THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

HSCSN Order for HOME HEALTH SERVICES

This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: **UM@hschealth.org**. **Medical records documenting the most recent face-to-face visit should be submitted with each request.**

IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.

DATE OF ORDER: Click here to enter a date.

PROVIDER	**ENROLLEE**
Ordering Provider (MD or NP): Click to enter text.	**Enrollee Name:** Click to enter text.
Provider NPI #: Click to enter text.	**Enrollee ID:** Click to enter text. **DOB:** Click to enter text.
Provider Phone #: Click to enter text. **Fax #:** Click to enter text.	**Primary Diagnosis: (Include ICD-10 code)** Click to enter text.
Provider Email: Click to enter text.	**Other Diagnoses:** Click to enter text.

OUTPATIENT vs HOME-BASED THERAPIES
Routine therapies are provided in an outpatient. Home-based therapies may be appropriate if the enrollee has difficulty getting in and out of the home or if the therapy addresses activities that are done in the home. Outpatient therapy can be authorized for up to 1 year. Home-based therapies are authorized for up to 60 days. Home-based therapies have limited availability.

SERVICE REQUESTED:
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech-Language Therapy ☐ Other Therapy:_____
☐ Outpatient ☐ Home-Based ☐ Outpatient if home-based not available

REASONS FOR REFERRAL:

GOALS OF THERAPY:

ACTIVITIES OF DAILY LIVING (Check the level of assistance needed)

Bathing: I☐ S☐ M☐ D☐ Toileting: I☐ S☐ M☐ D☐ Grooming: I☐ S☐ M☐ D☐ Dressing: I☐ S☐ M☐ D☐ Eating: I☐ S☐ M☐ D☐ Mobility-Ambulation: I☐ S☐ M☐ D☐ Bowel Incontinence: Yes ☐ No ☐ Bladder Incontinence: Yes ☐ No ☐	I=Independent (able to do it on their own) S=Requires supervision/prompting to minimal assistance M=moderate dependence (needs moderate physical assistance) D=dependent (requires maximal to total physical assistance)	**Safety Awareness/Judgment** ☐ Normal for Age ☐ Mildly Impaired ☐ Moderately Impaired ☐ Severely Impaired **Overall Need for Supervision** ☐ Independent (no supervision needed) ☐ Indirect (in home) ☐ Direct (line of sight) ☐ 1:1 Supervision

Signature of Ordering Provider: _____Date: _____
Printed Name: Click to enter text.