Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
		From: To:		

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis	Date
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures

16. Nutritional Req.

17. Allergies

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinance)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status
1 ☐ Oriented
2 ☐ Comatose
3 ☐ Forgetful
4 ☐ Depressed
5 ☐ Disoriented
6 ☐ Lethargic
7 ☐ Agitated
8 ☐ Other

20. Prognosis
1 ☐ Poor
2 ☐ Guarded
3 ☐ Fair
4 ☐ Good
5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date of HHA Received Signed POT

24. Physician's Name and Address

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861 and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to: Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

NC MEDICAID
PRIVATE DUTY NURSING (PDN)
PHYSICIANS REQUEST FORM

NC Medicaid-3075

A. The payer for this service is: Medicaid: ☐

Requested SOC date:_____ * Complete form within 15 business days of the start of care date and submit to NC Medicaid.

1. Patient Name:_____ 2. Address: _____
3. Phone Number:_____ 4. Recipient ID #: _____
5. Date of Birth:_____ 6. Diagnosis: _____
7. Prognosis and expectations of specific disease process: _____
8. Date of last physician assessment: _____
9. Services requested and why: _____
10. Specify how many hours/days/weeks requested: _____
11. Informal caregivers' availability and training received: _____

Technology Requirements and Nursing Care Needs

12. Ventilator dependent? ☐ No ☐ Yes Type: _____
13. Hours per day on ventilator: _____
14. Oxygen? ☐ No ☐ Yes Actual liters per minute and hours per day required: _____
15. Continuous prescribed rate?_____ or adjusted daily or more often? (specify): _____
16. Maintain sats >_____% Frequent need for adjustments and interventions? _____
17. Non-ventilator dependent tracheostomy? Circle one. ☐ No ☐ Yes
18. Name of Provider Agency: _____
19. Requesting Provider #:_____ NPI: ☐ Atypical: ☐ 20. Taxonomy: _____
21. Address: _____ 22. Nine Digit Zip Code: _____
23. Does that patient have insurance in addition to Medicaid? ☐ Yes ☐ No
24. Is PDN covered by private insurance? ☐ Yes ☐ No If Yes, explain coverage: _____
25. Date of last approval period: _____
26. Current attending physician: _____
27. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____
28. Date of last weight (adults), height and weight for pediatric recipients: _____
29. Date of last examination by MD (name of MD): _____
30. Changes in recipient's condition: _____

NC MEDICAID
PRIVATE DUTY NURSING (PDN)

NC Medicaid-3075

31. Home visit observations. Safety of environment, and caregiver information: _____

_____

_____

32. Critical incidents with the recipient (hospitalizations, falls, infections, etc.): _____

_____

_____

33. Therapies recipient is receiving (PT, OT, ST, RT, etc.): _____

_____

34. Emergency plan of care if nurse is not available; _____

_____

35. Training needs: _____

_____

_____

_____

36. Education provided, return demonstrations and identification of ongoing needs: _____

Print Physicians Name: _____

Print Physicians Address & Phone Number: _____

Physicians Signature: _____ Date:_____

NC MEDICAID
PRIVATE DUTY NURSING (PDN)

NC Medicaid-3061

PRIOR APPROVAL REFERRAL FORM

For initial PDN requests, submit either a) this form along with a NC Medicaid-3075 or b) a physician's letter of medical necessity.

PATIENT INFORMATION

Name:
Address: Phone Number:
MID #: Medicare #: Birthdate: Sex:

RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name:
Address:
Phone Number: Relationship:

CAREGIVER INFORMATION

Name:
Address:
Phone Numbers: work home
Relationship to Recipient:
Hours/Day Available to Care for Recipient:

PHYSICIAN INFORMATION

Community Attending's Name:
Address: Phone Number:
Names and Phone Numbers of Other Physicians Ordering Care:

NURSING AGENCY INFORMATION

PDN Agency:
Address:
Nursing Contact Person: Contact's Phone Number:
PDN Provider Number:

INSURANCE INFORMATION

Insurer's Name:
Address:
Contact Person & Phone Number:
Policy or ID Number: Amount of PDN Covered by Insurance:

MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN:

Primary nursing interventions and the frequency with which these are performed at home:

Physician Orders for Daily Hours and Weeks' Duration:
Decreasing Hours:
Referred by Name/Agency:
Phone Number:

NC Medicaid Private Duty Nursing
Medical Update/Patient Information Form

NC Medicaid-3062

1. Patient Name:_____ 2. Recipient ID: _____
3. Name of Provider Agency:_____ 4. PDN Provider Number: _____
5. Does that patient have insurance in addition to Medicaid? ☐ Yes ☐ No
6. Is PDN covered by private insurance? ☐ Yes ☐ No If Yes, explain coverage: _____

