GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DHCF Transmittal No. 11- 21

Officer of the Director

TO: **Physicians and Hospitals Enrolled in the District of Columbia Medicaid Program**

FROM: **Linda Elam, PhD, MPH**
Deputy Director, Medicaid

DATE: **July 8, 2011**

SUBJECT: **Revision of Form for Ordering Medicaid Personal Care Aide Services (previously sent in DHCF Transmittal No. 11-13 dated May 27, 2011)**

It has been called to the Department of Health Care Finance's attention that that when the *Prescription Form for Medicaid Personal Care Aide Services* (sent to you on May 27, 2011 in DHCF Transmittal No. 11-13) is faxed to the Home health Agency that is to provide the service, the shaded sections that the ordering physician or nurse practitioner is to complete can sometimes be unreadable. Therefore, we have revised the original Prescription Form for Medicaid Personal Care Aides Services by removing the shading and inserting instructions that relate to numbered, rather than shaded, boxes.

Please use the attached, new version of the form in place of the older, shaded version. As before, the ordering physician or nurse practitioner is to complete all sections of the form, with the exception of section (3), Health Insurance Coverage and section (7), Procedure Code. The home health provider agency is responsible for completing sections (3) and (7).

Thank you in advance for your cooperation. Please contact Pamela L. Hodge, Management Analyst at 202-724-4282 or Pamela.hodge@dc.gov, if you have any questions.

Attachment:
Prescription Form for Medicaid Personal Care Aide Services

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION FORM FOR MEDICAID PERSONAL CARE AIDE SERVICES

Physician / Nurse Practitioner (NP) is to complete all sections except sections 3 and 7 and transmit to home health agency as the order for personal care services. Sections 1, 2, 4, 5, 6, and 8-13 are NOT to be completed by home health agency.

1 PATIENT INFORMATION			2 ORDERING PHYSICIAN / NP INFORMATION	
A. PATIENT D.C. MEDICAID NUMBER:			A. NPI NUMBER: B. DC MEDICAID PROVIDER NUMBER:	
B. NAME (LAST, FIRST, M.I.) PRINT			C. NAME (LAST, FIRST, M.I.) PRINT	
C. PERMANENT ADDRESS			D. ADDRESS	
D.TELEPHONE NUMBER	E. DATE OF BIRTH	F. SEX M ☐ F ☐	E. TELEPHONE NUMBER	F. FAX NUMBER

3 IS THERE OTHER HEALTH INSURANCE COVERAGE: Y N If yes, please provide the following: (To be completed by Home Health Agency providing personal care services)	4 DATE OF ORDER: 5 PATIENT LOCATION AND ADDRESS ON DATE OF ORDER: HOME: HOSPITAL (name): NURSING FACILITY(name): ICF/MR(name): OTHER (name): IF IN A FACILIITY, EXPECTED DATE OF DISCHARGE: ADDRESS TO WHICH PATIENT WILL BE DISCHARGED :
PLAN NAME AND POLICY NUMBER:	
NAME OF POLICYHOLDER:	
PLAN ADDRESS AND PHONE #:	

PRESCRIPTION

6 ICD DIAGNOSIS CODE(S)	7 PROCEDURE CODE (to be completed by home health agency provider of personal care services)	8 DESCRIPTION OF PERSONAL CARE SERVICES TO BE PROVIDED: e.g., bathing, feeding, and transferring.	9 Estimated # of days needed per week :	10 Estimated # of hours per day	11 Expected duration of need

12 JUSTIFICATION. ORDERING PHYSICIAN / NP MUST SPECIFY:

A) Diagnosis(es) causing patient's disability(ies):

B) Functional disability/ies of patient. (NOTE: personal care services are available only to individuals with functional limitations in one or more of the following activities: bathing, toileting, dressing, eating, getting in and out of bed, and taking medication prescribed for self-administration. Please write below which of these disabilities are present in this patient.

13. SIGNATURE OF ORDERING PHYSICIAN / NP – I CERTIFY THAT THE SERVICES REQUESTED ABOVE ARE MEDICALLY INDICATED AND PART OF MY TREATMENT PLAN FOR THIS PATIENT, AND THAT THE FOREGOING INFORMATION IS ACCURATE AND COMPLETE.

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Signature **Date**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DHCF Transmittal No. 11- 18

Officer of the Director

TO: **Home Health Agencies Enrolled in the District of Columbia Medicaid Program**

FROM: **Linda Elam, PhD, MPH**
Deputy Director, Medicaid

DATE: **Friday June 24, 2011**

SUBJECT: Revision of Form for Ordering Medicaid Personal Care Aide Services, DHCF Transmittal No. 11-10 dated May 25, 2011

A number of you have called to our attention that when the *Prescription Form for Medicaid Personal Care Aide Services* (sent to you on May 25, 2011) is faxed, the shaded sections the physician and advance nurse practitioner are to complete and sign are unreadable. Therefore, we have revised the original Prescription Form for Medicaid Personal Care Aides Services by removing the shading and inserting instructions that relate to numbered, rather than shaded, boxes.

Please replace the older, shaded version of the form with the attached, new one. As before, the physician or nurse practitioner is to complete all sections of the form, with the exception of section (3), Health Insurance Coverage and section (7), Procedure Code. The home health provider agency is responsible for completing sections (3) and (7).

Thank you in advance for your cooperation. Please contact Pamela L. Hodge, Management Analyst at 202-724-4282 or Pamela.hodge@dc.gov, if you have any questions.

Attachment: *Prescription Form for Medicaid Personal Care Aide Services*