- **Date of Examination.** Enter the date the patient was examined. This must be within 30 days of the date the physician signed the form.

3. **Medical Findings**
Note: Indicate N/A if an item does not apply to this patient or Unk if the requested information is unknown to the physician signing this form.

- **Height, Weight.** Enter the patient's height and weight.
- **Primary and Secondary Diagnosis.** Enter the primary and secondary diagnosis with ICD-9-CM codes for the primary and secondary conditions which result in the patient being evaluated for home care services.
- **Describes the current condition.** Describe the patient's current medical/physical condition, including any relevant history.
- **Stability.** Check Yes if the patient's condition is not expected to show marked deterioration or improvement. A stable medical condition shall be defined as follows:

  (a) the condition is not expected to exhibit sudden deterioration or improvement; and
  (b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and
  (c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or
  (2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

- **Hospice.** If the patient's condition is terminal, indicate if the patient is appropriate for Hospice services.
- **Describe the current treatment plan.** Include therapeutic goals and prognosis for recovery and anticipated duration of the current treatment plan.
- **Limitations.** Indicate any functional limitations or prohibited activities.
- **Self-Directing.** Indicate if the patient is self-directing. Self-directing means that the patient is capable of making choices about activities of daily living, understanding the impact of the choices, and assuming responsibility for the results of the choices. A **No** response to this item should be reflected in the description of the patient's condition as documented in the applicable section.
- **Able to Summon Help.** Check **Yes** if the patient is able to summon assistance in an emergency situation by any means. If the patient is not able to summon assistance, check **No** and explain.
- **Ambulation.** Indicate the patient's ability to ambulate independently, or with the need for assistance or devices. Specify assistance/devices used or needed.
- **Bowel/Bladder.** Indicate if the patient is continent. Describe any catheter or colostomy needs.
- **Medications Required.** List all prescription and over-the-counter medications the patient is taking and note dosage, frequency and any special instructions.
- **Medication Administration.** Indicate the patient's ability to self-administer medications.
- **Dietary Needs.** Indicate if the patient has special nutritional or dietary needs, i.e. low salt or high potassium.
- **Tasks/Treatments/Therapies.** Indicate any tasks, treatments or therapies which the patient receives or requires in the home and describe.
- **Need for completion/assistance with skilled tasks.** If the patient requires assistance with skilled tasks including, but not limited to, glucose monitoring, wound care, vital signs, describe the need for such assistance.
- **Recommendation to provide assistance.** Check Yes if, in your opinion, the patient can be maintained in his or her home with provision of home care services.
- **Contributing factors to need for assistance.** Please indicate the functional deficits that support the need for the provision of home care services. Please include any pertinent information you may have regarding the patient's surroundings, physical condition or other factors that may affect the ability of the patient to function in the community or the patient's need for assistance with personal care tasks.

4. Physician's Signature/Date of completion. The signature of the ordering physician as identified in item 2. Note that by signing this document, the physician certifies that the patient's condition and needs are accurately described. Forms lacking a signature and/or date are not acceptable.

5. Return Form To. The local district or other case management entity to whom the form is to be returned.

IMMEDIATE NEED FOR PERSONAL CARE SERVICES/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES: INFORMATIONAL NOTICE AND ATTESTATION FORM

If you think you have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), such as housekeeping, meal preparation, bathing, or toileting, your eligibility for these services may be processed more quickly if you meet the following conditions:

- You have no informal caregivers available, able and willing to provide or continue to provide care;
- You are not receiving needed help from a home care services agency;
- You have no adaptive or specialized equipment or supplies in use to meet your needs; and
- You have no third party insurance or Medicare benefits available to pay for needed help.

If you don't already have Medicaid coverage, and you meet the above conditions, you may ask to have your Medicaid application processed more quickly by sending in: a completed Access NY Health Insurance Application (DOH-4220); the Access NY Supplement A (DOH-4495A or DOH-5178A), if needed; a physician's order for services; and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that does not include coverage for community-based long term care services, you must send in a completed Access NY Supplement A (DOH-4495A or , a physician's order for services and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that includes coverage for community-based long term care services, you must send in a physician's order for services and a signed *"Attestation of Immediate Need."

If you don't already have Medicaid coverage or you have Medicaid coverage that does not include coverage for community-based long term care services: All of the required forms (see the appropriate list, above) must be sent in to your local social services office or, if you live in NYC, to the Human Resources Administration (HRA). As soon as possible after receiving all of these forms, the social services office/HRA will then check to make sure that you have sent in all the information necessary to determine your Medicaid eligibility. If more information is needed, they must send you a letter, by no later than four days after receiving these required forms, to request the missing information. This letter will tell you what documents or information you need to send in and the date by which you must send it. By no later than 7 days after the social service office/HRA receives the necessary information, they must let you know if you are eligible for Medicaid. By no later than 12 days after receiving all the necessary information, the social services office/HRA will also determine whether you could get PCS or CDPAS if you are found eligible for Medicaid. You cannot get this home care from Medicaid unless you are found eligible for Medicaid. If you are found eligible for Medicaid and PCS or CDPAS, the social services office/HRA will let you know and you will get the home care as quickly as possible.

If you already have Medicaid coverage that includes coverage for community-based long term care services: The physician's order and the signed Attestation of Immediate Need must be sent to your local social services office or HRA. By no later than 12 days after receiving these required forms, the social services office/HRA will determine whether you can get PCS or CDPAS. If you are found eligible for PCS or CDPAS, the social services official/HRA will let you know and you will get the home care as quickly as possible.

The necessary forms may be obtained from your local department of social services or are available to be printed from the Department of Health's website at: http://www.health.ny.gov/health_care/medicaid/#apply

*Found on the back side of this page.

Attestation of Immediate Need
for
Personal Care Services/Consumer Directed Personal Assistance Services

I, _____ attest that I am in need of immediate Personal Care Services
(Name)
or Consumer Directed Personal Assistance Services.

I also attest that:

- no voluntary informal caregivers are available, able and willing to provide or continue to provide needed assistance to me;
- no home care services agency is providing needed assistance to me;
- adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers or wheelchairs, are not in use to meet, or cannot meet, my need for assistance; and
- third party insurance or Medicare benefits are not available to pay for needed assistance.

I certify that the information on this form is correct and complete to the best of my knowledge.

X _____ _____
SIGNATURE OF APPLICANT/ REPRESENTATIVE **DATE SIGNED**

Individuals Receiving Long Term Care Services
in a Nursing Home or Hospital Setting

If you are receiving long term care services in a nursing home or a hospital setting and intend to return home, you may have your eligibility for Personal Care Services or Consumer Directed Personal Assistance Services processed more quickly. Follow the directions on the previous page and fill in the information requested below.

I am in a nursing home or a hospital setting and have a date set to return home on _____.
DATE

Contact me or my legal representative by calling _____.