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*) (if available)
- 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 **www.dcpdms.com** by clicking, "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. 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 (*9 digits*) (if applicable)
- 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 (PCA),
- homemaker,
- chore aide,
- personal emergency response,
- assisted living,
- occupational therapy,
- physical therapy,
- adult day health program (ADHP),
- environmental accessibility adaptation, and
- nursing facility (NF).

Parts A and B of this section are REQUIRED for 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, ongoing ADHP or PCA, interest in enrolling in the Persons who are Elderly and Individuals with Physical Disabilities Waiver (EPD), NF, etc.). 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. Initial EPD applicants must fax the completed form to the ADRC at 202-724-2008. All other program requests 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

Initial EPD applicants must fax the completed form to the ADRC at 202-724-2008. All other program requests must be faxed to the Delmarva Foundation at 202-698-2075.

SECTION I: PATIENT INFORMATION

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

SECTION II: PHYSICIAN/APRN INFORMATION

A. **PROVIDER NAME (*LAST, FIRST*)	B. **DC MEDICAID PROVIDER NUMBER (*9 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*): ☐ Bathing ☐ Dressing ☐ Overall Mobility ☐ Eating ☐ Medication Management ☐ Using Telephone ☐ Housekeeping ☐ Meal Preparation ☐ Toilet Use
C. This patient's condition has changed significantly, as follows:	D. The reason for this referral to services is: (e.g. ADHP, PCA, Initial EPD, EPD Re-cert, NF)

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: _____/_____/_____

****These fields are required for the Department of Health Care Finance to process this form.**

[t] If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."