MEDICAL REQUEST FOR HOME CARE

Human Resources Administration
Department of Social Services

HCSP- M11Q 12/09/2014

GSS District Office _____ Attn: Case Load No._____

Return Completed Form to:

Address_____ Borough _____

Zip Code _____ Tel. No. _____

Date Returned to/Received byGSS

FOR GSS USE ONLY

1. CLIENT INFORMATION

Patient's Name	Birthdate	Social Security Number		Medicaid No.
Home address (No. & Street)		Borough	Zip Code	Telephone No.
Hospital/Clinic Chart No.	II. MEDICAL STATUS	Contact Person		Contact Tel. No.

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	Anticipated Recovery 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. Primary Diagnosis/ ICD Code			
	2. Secondary Diagnosis/ ICD Code			
	3.			
	4.			
	5.			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN:
(Hospital Name)_____

Admission Date: _____

Reason for Hospitalization: _____

Expected Date of Discharge:

C. MEDICATION	Dosage	Oral or Parenteral	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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? ☐ Yes ☐ No
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.

	Has	Needs	Ordered
Cane			
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

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

_____

_____

_____

SSN: _____

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? Yes ☐ No ☐

*IDENTITY AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

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.

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	

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 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, 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 ____

*Business Address _____ *City _____ *State _____ *Zip Code _____

Signature date must be within thirty days after medical exam of patient.

*Date Form Completed _____ *Registry Number _____ *NPI Number _____ *Physician's Telephone _____ Physician's E-mail _____

Indicate where form was completed:

Hospital/Clinic/Institution Name _____ Address _____ Telephone No. / E-mail _____

If Nurse /Social Worker/other person assisted in completing this form:

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

*Mandatory

NYC Human Resources Administration Department of Social Services
HCSP-712b 12/09/2014

* Please provide this sheet to the physician filling out the Medical Request for Home Care (M-11Q).

Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care (M-11Q)

1. The client's name, address and Social Security number must be provided.
2. The medical professional must complete the M-11Q by accurately describing the patient's medical condition.
3. The medical professional must not recommend or request the number of hours of personal care services.
4. The M-11Q must be signed by a NY State licensed physician.
5. The date of the examination must be provided.
6. The physician must sign and date the M-11Q within 30 days after the exam date.
7. The registry number, NPI (national provider ID), and the complete business address of the physician must be indicated.
8. The completed signed copy of the M-11Q must be forwarded within 30 calendar days after the medical examination.

DOH-4359 (2010)

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

COMPLETE ALL ITEMS *INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN*

1. Patient Identifying Information *(Use Additional Paper If Necessary)*

PATIENT NAME	CIN	DATE OF BIRTH	SEX

ADDRESS: APT/STREET	CITY	STATE	ZIP CODE

TELEPHONE NO. ( )	MEDICARE NO.	IF CURRENTLY HOSPITALIZED: Name of Hospital	DATE OF ADMISSION:	ANTICIPATED DATE OF DISCHARGE

TO ABOVE ADDRESS? ☐ YES ☐NO IF NO EXPLAIN: _____

2. General Information

PHYSICIAN NAME	LICENSE #	TELEPHONE NO. ( )

ADDRESS: STREET	CITY	STATE	ZIP CODE

If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify:
Name _____ Profession: _____ License # _____

PLACE OF EXAMINATION: _____

DATE OF EXAMINATION: _____

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: _____

For the condition(s) requiring personal care:

Primary Diagnosis _____ ICD-9-CM Code _____

Secondary Diagnosis _____ ICD-9-CM Code _____

Describe the patient's current medical/physical condition _____

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

Is the 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: _____

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

Catheter/Colostomy Needs: _____

List all current medications (prescription 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:

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 patient's 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 THAT 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 PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT 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, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature _____ Date _____

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

_____

_____

_____

_____

_____

_____

New York State Department of Health

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. I**f 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.