_____

7. Date of last approval period: _____
8. Current attending physician: _____
9. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____

_____

_____

_____

_____

_____

_____

10. Date of last weight (adults), height and weight for pediatric recipients: _____
11. Date of last examination by MD (name of MD): _____
12. Changes in recipient's condition: _____

_____

_____

13. Home visit observations. Safety of environment, and caregiver information: _____

_____

_____

14. Critical incidents with the recipient (hospitalizations, falls, infections, etc): _____

_____

_____

15. Therapies recipient is receiving (PT, OT, ST, RT, etc): _____

_____

16. Emergency plan of care if nurse is not available; _____

_____

17. Training needs: _____
18. Education provided, return demonstrations and identification of ongoing needs: _____

_____

_____

_____

Nurse Signature and Title:_____ Date:_____

VERIFICATION OF EMPLOYMENT

Recipient's Name: _____
Recipient's Medicaid ID Number_____

Caregiver Name_____

This form is to be used only when verification of employment by the employer is unavailable.

A. ☐ I am self-employed.
☐ I am an independent contractor.
☐ I am an employee of_____.

B. I work as a_____.

C. ☐ I do most of my work outside the home.
☐ I do most of my work at my home.

D. If I do most of my work at my home,
☐ I have a separate, dedicated work space in my home.
☐ I do not have a separate, dedicated work space in my home.

E. If I do most of my work at my home,
☐ I can arrange my hours, interrupt my work, or be otherwise available for care if needed.
☐ I can not be available for care; I would need to hire a caregiver to supplement the hours that PDN could not provide

F. My typical work hours are (do not include on-call hours):

Monday_____	Thursday_____	Saturday_____
Tuesday_____	Friday_____	Sunday _____
Wednesday_____		

G. My typical work schedule:
☐ never or rarely varies.
☐ varies sometimes.
☐ varies a lot.

H. My typical work hours are:
☐ very flexible.
☐ somewhat flexible.
☐ not flexible.

I. Please elaborate on any of the above or include any additional relevant information on the back of this form.

An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate professional licensing agency for investigation.

Signature_____Date_____

NC Division of Medical Assistance
Refer to instructions before completion

RECIPIENT NAME		RECIPIENT MID		PROGRAM ☐ PDN ☐ CAP/C
PRIMARY DIAGNOSIS		ADMIT DATE OR CAP EFFECTIVE DATE		DOB	

TECHNOLOGY NEEDS			
ventilator dependent	☐ dependent ☐ needs assistance ☐ independent ☐ intervention, continuous ☐ intervention, intermittent ☐ monitoring	total 60	intermittent 50
tracheostomy not ventilator dependent	☐ dependent ☐ needs assistance ☐ independent ☐ intervention, continuous ☐ intervention, intermittent ☐ monitoring	continuous 50	passey-muir/cap 40
CPAP/BIPAP not tracheostomy	☐ dependent ☐ needs assistance ☐ independent ☐ intervention, continuous ☐ intervention, intermittent ☐ monitoring	continuous 40	intermittent 35
oxygen	☐ dependent ☐ needs assistance ☐ independent ☐ intervention, continuous ☐ intervention, intermittent ☐ monitoring	unstable 35	stable 15
hospitalizations	☐ greater than three hospitalizations within the last year ☐ at least one extended (> two months) hospitalization within the last year	related to primary diagnosis	unrelated to primary diagnosis
SUBTOTAL TECHNOLOGY NEEDS			

SKILLED CARE NEEDS					
endotracheal suctioning	☐ dependent ☐ needs assist ☐ independent	> QH 10	Q 2-4 hrs 8	Q 5-8 H 6	< Q8H 4
sterile dressing	☐ dependent ☐ needs assist ☐ independent	QID 8	TID 6	BID 4	daily or less 2
nasogastric,gastrostomy, or jejunostomy tube feeds	☐ dependent ☐ needs assist ☐ independent	bolus with reflux 8	bolus without reflux 6	daily or continuous with reflux 4	daily or continuous without reflux 2
intake and output specialized intervention	☐ dependent ☐ needs assist ☐ independent	QID intervention 8	TID intervention 6	BID intervention 4	daily intervention 2
intermittent catheterization	☐ dependent ☐ needs assist ☐ independent	QID 8	TID 6	BID 4	daily or as needed 2
intravenous: fluids or medications or nutrition	☐ dependent ☐ needs assist ☐ independent	QID 8	TID 6	BID 4	daily or continuous 2
pulse oximetry, CO_2 levels, nebulizers, chest PT, _____	☐ dependent ☐ needs assist ☐ independent	QID 8	TID 6	BID 4	daily or continuous 2
medication	☐ dependent ☐ needs assist ☐ independent	complex 8	moderate 4		simple 2
SUBTOTAL SKILLED CARE NEEDS					

