MEDICAL REQUEST FOR HOME CARE

NYC 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