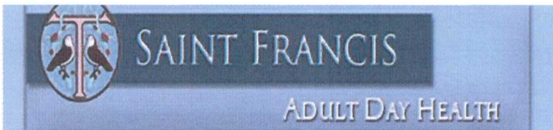


37 Thorne Street, Worcester MA 01604
Telephone (508) 752- 2546

PARTICIPANT ENROLLMENT APPLICATION

Last name: First Name: M.I.

Address: ____

Street *City* *Zip*

Contact Info: ____

Home Phone *Cell Phone* *Email*

I live in:	I live with:	Marital status:
☐ Own home ☐ Apartment ☐ Rooming house ☐ Other	☐ Spouse ☐ Children ☐ Relatives ☐ Alone ☐ Other ☐ # of people living in home	☐ Married, Spouse's name ________, # of yrs. Married ____________ ☐ Widowed, Spouse's name________ , # of yrs. Widowed ____________ ☐ Separated, Spouse's name ________, # of yrs. separated ____________ ☐ Divorced, Ex-spouse's name_______, # of yrs. Divorced____________ ☐ Single, never married

Date of Birth: ______________Birthplace: ____________________Age: __________

Do you have children? ______ # of Sons_____ Names______________________________

# of Daughters________ Names____

Do you stay in touch with your children?______________________________________

Where do your children live?____

Pets: ☐ No ☐ Yes What kind of pets and how many do you have? ____________________

____

Former occupation or trade: ____________________Year of retirement: _____________

Language(s) spoken: __________________Religious preference: __________________

Special interests, hobbies (how applicant spends day): ______________________________

____

____

SAINT FRANCIS
ADULT DAY HEALTH
37 Thorne Street, Worcester MA 01604
Telephone (508) 752- 2546

PARTICIPANT ENROLLMENT APPLICATION

Emergency contact information: List all interested/ responsible persons to be notified in case of illness/ emergency (must include 2 emergency contacts)					
1 Name			Relationship		
Street					
City		Zip Code			
Home Phone		Mobile		Email	
2 Name			Relationship		
Street					
City		Zip Code			
Home Phone		Mobile		Email	
3 Name			Relationship		
Street					
City		Zip Code			
Home Phone		Mobile		Email	

Primary Care Physician (PCP): ______________________________ Phone:________________________

Office Address: ____

Counselor or Psychiatrist: ____________________________________Phone: ________________________

Office Address:____

It is required that an applicant has a physical examination by a physician within <u>12 months</u> prior to admission to the program. **Date of the last physical exam: ____________**

Activities of daily living

MARK ALL THAT APPLY:			
☐ Mentally alert ☐ Forgetful ☐ Confused	☐ Able to get in & out of car ☐ Able to transfer chair to toilet ☐ Walks unassisted ☐ Walk using aids (canes, crutches, walker, wheelchair) ☐ Climbs stairs ☐ Shower Self ☐ Shower Support ☐ Dress Self ☐ Dress Support	Bladder : ☐ Continent ☐ Incontinent Bowel : ☐ Controlled ☐ Involuntary	☐ Feeds self ☐ Special diet ☐ Self care Who makes meals__________ ______________

37 Thorne Street, Worcester MA 01604
Telephone (508) 752- 2546

PARTICIPANT ENROLLMENT APPLICATION

Medicare ID:	Check if you have: ☐ Part A ☐ Part B
Other Insurance Name:	
Other Insurance ID:	
Social Security Number:	
MassHealth/ Medicaid ID:	☐ N/A

Reason(s) for application to the adult day health program:

___

___

Please check which days you would prefer to attend:

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday

Do you receive services from other agencies?

☐ No

☐ Yes Name of Agency: ________________ Services: ______________________________

Days: ___________________________ # of hrs. per day: __________________

PT/OT/Speech: ________________ Specific Instructions: ______________

All applicants will be scheduled for a center visit prior to admission.
This will be arranged by our adult day health program staff.

Please share any special needs or concerns:

___

___

Signature: ____ Date: _____________________

☐ Self/ Participant

☐ Other:
Print name: ____________________ Relationship: __________________

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MASSHEALTH ADULT DAY HEALTH

Primary Care Provider (PCP) Order Form

INSTRUCTIONS:

This form must be completed by the Adult Day Health (ADH) provider and reviewed, verified, and signed by the member's primary care physician (PCP) in order to receive prior authorization (PA) ADH services.

For Initial Prior Authorization (PA) requests: the *ADH provider* completes and signs the Section 1 of this form and the MassHealth member's PCP completes and signs the Section 2 of this form.