ACTIVITIES OF DAILY LIVING NEEDS			
naso-oropharyngeal suctioning frequency_____	dependent 2	needs assist 1	independent 0
nonsterile dressing/site care	dependent 2	needs assist 1	independent 0
oral feeding assistance (N/A for children < 3 yrs of age)	dependent 2	needs assist 1	independent 0
recording of intake and output	dependent 2	needs assist 1	independent 0
incontinence care (N/A for children < 3 yrs of age)	dependent 2	needs assist 1	independent 0
personal care (age inappropriate) (N/A for children < 3 yrs of age)	dependent 2	needs assist 1	independent 0
range of motion	dependent 2	needs assist 1	independent 0
ambulation assist, transfers, bed mobility	dependent 2	needs assist 1	independent 0
SUBTOTAL ACTIVITIES OF DAILY LIVING NEEDS			

TOTAL POINTS	
CURRENT NURSE HOURS	
CURRENT AIDE HOURS	
LEVEL OF CARE/ HOURS AUTHORIZED	
SIGNATURE AND TITLE OF PERSON COMPLETING FORM*	
DATE	

COMMENTS/HOME ENVIRONMENT/CAREGIVER INFORMATION

*This certifies the signee, and no one else, has completed the above in-home assessment of the client's condition. Falsification: an individual who certifies a material and false statement will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate licensing agency for investigation.

Rev 3/06

Nursing Review Criteria Form Instructions
NC Division of Medical Assistance

This is ONE of several submitted documents that is reviewed and utilized for prior approval decisions and/or authorization. All recipients will be scored with the initial assessment and every two months thereafter by the Case Manager or Nurse Supervisor. Forms for PDN recipients should be submitted to DMA with the initial approval and with each 60 day reauthorization. Forms for CAP/C recipients should be submitted to DMA with the initial assessment, with each annual Continued Needs Review, and any time there is a change in the recipient's condition. It is expected that if total points start to decline, indicating that the recipient is improving, that total nursing hours will also decline.

RECIPIENT NAME as it is written on the Medicaid card		**RECIPIENT MID**		**PROGRAM** ☐ **PDN** ☐ **CAP/C**	
PRIMARY DIAGNOSIS should match the primary diagnosis listed on the FL-2 and/or the CMS-485, as applicable		**ADMIT DATE OR CAP EFFECTIVE DATE**		**DOB**	

TECHNOLOGY NEEDS Scores in the technology section reflect the risk of death or disability if the technology is lost, as well as the degree of licensed skilled nursing assessment/judgment necessary to operate the technology.	
ventilator dependent	Recipients using ventilators will not receive additional points for tracheostomy. The need for this technology is included in the points for the ventilator. Total is used for a recipient who is on the ventilator 24 hours per day. Intermittent is used for a recipient who is able to come off of the ventilator for a period of time; e.g., someone who uses the ventilator only during sleep.
tracheostomy not ventilator dependent	Recipients with a tracheostomy will not receive additional points for tracheostomy dressing changes. The need for this procedure is included in the points for the tracheostomy. Continuous is scored for a recipient who always breathes through an open tracheostomy. Passey-Muir/cap is scored for a recipient who is able to tolerate the use of a speaking valve or having the tracheostomy capped for a period of time.
CPAP/BIPAP not tracheostomy	Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure Continuous is scored for a recipient who is on the CPAP or BiPAP 24 hours per day. Intermittent is scored for a recipient who is able to come off of the CPAP or BiPAP for a period of time; e.g., someone who uses it only during sleep.
oxygen	Recipients are eligible to receive the points for unstable oxygen if the recipient has daily desaturations below doctor-ordered parameters AND if those desaturations require a response based on skilled nursing assessment and intervention. Recipients are NOT eligible for the unstable points if the oxygen use is routine and predictable; i.e., a recipient with Chronic Obstructive Pulmonary Disease who requires oxygen when walking would not receive the points for unstable.
hospitalizations	Use a rolling twelve month calendar. Emergency room visits without admission do not count. Recipients who have been hospitalized since birth and are just now going home for the first time are eligible to have this item checked.
SUBTOTAL TECHNOLOGY NEEDS Recipients must receive ?? or more points in the technology section to qualify for PDN or CAP/C Hospital Level of Care. A score of ?? or greater does not guarantee approval; rather, it is necessary to even be considered for approval for either PDN or CAP/C Hospital Level of Care.	

