* = Required

Request Date *	
Service Requested	*CAP Children* *CAP Adults* *Private Duty Nurse* *PACE*

Beneficiary Demographics	
Beneficiary's First Name	
Last Name	
Beneficiary has Medicaid? *	*Yes* *Pending* *Not Applied* *No*
Medicaid MID	
Social Security Number *	
Medicare ID	
Date of Birth *	
Age	
Gender *	*Male* *Female*
Marital Status *	*Married* *Never Married* *Partner or Significant Other* *Separated* *Divorced* *Widowed*
County *	
Primary language	*English* *Spanish* *Other*

Beneficiary Address	
Address 1	
Address 2	
City	
State	
Zip	
Phone	
Receiving Protective Services? *	*Yes* *No*

Legal Guardian Details	
Legal guardian in place? *	*Yes* *No*
Guardian Last Name	
First Name	
Phone	
Address 1	
Address 2	
City	
State	
Zip	

Private Insurance Details	
Private Insurance? *	*Yes* *No*
If private insurance in place, does private insurance cover in-home aide or nursing services?	*Yes* *No*
If in-home aide or nursing coverage, enter coverage amount	
Insurer's Name	
Policy ID #	
Phone	

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? *	*Yes* *No*
Specify	
Beneficiary has been informed regarding their choice of providers.	*Yes* *No*
Specify Agency *	
Is beneficiary interested in the CAP Choice Option?	*Yes* *No*
Beneficiary (legal guardian) has agreed to this request? *	*Yes* *No*
Is beneficiary currently in an institution (hospital or nursing facility)?	*Yes* *No*

Beneficiary Conditions and Related Support Needs

Diagnosis Information			
Diagnosis	ICD Code	ICD Version (9 or 10)	Primary Dx?
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*
		9 *10*	*Yes* *No*

Is there an active AIDS diagnosis? *	*Yes* *No*
If AIDS dx present, current CD4 (T) count?	*200 or less* *201-349* *350-499* *500 or greater*
Is there a MH diagnosis?	*Yes* *No*
Is there a IDD diagnosis?	*Yes* *No*
Medically Stable? *	*Yes* *No*
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, did any hospitalization result in a length of stay greater than 10 days?	*Yes* *No*

Medications			
Medication Name	Strength	PRN	If PRN, freq > every 4 hrs?
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*
		Yes *No*	*Yes* *No*

# of Prescription Meds	
# of Meds Requiring Nurse to Administer	
# of Psychiatric/Psychotropic Meds Used for MH Dx	
Requires RN Monitored injections and/or IVs	*Yes* *No*
Considering all current medications, does beneficiary require medications assistance?	*Yes* *No*

Sensory/Communication Limitations	
Speech ability/making self-understood (Rarely/never)	*Yes* *No*
Hearing (Severe difficulty or none)	*Yes* *No*
Vision (Severe difficulty or blind)	*Yes* *No*

Orientation and Cognitive Status	
Is Beneficiary Oriented	
- To Time *	*No* *Yes-Intermittently* *Yes-Continuously*
- To Person *	*No* *Yes-Intermittently* *Yes-Continuously*
- To Place *	*No* *Yes-Intermittently* *Yes-Continuously*
Beneficiary has Cognitive Skills for Daily Decision-making *	*No* *Yes - Intermittently* *Yes - Continuously*

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*	*Every hour* *Every two hours* *Every four hours* *Every six hours*	*Every eight hours* *Every 12 hours* *Every 24 hours* *Less than once a day*	*3-6 times per week* *1-2 times per week* *Less than weekly* *PRN* *Other*

Suctioning - other		*Frequency*	*Every hour* *Every two hours* *Every four hours* *Every six hours*	*Every eight hours* *Every 12 hours* *Every 24 hours* *Less than once a day*	*3-6 times per week* *1-2 times per week* *Less than weekly* *PRN* *Other*
Ventilator dependent		*Frequency*	*Continuous* *Continuous during sleep* *Every hour* *Every two hours* *Every four hours*	*Every six hours* *Every eight hours* *Every 12 hours* *Every 24 hours* *Less than once a day*	*During Sleep* *Being weaned* *PRN* *Other*
		Stable?	*Yes* *No*		
Vent Type		*Negative pressure* *Pressure-cycled* *Volume-cycled*	*Combination pressure and volume cycled* *Flow-cycled* *Time-cycled*		
Infection free?		*Yes* *No*			
Pulse oximetry		*Frequency*	*Continuous* *Continuous during sleep* *Every hour* *Every two hours* *Every four hours*	*Every six hours* *Every eight hours* *Every 12 hours* *Every 24 hours* *Less than once a day*	*During Sleep* *Being weaned* *PRN* *Other*
Non-vent tracheostomy		*Problems with weaning?*		*Yes* *No*	
Nebulizer care		*At least 2 schedule/day & 1 PRN/day?*		*Yes* *No*	

Cardiac monitoring			
Chest physiotherapy/use of chest PT vest			
Use of cough assist device			
Apnea monitoring			
CPAP/BiPAP		*Help getting device on?*	*Yes* *No*
Oxygen therapy		*Requires rate adjustments?*	*Yes* *No*
Respiratory assessment		*Multiple times/day?*	*Yes* *No*