For PA Requests Based on Re-evaluations, Significant Changes or Transfers: the *ADH provider* completes both sections of the form. The *MassHealth member's PCP* is then required to review the form, make any applicable revisions, and sign the form before returning it to the ADH provider.

☐ Initial

☐ Re-evaluation ☐ Significant Change ☐ Transfer

MassHealth Member Information

Member's Name

MassHealth ID Date of Birth

Member's Address

Member's Telephone Number

ADH Provider Name

ADH Provider Address

ADH Provider Telephone # ADH Provider Fax #

Assessment of Medical Necessity Criteria (130 CMR 404.000 and 130 CMR 450.000)

Section 1: To be completed by ADH Provider and reviewed/approved by PCP

Activities of Daily Living (ADL). *All ADLs identified below must occur at the ADH program.*

☐ Bathing:

Full body bath or shower occurring at the Adult Day Health Program? ☐ Yes ☐ No

Partial (sponge bath), may include total body cleansing, personal hygiene, oral care, shaving, and applying makeup, when applicable ☐ Yes ☐ No

Hands-on Physical Assistance Needed Daily or on a Regular Basis ☐ Yes ☐ No

Cueing and Supervision Required During Entire Activity? ☐ Yes ☐ No

☐ Toileting:

Incontinent

Bowel: ☐ Yes ☐ No Frequency: ☐ Daily/Regular Basis ☐ Occasionally

Bladder: ☐ Yes ☐ No Frequency: ☐ Daily/Regular Basis ☐ Occasionally

Needs scheduled assistance: ☐ Yes ☐ No Routine catheter/colostomy care: ☐ Yes ☐ No

Hands-on Physical Assistance Needed Daily or on a Regular Basis? ☐ Yes ☐ No

Cueing and Supervision Required During Entire Activity? ☐ Yes ☐ No

☐ Transferring:

Hands-on Physical Assistance Needed Daily or on a Regular Basis? ☐ Yes ☐ No

Cueing and Supervision Required During Entire Activity? ☐ Yes ☐ No

☐ Mobility (Ambulation):

Hands-on Physical Assistance Needed Daily or on a Regular Basis? ☐ Yes ☐ No

Cueing and Supervision Required During Entire Activity? ☐ Yes ☐ No

☐ Wheelchair (☐ Manual ☐ Electric) ☐ Walker ☐ Cane ☐ Independent

☐ Eating:

Daily hands-on physical assistance needed? ☐ Yes ☐ No

Cueing and supervision required during entire activity? ☐ Yes ☐ No

Diet: ☐ Regular/House ☐ Diabetic ☐ Chopped ☐ Ground ☐ Pureed ☐ Other:

Behaviors: (Check all that apply.)

Wandering: exit seeking behavior, elopement, elopement attempts ☐ Yes ☐ No

Verbally abusive: threatening, screaming, cursing at others ☐ Yes ☐ No

Physically abusive: hitting, shoving, scratching ☐ Yes ☐ No

Socially inappropriate or disruptive symptoms: Disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, rummaging, repetitive behavior, eating non-food items, smearing or throwing food/feces, causing general disruption ☐ Yes ☐ No

Inability to self-manage care ☐ Yes ☐ No

Pattern of disordered thinking: impaired executive function, confusion, delusions or hallucinations, impaired judgement/decision making leading to lack of safety ☐ Yes ☐ No

Skilled Services: Provide a brief description of any skilled service need(s) below. Must occur at the ADH Program.
{130 CMR 404.405: Clinical Eligibility Criteria. B Skilled Services (1-15)}

Tuberculosis:

☐ Risk Assessment: Date Completed ....

☐ No Risk, No Symptoms ☐ Needs Additional Screening

ADH Provider Attestation:

I certify that I am the requesting ADH provider. I certify that the clinical eligibility/medical necessity information (per 130 CMR 404.405 and 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

ADH Provider's Signature
Circle Applicable Credentials: RN, NP

Date

Section 2: (PCP Signature Required with Attestation below)

Prescribing Provider (PCP): Please complete or review the following information, or indicate that this information and any supporting documentation are attached

Diagnoses:

Medications: (Please include dosage and amount.)

Known Allergies:

Dietary Needs/Restrictions:

Treatments/Rehab Services recommended at ADH:

PCP Visit History:

Date of Last Physical Exam: .... Date of Last Office Visit: ....

Pertinent Findings of Physical Exam (Includes vital signs and current weight, cognitive assessment/status, physical capabilities):

Current Rehabilitative Services:

....

