Service Request For CAP Services

* = Required Print

Request Date * 10/03/2016 Service Requested * CAP Children Service Request ID 0

Beneficiary Demographics

MMIS Lookup

Beneficiary's First Name	
Last Name *	
Beneficiary has Medicaid? *	-- select --
Medicaid MID	
Social Security Number *	
Medicare ID	
Date of Birth *	Age
Gender *	-- select --
Marital Status *	-- select --
County *	-- select --
Primary language	-- select --

Beneficiary Address

Address 1	
Address 2	
City	
State	NC Zip
Phone	
Receiving Protective Services? *	-- select --
Legal guardian in place? *	-- select --
Private Insurance? *	-- select --

Other Services Beneficiary Is Receiving

Home Health	☐
PCS	☐
Hospice	☐
CAP/C or CAP/DA	☐
Independent Living Services	☐
Block grant services	☐
Is beneficiary receiving another Medicaid program about to end? *	-- select -- Specify
Beneficiary has been informed regarding their choice of providers.	-- select --
Is beneficiary interested in the CAP Choice Option?	-- select --
Beneficiary (legal guardian) has agreed to this request? *	-- select --
Is beneficiary currently in an institution (hospital or nursing facility)? *	-- select --

Beneficiary Conditions and Related Support Needs

Diagnosis Information

Diagnosis	ICD Code	ICD Version	Primary Dx

Diagnosis Entry

Is there an active AIDS diagnosis? *	-- select --
If AIDS dx present, current CD4 (T) count?	-- select --
Is there a MH diagnosis?	-- select --
Is there a IDD diagnosis?	-- select --
Medically Stable? *	-- select --
Prognosis	

Hospitalizations (Include current stay if applicable)	
Total number of hospital stays in the last year? *	
# of hospital readmissions in the last year (for the same admitting diagnosis)? *	
# of unplanned hospitalizations in the last year (regardless of diagnosis)? *	
If hospitalized in the last six months, were any of the stays greater than 10 days?	-- select --

Medications			
Medication Name	PRN	Strength	If PRN, freq > every 4 hrs?

Meds Entry

# of Prescription Meds	
# of Meds Requiring Nurse to Administer	
# of Psychiatric/Psychotropic Meds Used for MH Dx	
Requires RN Monitored injections and/or IVs	-- select --
Considering all current medications, does beneficiary require medications assistance?	-- select --

Sensory/Communication Limitations	
Speech ability/making self-understood (Rarely/never) *	-- select --
Hearing (Severe difficulty or none) *	-- select --
Vision (Severe difficulty or blind) *	-- select --

Orientation and Cognitive Status	
Is Beneficiary Oriented	
- To Time *	-- select --
- To Person *	-- select --
- To Place *	-- select --
Beneficiary has Cognitive Skills for Daily Decision-making *	-- select --

Mood			
Unrealistic fears	☐	Crying/tearfulness	☐
Sad, pained, worried facial expressions	☐	Negative statements	☐
Persistent anger	☐	Anxious non-health concerns	☐
Elevated mood, euphoric	☐	Expansive	☐
Unpleasant mood in morning	☐	Hallucinations	☐
Excessive irritability	☐		

Behavior			
Wandering	☐	Verbal expressions of distress	☐
Repetitive verbalizations	☐	Angry outbursts	☐
Repetitive physical movements	☐	Dangerous to self	☐
Self-deprecation	☐	Withdrawal from activities of interest	☐
Insomnia/disturbed sleep patterns	☐	Paranoid ideation	☐
Suicide attempt/ideation	☐		

Interpersonal Functioning			
Homicidal	☐	Combative/Hx of Altercations	☐
Dangerous to others	☐	Physically abusive	☐
Verbally abusive	☐	Socially inappropriate behavior	☐
Evictions due to inapprop. behavior	☐	Resists care	☐
Fear of strangers	☐	Illogical comments	☐
Reduced social interaction/isolation	☐		

