NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Private Duty Nursing (PDN) Medical Update Form – DHB-3509

Instructions: The form below must be completed in its entirety and submitted to NC Medicaid.

General Information
Beneficiary Name:
MID #:
PDN Provider Agency Name:
Provider NPI #:
Current attending physician:
Date of last examination by MD (with name of MD):
Prior Approval Information
Dates of last approval period:
Weekly PDN hours currently approved (specify home and school hours if needed): Total weekly PDN hours approved (shared cases):
Private Insurance Information
Does the beneficiary have insurance in addition to Medicaid? ☐ Yes ☐ No
Is PDN covered by private insurance? ☐ Yes ☐ No
If Yes, please detail the insurance company name, # of hours/week covered and the dates of coverage: *Note: If private insurance covers any portion of PDN services, an Explanation of Benefits document must be submitted with the PDN referral.*
COMMENT:
School Information
Does the beneficiary (between the age of 3 and 20) attend school? ☐ Yes ☐ No ☐ N/A Is this a change from the last PA approval period? ☐ Yes ☐ No If Yes, please explain in the fields below.
Name of school: School district:
What is the typical school schedule?

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Start: _____ End: _____ How many days per week? _____

Number of weekly hours contracted: _____

Note: Please include transportation time if a nurse must accompany beneficiary.

What type of support does the beneficiary have in school?

☐ None ☐ 1:1 support staff ☐ School nurse ☐ Skilled nurse

If skilled nursing support is provided, are the hours billed to NC Medicaid by the LEA by school contract? ☐ Yes ☐ No

If No, please specify why.

Medical Information

Ventilator dependency? ☐ Yes ☐ No

If Yes, what type of ventilator?

How many hours per day is the beneficiary dependent on the ventilator?

☐ 24 hours/day ☐ 8-23 hours per day ☐ less than 8 hours per day or PRN

Tracheostomy requiring suctioning? ☐ Yes ☐ No

If Yes, how often is tracheal suctioning completed?

☐ Q 1 hour or more frequently ☐ Q 2-4 hours ☐ Q 5 hours or less frequently

How often is routine tracheostomy care completed?

Oxygen dependency? ☐ Yes ☐ No

If Yes, please choose one:

☐ Continuous (eight hours or more per day)

☐ Intermittent with pulse ox at least every shift

Specify orders for oxygen below.

Scheduled nebulizers/cough assist device/chest physiotherapy?

☐ Yes ☐ No

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Specify orders for nebulizers, cough assist devices and/or chest physiotherapy below.

G/J Tube? ☐ Yes ☐ No

If Yes, please choose the appropriate option below:

- ☐ Continuous (eight hours or more)
- ☐ Bolus feeds
- ☐ Continuous AND bolus feeds

Specify enteral feed name, dosage, and frequency below:

TPN? ☐ Yes ☐ No

If Yes, please specify the frequency and duration below:

Please detail any other skilled nursing interventions and the frequency with which these are completed at home.

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Critical incidents for the beneficiary (e.g., hospitalizations, falls, infections):

Trained Caregiver Information
Caregiver name:
Relationship to beneficiary:
Employed or attending college courses? ☐ Yes ☐ No If employed, please detail work hours below: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____ Number of weekly hours worked (or average weekly hours): _____ Is this a change from the last PA approval period? ☐ Yes ☐ No If Yes, please explain in comment section below. *Note: If attending college courses, please include a recent copy of caregiver's class schedule.*
COMMENT:
Training needs or education provided:
Trained Caregiver Information
Additional caregiver name:
Relationship to beneficiary:

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Employed or attending college courses? ☐ Yes ☐ No If employed, please detail work hours below: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____ Number of weekly hours worked (or average weekly hours): _____ Is this a change from the last PA approval period? ☐ Yes ☐ No If Yes, please explain in comment section below. *Note: If attending college courses, please include a recent copy of caregiver's class schedule.*
COMMENT:
Training Needs
Training needs or education provided:
Home Environment
Please describe safety of home environment:
Please describe emergency plan of care if nurse and/or trained caregivers are not available:
Nurse Attestation and Signature
Nurse signature and title:
Date:
"I hereby attest that the information contained herein is current, complete and accurate to the best of my knowledge and belief."