SKILLED CARE NEEDS Scores in the skilled care needs section reflect the time needed to perform the assessment and intervention. The recipient's nursing documentation, including the nurses' notes, nursing supervisor's reports, and/or case manager's assessment and notes, must support the frequency chosen. The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient with a tracheostomy has an acute respiratory infection, and the need for endotracheal suctioning increases for the duration of the illness, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill.	
endotracheal suctioning	If the recipient is able to self-suction at least some of the time, choose the frequency at which the caregiver has to perform the suctioning.
sterile dressing	Recipients with a tracheostomy will not receive an additional score for tracheostomy dressing changes. The need for this procedure is included in the score for the tracheostomy.
nasogastric,gastrostomy, or jejunostomy tube feeds	A continuous tube feeding is one that is administered over at least eight consecutive hours. If the tube feeding occurs more frequently, it is considered bolus. If the recipient uses a combination of a continuous and bolus feedings, score the feeding as bolus. To receive the points for reflux, the recipient must meet at least ONE of the following criteria: 1) a positive swallowing study performed within the last six months, 2) documented current and ongoing treatment for reflux, i.e., medications such as metoclopramide (Reglan), ranitidine (Zantac), or lansoprazole (Prevacid), 3) documented treatment for aspiration pneumonia within the last twelve months, or 4) a need for suctioning due to reflux at least daily (NOT including suctioning of oral secretions).
intake and output specialized intervention	This is intake and output which requires intervention; i.e., the nurse has to make adjustments to feedings or IV fluids based on the intake and output data. If there are no interventions other than recording the data and/or calling the physician, the recipient is ineligible for these points; see intake and output non-specialized monitoring below.
intermittent catheterization	If the recipient is able to self-catheterize at least some of the time, choose the frequency at which the caregiver has to perform the catheterization.
intravenous: fluids or medications or nutrition	The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient becomes acutely ill and requires a ten-day course of intravenous antibiotics, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill.
pulse oximetry, CO_2 monitoring, nebulizers, chest PT, _____	Include treatments that are done on a routine basis, whether standing or PRN. If the treatments are done together; i.e., nebulizer treatments (QID) followed by chest physiotherapy (BID), choose the frequency of the one done most often (choose QID). If the treatments are not done together; i.e., chest physiotherapy (BID) and specialized ostomy care (TID), award points based on the total frequency (five times per day). A recipient can not be awarded more than eight points in this category no matter how many treatments he or she receives or how frequently he or she receives them.

medication	Simple medications include scheduled, routine medications that do not require dosage adjustments, regardless of the number of those medications. Moderate and Complex medication includes medications which are PRN and/or require dosage adjustments by a licensed nurse. Recipients who have one to three such medications ACTUALLY GIVEN by the caregiver within an eight hour period qualify for moderate points. Recipients who have more than three such medications ACTUALLY GIVEN by the caregiver in an eight hour period qualify for complex points. PRN seizure medication; i.e., Diastat, should always be awarded moderate points. Oxygen, nebulizer treatments, and intravenous medications are not scored in this category, as they are scored elsewhere on the form. Please note that there are only three scores to choose from for medications.

SUBTOTAL SKILLED CARE NEEDS
The total score for the nursing needs section will be used to determine the need for continuous, complex, and substantial skilled nursing care. Not all of the items in this section can be considered substantial, as they fall within the scope of practice for a Nurse Aide according to the regulations of the North Carolina Board of Nursing regarding delegation of tasks to Nurse Aides.

ACTIVITIES OF DAILY LIVING NEEDS
The activities of daily living section has minimal impact on approval, except for those recipients applying for CAP/C Nurse Aide services. These recipients must receive a score on at least two items in this section AND have a primary diagnosis that is medical in order to be considered for the CAP/C program. Meeting these criteria does not guarantee CAP/C approval. Normal age-appropriate care and parental responsibility should be considered; i.e., all 4 year olds need assistance with getting bathed and dressed, therefore 'needs assist' in this category is not scorable as it is an age-appropriate need, not a medical need.