Tuberculosis Screening:

Per TB Risk Assessment completed by ADH Provider RN, additional screening warranted. Yes ☐ No ☐

(If Yes, see attached Adult TB Risk Assessment and Screening Form, complete, sign and return to ADH program with this form or provide alternate written documentation.)

PCP Information

MassHealth requires that services be ordered, referred, or prescribed (ORP). ACA Section 6401(b) requires that 1) the billing provider include the ORP provider's NPI on the claim; and 2) the ORP provider be actively enrolled with MassHealth as a fully participating provider or as a non-billing provider.

Prescribing Provider's Name

Prescribing Provider's Address

Prescribing Provider's Telephone

Prescribing Provider's MassHealth Provider ID/Service Location

Prescribing Provider's NPI

Prescribing Provider Attestation

I certify that I am the prescribing provider and recommend this patient for Adult Day Health. I certify that the clinical eligibility/ medical necessity information (per 130 CMR 404.405 and 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

....

Prescribing Signature Provider's Date

Circle Applicable Credentials: MD, NP, PA, DO

Attach additional narration or documentation as necessary.

HOW TO APPLY FOR MASSHEALTH / MEDICAID

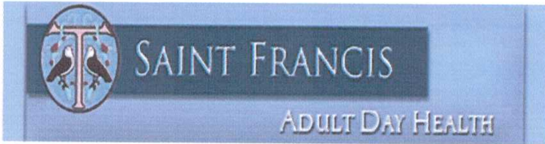
MassHealth may provide health and dental coverage for individuals, families, and people with disabilities. Benefits are offered to you directly or by paying part or all of your other health insurance premiums. Explore their website to learn more about applying, view coverage types and covered services, and to find help enrolling in a health plan. You will also find information about related programs and benefits, including **Adult Day Health.** If you need help with personal care and/or nursing services provided in a medically supervised, structured day program setting, adult day health may be right for you.

For applicants and members with disabilities who need accommodations:
MassHealth Disability Accommodation, Ombudsman
617-847-3468 (TTY: 617-847-3788)
100 Hancock Street, 6th floor
Quincy, MA 02171
ADAAccommodations@state.ma.us.

IF YOU ARE UNDER THE AGE 65:	IF YOU ARE OVER THE AGE 65:
By mail: MassHealth Program P.O. Box 120045 Boston, MA 02112 – 9912 **By fax:** You can fax your MassHealth Health Plan Enrollment Form to (617) 988-8903 **By phone:** Monday through Friday, from 8 a.m. to 5 p.m. (800) 841-2900 TTY: (800) 497-4648) **Online:** The fastest way to enroll in a health plan is online.	**By mail:** MassHealth Enrollment Center Central Processing Unit P.O. Box 290794 Charlestown, MA 02129-0214 **By fax:** You can fax your MassHealth Health Plan Enrollment Form to (617) 887-8799 **Hand deliver to:** MassHealth Enrollment Center Central Processing Unit / The Schrafft Center 529 Main Street, Suite 1M Charlestown, MA 02129. **Where to call:** Call us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled)

To apply in person, you can go to any one of the four following enrollment centers listed below Monday through Friday from 8:45 a.m. to 5 p.m. Do not send an application to any of these enrollment centers.

MassHealth Enrollment Center 45 Spruce Street **Chelsea**, MA 02150	MassHealth Enrollment Center 88 Industry Avenue, Suite D **Springfield**, MA 01104
MassHealth Enrollment Center 21 Spring Street, Suite 4 **Taunton**, MA 02780	MassHealth Enrollment Center 367 East Street **Tewksbury**, MA 01876



37 THORNE STREET, WORCESTER MA 01604
TEL: 508.752.2546 FAX: 508.749-2997

☐ NEW PARTICIPANT	EFFECTIVE DATE:
☐ EXISTING PARTICIPANT; PERMANENT CHANGE	

TRANSPORTATION REQUEST

Participant Name: ______________________ D.O.B.__________ Participant Phone: ____________

Emergency Contact: __________________________ Relationship: __________________________

Mobile : _________________________________ Home Phone: ______________________________

Attendance Days:

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday

Pick- Up Time (AM): ____________________ Pick- Up Time (PM): ____________________

AM Pick-Up Location: ____

PM Drop- Off Location: ____

☐ Same as AM

Special Directions once at address: ____

____

____

____

____

____

Wheelchair Needed?	Fall Risk?	Dementia?	OK Home Alone?
☐ Yes ☐ No Walker? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

St. Francis ADH Staff Signature ___________________________ Date Sent _________________