Cardio-Respiratory Support Needs	
Suctioning - tracheal	☐ Frequency -- select --
Suctioning - other	☐ Frequency -- select --
Ventilator dependent	☐ Frequency -- select -- Stable? -- select --
Vent Type	-- select --
Infection free?	-- select --
Pulse oximetry	☐ Frequency -- select --
Non-vent tracheostomy	☐ Problems with weaning? -- select --
Nebulizer care	☐ At least 2 schedule/day & 1 PRN/day? -- select --
Cardiac monitoring	☐
Chest physiotherapy/use of chest PT vest	☐
Use of cough assist device	☐
Apnea monitoring	☐
CPAP/BiPAP	☐ Help getting device on? -- select --
Oxygen therapy	☐ Requires rate adjustments? -- select --
Respiratory assessment	☐ Multiple times/day? -- select -- Is respiratory pacer required? -- select --

Nutrition-Related Support Needs	
Enteral Feeding/Tube Feeding	☐ Frequency -- select --
% of daily nutrition/fluids	Feeding Tube Type -- select --
Parenteral Nutrition (TPN)	☐
Soft/Mechanical Soft	☐
Thickened Diet	☐
Pureed Diet	☐
Supplemental formula diet physician prescribed	☐
Diabetes management (daily)	☐ Insulin use -- select -- Sliding Scale -- select --
Weight management	☐

Fluid mgmt/force fluids	☐
Input/output monitoring	☐
Other nutrition treatment/Diet?	☐ Other, Desc

Ancillary Therapies Being Received	
Physical Therapy	☐ Frequency -- select --
Physical Therapy Details	
Occupational Therapy	☐ Frequency -- select --
Occupational Therapy Details	
Speech Therapy	☐ Frequency -- select --
Speech Therapy Details	
Other	☐ Other, Desc
Other Therapy Details	

Other Support Needs	
Continence Management	☐ If checked, is Continence Management for: Bowel ☐ Bladder ☐
Indwelling Catheter	☐
Colostomy Bag	☐
Seizure management	☐ Requires PRN supports involving assessment and intervention by RN? -- select --
Dialysis	☐ Dialysis Type -- select -- Dialysis Frequency -- select --
Wound Care	☐ Open Wound? -- select -- Sterile Dressing -- select --
Ulcer Care	☐ Ulcer Staging -- select --
Isolation - infection/disease	☐

Functional Limitations

ADL Limitations

Bathing - Does beneficiary need hands-on assistance?	-- select --
Personal Hygiene - Does beneficiary need hands-on assistance?	-- select --
Dressing - Does beneficiary need hands-on assistance?	-- select --
Bed Mobility - Does beneficiary need hands-on assistance?	-- select --
Mobility - Does beneficiary need hands-on assistance?	-- select --
Transfer - Does beneficiary need hands-on assistance?	-- select --
Toileting/Elimination - Does beneficiary need hands-on assistance?	-- select --
Eating - Does beneficiary need hands-on assistance?	-- select --

Other Functional Limitations

Can the beneficiary ambulate without person assistance? *	-- select --
Is the beneficiary confined to a wheelchair or bedbound?	-- select --
Contractures	☐
Paralyzed	☐
Fall risk	☐

Additional Comments about Treatment Needs

Additional Comments	

Informal Caregiver Availability

First Name	Last Name	Relationship	Lives with Beneficiary	Contact Phone

Caregivers Entry

Will 24-hour caregiver availability be required to ensure beneficiary safety? *	-- select --

Beneficiary Consent

The beneficiary has consented to sharing the information documented in this Service Request Form with any agency or organization responsible for enrolling or assisting the beneficiary once enrolled in the requested service or program(s). *	-- select --

Submitting Agency Identification and Beneficiary Primary Care Physician

Submitter Name	
CAP Case Management Agency	-- select --
Submitting Agency Name (If not a CAP Agency)	
Address	
City	
State	NC Zip
Phone	
Fax	
Beneficiary's Primary Care Physician	
Physician NPI	
Primary Physician Practice Name	
Primary Care Physician Telephone	

Required Document List

Document	Present?
Consumer Consent (Release of Information) Form	☐

Supporting Documentation

Record Date	Type	Record

Add Document

Comments

Is Request Complete? * ○ Yes ○ No

Date SRF Completed

Save Show Errors