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

HSCSN Order for Home Care 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:

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

Caregiver (CG) Information:
CG Limitations (physical/cognitive/social):

☐Specify: _____

☐Single primary CG ☐CG Responsible for Additional Disabled Individual(s) In Home: _____ Other Dependents in Home: _____

☐Working primary CG ☐Full-Time ☐Part-Time Work Schedule:

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

TECHNOLOGY-DEPENDENCE and/or NEED FOR NURSING INTERVENTION

CARDIO-RESPIRATORY
Monitoring:
☐ When asleep ☐ 24 hrs./day
☐ Pulse Oximetry
☐ Apnea Monitor
Ventilatory Support:
☐ Ventilation Schedule: _____
☐ BiPAP/CPAP Schedule: _____
Supplemental Oxygen:
Delivery: ☐ NC ☐ TC ☐ Ventilation
Amount: _____ LPM _____ % ____ FIO2
Schedule: _____
Other Respiratory:
☐ Tracheostomy ☐ Suctioning
☐ Dysphagia/Aspiration precautions
☐ Chest physiotherapy
☐ Airway clearance device

Tube Feeding
☐ Tube: ☐ NGT ☐ GT ☐ GJT ☐ JT
Schedule:

Elimination
☐ Ostomy care – Schedule and provide details:

☐ Catheterization – Schedule:

Skin Care
☐ Wound care – Schedule:
☐ Other:

☐ Medications – Attach medication list

Neurological
☐ Seizures:
Frequency _____
☐ CSF Shunt
☐ IT Baclofen pump
☐ Motor Impairment (BR)
☐ Quadriplegia ☐ Diplegia/paraplegia
☐ Other

Cognitive Impairment/ Intellectual disability
☐ Mild ☐ Mod ☐ Severe ☐ Profound
Height: _____ Weight: _____
BMI:

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HOME-BASED THERAPY (Physical therapy, Occupational Therapy and Speech-Language Therapy)
See separate order form for Rehabilitative Therapies

SKILLED NURSING VISITS: These are typically visits by an RN lasting ½ to 4 hours and occurring intermittently.

Visit Frequency and Duration:

Reasons for nursing visits (check all that apply and provide explanation):

☐ Follow-up after Hospital Discharge / ED Visit: .

☐ Assessment (of what):

☐ Education & Training of Caregiver:

☐ Administration of medication/treatment:

☐ Wound care:

☐ Other:

HOME HEALTH AIDE (HHA) SERVICES: HHA services are for short-term, intermittent in-home care to assist with activities of daily living and/or assistance with tasks that can be delegated to a nurse's aide. Acceptable tasks include measuring temperature, pulse, respiratory rate, and blood pressure, measuring and recording height and weight, assisting with self-administered medications, changing urinary drainage bags, preparing meals, assisting with food consumption, changing simple dressings, and assisting with activities that are directly supportive of skilled therapy services. Typically requested due to illness or injury. HHA services must be re-authorized every 60 days. HHA services should not be used in lieu of childcare.

PERSONAL CARE AIDE (PCA) SERVICES: PCA services are long-term support services (LTSS). HSCSN refers to each enrollee (4 & older) being considered for PCA for an LTSS assessment by Liberty Healthcare. The primary purpose of PCA services is assistance with activities of daily living (ADLs). Based on review of documents submitted with the request, information from the Care Manager, and an independent nursing assessment, HSCSN will make a determination of hours. PCA is typically not appropriate for children under 4 years of age and should not be used in lieu of childcare. **Medical records documenting a face-to-face visit within 90 days of the order must be submitted along with the form.** If specific hours are being requested, then HSCSN also requires a rationale for hours being requested.

PRIVATE-DUTY NURSING (PDN): Shifts of nursing care typically provided by an LPN or RN to a person who is technology-dependent and requires skilled nursing intervention multiple times per day. Please include reasons for private-duty nursing services and justification of the hours being requested below or submit medical records that provide the justification.

REQUESTED SERVICES (check one):

☐ **HOME HEALTH AIDE** ☐ **PERSONAL CARE AIDE OR** ☐ **PRIVATE DUTY NURSING SERVICES**

Proposed Schedule (Indicate hours per day or timeframe):

☐ HSCSN to make determination of hours (PCA)

☐ Other, please explain:

☐ Monday-Friday _____ hours/day

☐ Saturday/Sunday _____ hours/day

☐ 8 hours overnight for awake/alert caregiver

RATIONALE FOR HOME CARE SERVICE REQUESTED:
If you are ordering HHA, PCA or PDN, please include reasons for the service and justification of hours being requested below.

Signature of Ordering Provider: _____ Date: _____

Printed Name: