HSCSN Order for HOME HEALTH SERVICES

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

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	**MEMBER**
Ordering Provider (MD or NP):	**Member Name:**
Provider NPI #:	**Member 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 CG
☐Working CG

☐CG Responsible for Additional Disabled Individuals (s) In Home Other Dependents in Home:

☐ Full-Time ☐Part-Time Work schedule:

Times when assistance PCA/Nursing is most needed:

ACTIVITIES OF DAILY LIVING (Circle level of assistance needed)

Bathing: I ☐ S☐ M☐ D☐ Toileting: I ☐ S☐ M☐ D☐ Grooming: (Check one) I ☐ S☐ M☐ D☐ Dressing: (Check one) I ☐ S☐ M☐ D☐ Eating: (Check one) I ☐ S☐ M☐ D☐ Mobility-Ambulation I ☐ S☐ M☐ D☐ Bowel Continence Yes ☐ No ☐ Bladder Continence 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 (check one)** ☐ Independent (no supervision needed) ☐ Indirect (in home ☐ Direct (line of sight) ☐ 1:1 Supervision

HOME-BASED THERAPY:
Order for Evaluation and Treatment:
☐Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech Therapy ☐Social Work (SW)
For PT, OT, ST, and SW, HSCSN will authorize an evaluation and 4 visits based on this order. Authorization of additional visits will depend on clinical information submitted by the home health care agency.

Reason for Referral:
Goals of Treatment:

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):

- ☐ Follow-up after Hospital Discharge / ED Visit
- ☐ Assessment
- ☐ Education & Training of Caregiver
- ☐ Administration of medication/treatment
- ☐ Wound care

Description of Member and Need for Nursing Visits:

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PERSONAL CARE AIDE (PCA) SERVICES: The primary purpose of PCA services is assistance with activities of daily living (ADLs). Based on review of documents submitted with request, information from the Care Manager, and when appropriate, an independent nursing assessment, HSCSN will make a determination of hours. Medical records documenting a face-to-face visit within 90 days of the order should 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 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 in medical records submitted.

REQUESTED SERVICES (check one):

☐ **PERSONAL CARE AIDE (PCA) SERVICES** ☐**PRIVATE DUTY NURSING**

Proposed Schedule: (Indicate hours per day or timeframe)

- ☐ HSCSN to make determination of hours OR
- ☐ School Days: ☐Monday-Friday hours/day
- ☐ Non-School Weekdays: ☐ Saturday/Sunday hours/day
- ☐ Weekends/Holidays:
- ☐ 8 hours overnight for awake/alert caregiver
- ☐ Other, please explain:

Is there any additional information you would like to provide:

TECHNOLOGY-DEPENDENT AND NEED FOR NURSING INTERVENTION

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

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

Elimination
☐ Ostomy care – Schedule and provide details:
☐ Catheterization - Schedule:

☐ **Medications – Attach medication list**

Skin Care
☐ Wound care – Schedule:

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:

RATIONALE FOR PCA OR PDN:
If you are ordering PCA or PDN, please include reasons for PDN and justification of hours being requested below.

Signature of Ordering Provider: Date:
Printed Name: