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

Physician / Nurse Practitioner (NP) is to complete shaded sections and transmit to home health agency as the order for personal care services. Shaded sections 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:**
PLAN NAME AND POLICY NUMBER:	**HOME:** **HOSPITAL (name):**
NAME OF POLICYHOLDER:	**NURSING FACILITY(name):** **ICF/MR(name):** **OTHER (name):**
PLAN ADDRESS AND PHONE #:	**IF IN A FACILITY, EXPECTED DATE OF DISCHARGE:** **ADDRESS TO WHICH PATIENT WILL BE DISCHARGED :**

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**