

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Senior Deputy Director/Medicaid Director

Transmittal # 17-01

TO: Long Term Care Services and Supports Providers

FROM: Claudia Schlosberg, J.D. 
Senior Deputy Director and State Medicaid Director

DATE: January 12, 2017

SUBJECT: **Revised Prescription Order Form (POF) for Long Term Care Services and Supports (LTCSS)**

The Department of Health Care Finance (DHCF) is revising its process and format for the Prescription Order Form (POF) to establish standards governing the assessment process for the level of need for beneficiaries who receive Long Term Care Services and Supports (LTCSS).

As of February 1, 2017 Delmarva Foundation will be phasing out the current POF (version 4/21/15). As a result, starting in February, Delmarva will accept a new POF (version 4/06/16) in addition to the current POF. Effective April 1, 2017 Delmarva will no longer accept the current POF.

The accompanying form (version 4/06/16) – which is being distributed with this transmittal – will be used to initiate the face-to-face assessment for the following LTCSS: the Elderly and Persons with Physical Disabilities Waiver (EPD Waiver), Adult Day Health Program (ADHP) under the 1915(i) State Plan Option, Personal Care Aide (PCA) services available under the District's Medicaid State Plan and EPD Waiver, and nursing homes. The POF and subsequent assessment process is not applicable to Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities and Home and Community-Based Services for Individuals with Intellectual and Developmental Disabilities (IDD Waiver).

The POF is to be completed by Medicaid-enrolled physicians and advanced practice registered nurses (APRNs) as a requirement for receiving Medicaid-funded LTCSS. The form is divided into three sections, and each section contains information that is **required** for processing. This required information is detailed on the POF instruction sheet, and is also highlighted with a double asterisk on the form itself for easy identification. As clarification, a POF can only be

used to initiate one assessment. Further, the physician/APRN signature is valid for twelve (12) months from the date of signature.

Please note that all referring providers must be enrolled as a DC Medicaid Provider as stated above. DHCF has a streamlined application process for ordering and referring providers, which can be accessed at <https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/14934>. Providers who enroll as ordering and referring providers ONLY will not receive payment for any claims submitted, and will not be included in the Medicaid-eligible provider directory. The new version of the POF is available on DHCF's website in the Provider Information and Forms section: <http://dhcf.dc.gov/page/provider-information-and-forms>.

Please feel free to refer to the LTCSS rule posted on DHCF website. Questions regarding this transmittal should be directed to Ieisha Gray, Director, Long Term Care Administration, by telephone at 202.442.5818 or email at Ieisha.Gray@dc.gov.



DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION ORDER FORM (POF) GUIDE



This cover sheet provides guidance to physicians and advanced practice registered nurses (APRNs) on how to complete the attached Prescription Order Form (POF), which is required by the District of Columbia's Department of Health Care Finance (DHCF) to receive Medicaid-funded long term care services and supports.

Section I: Patient Information

This section provides information on the individual seeking Medicaid-funded long term care services and supports. The following is REQUIRED for the Department of Health Care Finance to process this form:

- Patient DC Medicaid Number (*8 digits*)
- Name (*First, Last*)
- Date of Birth
- Telephone Number

If there are special instructions for contacting this patient, please include these in this section.

Section II: Physician/APRN Information

This section provides information on the physician/APRN ordering Medicaid-funded long term care services and supports for the individual referenced in Section 1. Please note that all referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers, which can be obtained at <https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/10327>. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted, and will not be part of the Medicaid-eligible providers' directory.

The following is REQUIRED for the Department of Health Care Finance to process this form:

- Provider Name (*First, Last*)
- DC Medicaid Provider Number (*8 digits*)
- Telephone Number

Section III: Determining Need for Services

This section provides information on the individual's need for long term care services and supports, which include:

- case management,
- personal care aide,
- homemaker,
- chore aide,
- personal emergency response,
- assisted living,
- **occupational therapy (need MD signature),**
- **physical therapy (need MD signature),**
- adult day health,
- environmental accessibility adaptation, and
- nursing home.

Parts A and B of this section are REQUIRED for the DHCF to process this form. Part C allows the provider to note any changes in the patient's medical condition. Part D allows the provider to detail the reason for the referral (e.g., patient is being discharged and needs assistance at home, patient could benefit from day activities, etc.). **Note:** Occupational and physical therapy must be ordered by a doctor.

The ordering physician/APRN's signature on this POF certifies the individual's need for long term care services and supports.

Please ensure that all mandatory fields noted with ** are filled out—this will prevent delays in your patient's connection to services. The completed form must be faxed to the Delmarva Foundation at 202-698-2075.



**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
 PRESCRIPTION ORDER FORM (POF)
 FOR LONG TERM CARE SERVICES AND SUPPORTS**



This completed form must be faxed to the Delmarva Foundation at 202-698-2075.

SECTION I: PATIENT INFORMATION

A. **PATIENT D.C. MEDICAID NUMBER (8 digits)	B. **NAME (LAST, FIRST)	C. **DATE OF BIRTH: ____/____/____
Di. **TELEPHONE NUMBER _____ - _____ - _____	E. CURRENT ADDRESS	
Dii. SECONDARY TELEPHONE NUMBER _____ - _____ - _____	G. PERMANENT ADDRESS (if different than above)	
Fi. EMERGENCY CONTACT, NAME _____	G. PERMANENT ADDRESS (if different than above)	
Fii. TELEPHONE NUMBER _____ - _____ - _____		

SPECIAL INSTRUCTIONS

SECTION II: PHYSICIAN/APRN INFORMATION

A. **PROVIDER NAME (LAST, FIRST)	B. **DC MEDICAID PROVIDER NUMBER (8 digits)
C. **TELEPHONE NUMBER _____ - _____ - _____	D. NATIONAL PROVIDER IDENTIFIER NUMBER
E. PROVIDER ADDRESS	F. FAX NUMBER _____ - _____ - _____

SECTION III: DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s)/ICD-10 diagnosis(es):	B. **This patient is unable to independently perform the following (check all that apply): <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Overall Mobility <input type="checkbox"/> Eating <input type="checkbox"/> Medication Management <input type="checkbox"/> Using Telephone <input type="checkbox"/> Housekeeping <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Toilet Use
C. This patient's condition has changed significantly, as follows:	D. The reason for this referral to services is:

I have personally examined this patient. Based upon my professional opinion, long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN: _____ Date: ____/____/____