Nutrition-Related Support Needs

Enteral Feeding/Tube Feeding		*Frequency*	*Every hour* *Every two hours* *Every four hours* *Every six hours*	*Every eight hours* *Every 12 hours* *Every 24 hours* *Less than once a day*	*3-6 times per week* *1-2 times per week* *Less than weekly* *PRN* *Other*
% of daily nutrition/fluids	*%*	*Feeding Tube Type*	*DT (duodenal)* *GJ tube (gastrostomy-jejunostomy)* *GT (gastrotomy)* *JT (jejunostomy)*		*Low profile GT* *NG (nasogastric)* *0G (orogastric)* *Other*

Parenteral Nutrition (TPN)					
Soft/Mechanical Soft					
Thickened Diet					
Pureed Diet					
Supplemental formula diet physician prescribed					
Diabetes management (daily)		*Insulin use*	*Yes* *No*	*Sliding Scale*	*Yes* *No*
Weight management					
Fluid mgmt/force fluids					
Input/output monitoring					
Other nutrition treatment/Diet?					

Other, Desc	

Ancillary Therapies Being Received				
Physical Therapy		*Frequency*	*More than once a week* *Weekly* *Every two weeks*	*Monthly* *Less than monthly*
Physical Therapy Details				
Occupational Therapy		*Frequency*	*More than once a week* *Weekly* *Every two weeks*	*Monthly* *Less than monthly*
Occupational Therapy Details				
Speech Therapy		*Frequency*	*More than once a week* *Weekly* *Every two weeks*	*Monthly* *Less than monthly*
Speech Therapy Details				
Other		*Other, Desc*		
Other Therapy Details				

Other Support Needs					
Continence Management		*If checked, is Continence Management for:*			*Bowel* *Bladder*
Indwelling Catheter		*Yes* *No*			
Colostomy Bag					
Seizure management					
Dialysis		*Dialysis Type*	*Hemodialysis* *Peritoneal* *Hemofiltration* *Hemodiafiltration* *Intestinal dialysis*	*Dialysis Frequency*	*Once a week* *Twice per week* *Three times per week* *Four times per week* *Five times per week* *More than five times per week*
Wound Care		*Open Wound?*	*Yes* *No*	*Sterile Dressing*	*Yes* *No*
Ulcer Care		*Ulcer Staging*	*Normal* *Category/Stage One* *Category/Stage Two* *Category/Stage Three* *Category/Stage Four* *Unstageable* *Suspected Deep Tissue Injury*		
Isolation - infection/disease					

Functional Limitations		
ADL Limitations		
Bathing - Does beneficiary need hands-on assistance?	*Yes*	*No*
Personal Hygiene - Does beneficiary need hands-on assistance?	*Yes*	*No*
Dressing - Does beneficiary need hands-on assistance?	*Yes*	*No*
Bed Mobility - Does beneficiary need hands-on assistance?	*Yes*	*No*
Mobility - Does beneficiary need hands-on assistance?	*Yes*	*No*
Transfer - Does beneficiary need hands-on assistance?	*Yes*	*No*
Toileting/Elimination - Does beneficiary need hands-on assistance?	*Yes*	*No*
Eating - Does beneficiary need hands-on assistance?	*Yes*	*No*
Other Functional Limitations		
Can the beneficiary ambulate without person assistance?	*Yes*	*No*
Is the beneficiary confined to a wheelchair or bedbound?	*Yes*	*No*
Contractures		
Paralyzed		
Fall risk		
Additional Comments about Treatment Needs		
Additional Comments		

Informal Caregiver Availability

Caregiver Entry	
Last Name *	
First Name *	
Lives with Beneficiary?	*Yes* *No*
Has Power of Attorney?	*Yes* *No*
Relationship to Beneficiary	*Mother* *Father* *Sister* *Brother* *Grandmother* *Grandfather* *Spouse* *Other relative* *Friend* *Professional* *Other*
Other, Desc	
Hrs/Day Available?	
Trained as Caregiver?	*Yes* *No*
Contact Phone	

Caregiver Entry	
Last Name *	
First Name *	
Lives with Beneficiary?	*Yes* *No*
Has Power of Attorney?	*Yes* *No*
Relationship to Beneficiary	*Mother* *Father* *Sister* *Brother* *Grandmother* *Grandfather* *Spouse* *Other relative* *Friend* *Professional* *Other*
Other, Desc	
Hrs/Day Available?	
Trained as Caregiver?	*Yes* *No*
Contact Phone	

Will 24-hour caregiver availability be required to ensure beneficiary safety? *	*Yes* *No*

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). *	*Yes* *No*

Submitting Agency Identification and Beneficiary Primary Care Physician	
Submitter Name	
CAP Case Management Agency	
Submitting Agency Name (If not a CAP Agency)	
Address	
City	
State	
Zip	
Phone	
Fax	

Referring Physician Details	
Beneficiary's Referring Physician *	
Physician NPI *	
Physician Location Code	
Physician Telephone	
Comments	