naso-oropharyngeal suctioning	Suctioning of the nose, mouth, or upper throat with a bulb syringe, yankaeur, or suction catheter. Does not include deep, or endotracheal, suctioning.
nonsterile dressing/site care	Recipients with a tracheostomy or gastrostomy will not receive an additional score for tracheostomy or gastrostomy dressing changes. The need for this procedure is included in the score for the tracheostomy or gastrostomy.
oral feeding assistance (N/A for children < 3 yrs of age)	Does not include meal/formula preparation. Does include hands-on assist with feeding and supervision during feeding.
recording of intake and output	Normal daily measurement of intake and output without the need to assess for fluid replacement or restriction. If such assessment is required, see intake and output specialized monitoring, above.
incontinence care (N/A for children < 3 yrs of age)	Cleaning after an incontinence episode, changing incontinence devices such as diapers and chux, emptying a foley catheter or colostomy.
personal care (age inappropriate) (N/A for children < 3 yrs of age)	Includes bathing, dressing, and grooming, and application of orthotics and prosthetics.
range of motion	
ambulation assist, transfers, bed mobility	Moving around within the recipient's residence with or without the use of an assistive device such as a walker, wheelchair, Hoyer lift, or trapeze.

SUBTOTAL ACTIVITIES OF DAILY LIVING NEEDS

TOTAL POINTS
Total of technology, skilled care needs, and activities of daily living needs.

CURRENT NURSE HOURS
Record as number of hours per day and number of days per week; i.e., for a recipient who gets 18 hours 5 days per week and 10 hours 2 days per week, write as 18X5 & 10X2.

CURRENT AIDE HOURS
Record as number of hours per day and number of days per week; i.e., for a recipient who gets 18 hours 5 days per week and 10 hours 2 days per week, write as 18X5 & 10X2.

LEVEL OF CARE/
HOURS AUTHORIZED
Level of Care for CAP/C recipients,
Hours Authorized for PDN recipients.

SIGNATURE AND TITLE OF PERSON COMPLETING FORM
Case Manager or Nurse Supervisor

DATE
The date the form was COMPLETED, not the date it was submitted.

COMMENTS/HOME ENVIRONMENT/CAREGIVER INFORMATION
Include any special home environment needs or special caregiver needs in this section; i.e., a primary caregiver with health issues, multiple home-care recipients in the home, other stressors, other programs, other needs not identified above.

*This certifies the signee, and no one else, has completed the above in-home assessment of the client's condition. Falsification: an individual who certifies a material and false statement will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate licensing agency for investigation.

Submit the form to :
North Carolina Department of Health and Human Services
Division of Medical Assistance
Facility and Community Care
Home Care Initiatives Unit
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: 919 715 9025
Phone: 919 855 4380

Private Duty Nursing Employment Attestation Form

This Attestation of Employment Form services to provide information about employment status for the purpose of determining Medicaid Private Duty Nursing benefits.

Beneficiary:_____ MID#_____
DOB:_____

Primary Caregiver Attestation
On this date, I _____(Print Name), certify that I am:
□ Employed
□ Not currently employed
□ attend an institution of higher education part time
□ attend an institution of higher education full time
If employed or attending institution of higher education provide daily schedule:

Secondary Caregiver Attestation
On this date, I _____(Print Name), certify that I am:
□ Employed
□ Not currently employed
□ attend an institution of higher education part time
□ attend an institution of higher education full time
If employed or attending institution of higher education provide daily schedule:

I attest that, to the best of my knowledge, the above information can be supported by documentation.

Primary Caregiver (print)_____ Date:_____
Signature (required)_____

Secondary Caregiver (print)_____ Date:_____
Signature (required)_____

Verification of School Nursing

Beneficiary Name: _____ MID#: _____

Agency Name: _____ NPI#: _____

School System: _____

The child named above is a beneficiary of Private Duty Nursing (PDN) services.

Section A: Providing agency to complete this section
Please circle the appropriate option below.

Yes **No** The beneficiary has an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), 504 Plan, or Individual Health Plan (IHP).
Yes **No** Nursing services provided at school are billed to Medicaid by the LEA as outlined in the DMA LEA Policy 10C.
Yes **No** The beneficiary is attending a private school, per parent preference, and the beneficiary needs medically necessary service during school hours.

Nursing hours provided at school: _____

Mode of transportation to/from school: _____

***Note:** The CMS-485 may include up to 60 hours every calendar year for sick days, adverse weather days, and/or scheduled school closings. Any hours above this limit must be submitted on a change request form as short term intensive services, and be approved by a DMA Nurse Consultant. A parent/caregiver signed notification explaining any unscheduled school absences is required for PDN agency reimbursement of hours worked in the home.

Signature of agency representative: _____ Date: _____

Section B: Parent/Caregiver to complete this section

Missed school hours:

Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____

Signature of parent/caregiver: _____ Date: _____

***Note:** A current school calendar and this completed form shall be uploaded to NCTracks as an attachment to the Prior Approval request.