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| --- | --- |
|  | Case Name |
| MEDICAL NEEDS |  |
| Michigan Department of Health and Human Services**INSTRUCTIONS: To be completed annually by a physician, nurse practitioner, physical or occupation therapist. Please print or type.** | Case Number | Recipient ID Number |
|  |  |
| Patient’s Name | Patient’s Birth Date |
|  |  |
| County | District | Section | Unit | Specialist |
|  |  |  |  |  |
|  | Specialist | Specialist Phone Number |
|  |  |  |
|  | Medical Provider:We would appreciate your cooperation in completing the spaces checked below. In addition to a physician, Box A may be completed by a physician’s assistant, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist. Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience. |
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|  | You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services. |
| Patient’s or Representative’s Signature | Patient’s Name | Signature Date |
|  |  |  |
| Authorized Specialist’s Signature | Signature Date | Local MDHHS Office |
|  |  |  |
| ☐ A | Pregnancy Delivery (Expected) Date | Number of medically verified unborn children |
| ☐ B | Diagnosis(es) / Treatment plan for this patient |
| ☐ C | Chronic ongoing illness | ⏵ | ☐  | YES | ☐  | NO |
| ☐ D | Estimated number of office or clinic visits |  | Will this | ☐ | YES, When |  |
|  \_\_\_\_\_\_\_\_\_\_\_\_ times per | ☐ | week | ☐ | month | ☐ | quarter | ☐ | Other (Please Specify) | change? | ☐ | NO |  (Date) |
| ☐ E | Give estimated number of months for the diagnosis in B that medical treatment will be required | ☐ Lifetime |
| ☐ F | Is the patient non-ambulatory? | If Yes, explain:  |
| ☐ | YES | ☐ | NO |  |  |
| ☐ G | Does patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) |
| ☐ | YES | ☐ | NO | ⏵ |  |
| ☐ H | Does someone need to accompany the patient to the medical appointment? | If yes, who / why? |
| ☐ | YES | ☐ | NO | ⏵ |  |
| ☐ I | Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? | Check any complex care services needed. |
|  | ⏵ | ☐ | YES | ☐ | NO |  |  | ☐ | Specialized Feeding | ☐ | Suctioning  |
| Eating Dressing Meal PreparationToileting Transferring ShoppingBathing Mobility LaundryGrooming Taking Medications Housework | ☐ | Catheters or Leg Bags | ☐ | Bedsore Prevention |
| ☐ | Colostomy Care | ☐ | Range of Motion |
| ☐ | Bowel Program | ☐ | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ J | Can patient work at usual occupation? | ☐ YES ☐YES, but with limitations (Specify below) | ☐ | NO (How long): |
|  |  |  |
| Can Patient work at any job? | ☐ YES ☐YES, but with limitations (Specify below) | ☐ | NO (How long): |
|  |  |  |
| ☐ K | Other (Explain) |
|  |
| ☐ L | Is the spouse or parent of the above disabled individual needed in the home to provide care? | ☐ YES ☐ NO |
| Spouse or parent cannot engage in work due to the extent of care required. | ☐ YES ☐ NO |
| How long:  |  |
| Date patient was last seen | Are you a Medicaid enrolled provider? | ☐ | YES | ☐ | NO |
|  |  |
| Name and title (Print or type) | MA enrolled Provider Signature |
|  |  |
| National Provider Identifier (NPI) Number | Signature Date | Telephone Number |
|  |  |  |
| AUTHORITY: Federal 45 CFR of 233.20, CFR 440.10 and CFR 440.20COMPLETION: VoluntaryPENALTY: Benefits may be affected. | The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. |