**MEDICAL REQUEST FOR HOME CARE**

| Return  Completed Address | | Borough |
| --- | --- | --- |
| Form to: |  |  |
| 1. CLIENT INFORMATION | Zip Code | Tel. No. |

HCSP- M11Q 12/09/2014

GSS District Office

Attn: Case Load No.

Date Returned to/Received byGSS

Date:

Signature(X)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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. |

FOR GSS USE ONLY

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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **A. CURRENT CONDITION** |  | **■D cn**  **8**  **c o = O < or co** | **2 -5 2^e 6 o** | **c**  **■2 c**  **03 O 5 \ o S -S r S c >**  **<U 4- Z3 Q Q O U 1** |
| Date of Onset | Check( ^ ) prognosis of each |
| 1. Primary Diagnosis/ ICD Code |  |  |  |  |
| 2. Secondary Diagnosis/ ICD Code | |  |  |  |
| 3. | |  |  |  |
| 4. | |  |  |  |
| 5. | |  |  |  |

How long have you treated the patient?

Date of this Examination:

Place of this Examination:

Date of next Examination:

B. HOSPITAL INFORMATION CURRENTLY IN: (Hospital Name)

Admission

Date:

Expected Date of Discharge:

Reason for

Hospitalization:

Indicate patient’s ability to take medication: (\*)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| C. MEDICATION | Dosage | Oral or Parenteral | Frequency | 1. □ Can self-administer 2. □ Needs reminding 3. □ Needs supervision 4. □ Needs help with preparation 5. □ Needs administration |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |

(\*) 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?

1. 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:

1. 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

\*Mandatory

Title

Address

Telephone No. / E-mail

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HCSP-M11-Q (12/09/2014)

EIGHT HELPFUL HINTS FOR ACCURATE COMPLETION OF THE MEDICAL REQUEST FOR HOME CARE (M11Q)

**Human Ra sources Administration** □opa 101001 of SQSalS^rviCSS

HCSP-712b 12/09/2014

\* Please provide this sheet to the physician filling out the Medical Request for Home Care (M-11Q).

Eight Helpful Hints for Accurate Completion of the  
Medical Request for Home Care (M-11Q)

1. The client’s name, address and Social Security number must be provided.
2. The medical professional must complete the M-11Q by accurately describing the patient’s medical condition.
3. The medical professional must not recommend or request the number of hours of personal care services.
4. The M-11Q must be signed by a NY State licensed physician.
5. The date of the examination must be provided.
6. The physician must sign and date the M-11Q within 30 days after the exam date.
7. The registry number, NPI (national provider ID), and the complete business address of the physician must be indicated.
8. The completed signed copy of the M-11Q must be forwarded within 30 calendar days after the medical examination.