

# MEDICAL NEEDS

Michigan Department of Health and Human Services

**INSTRUCTIONS: To be completed annually by a physician, nurse practitioner, physical or occupation therapist. Please print or type.**

Case Name				
Case Number			Recipient ID Number	
Patient's Name				Patient's Birth Date
County	District	Section	Unit	Specialist
Specialist			Specialist Phone Number (   )	

Medical Provider:  
We would appreciate your cooperation in completing the spaces checked below. In addition to a physician, Box A may be completed by a physician's assistant, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist. Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's or Representative's Signature		Patient's Name		Signature Date
Authorized Specialist's Signature		Signature Date	Local MDHHS Office	
<input type="checkbox"/> A	Pregnancy Delivery (Expected) Date	Number of medically verified unborn children		
<input type="checkbox"/> B	Diagnosis(es) / Treatment plan for this patient			
<input type="checkbox"/> C	Chronic ongoing illness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> D	Estimated number of office or clinic visits _____ times per <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> quarter <input type="checkbox"/> Other (Please Specify)	Will this change?	<input type="checkbox"/> YES, When _____ (Date)	<input type="checkbox"/> NO
<input type="checkbox"/> E	Give estimated number of months for the diagnosis in B that medical treatment will be required			<input type="checkbox"/> Lifetime
<input type="checkbox"/> F	Is the patient non-ambulatory? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, explain:		
<input type="checkbox"/> G	Does patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> H	Does someone need to accompany the patient to the medical appointment? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who / why?		
<input type="checkbox"/> I	Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? <input type="checkbox"/> YES <input type="checkbox"/> NO Eating                      Dressing                      Meal Preparation Toileting                      Transferring                      Shopping Bathing                      Mobility                      Laundry Grooming                      Taking Medications                      Housework	Check any complex care services needed. <input type="checkbox"/> Specialized Feeding <input type="checkbox"/> Suctioning <input type="checkbox"/> Catheters or Leg Bags <input type="checkbox"/> Bedsore Prevention <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Range of Motion <input type="checkbox"/> Bowel Program <input type="checkbox"/> Other _____		
<input type="checkbox"/> J	Can patient work at usual occupation? <input type="checkbox"/> YES <input type="checkbox"/> YES, but with limitations (Specify below) <input type="checkbox"/> NO (How long):			
	Can Patient work at any job? <input type="checkbox"/> YES <input type="checkbox"/> YES, but with limitations (Specify below) <input type="checkbox"/> NO (How long):			
<input type="checkbox"/> K	Other (Explain)			
<input type="checkbox"/> L	Is the spouse or parent of the above disabled individual needed in the home to provide care? <input type="checkbox"/> YES <input type="checkbox"/> NO Spouse or parent cannot engage in work due to the extent of care required. <input type="checkbox"/> YES <input type="checkbox"/> NO How long:			
Date patient was last seen		Are you a Medicaid enrolled provider? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Name and title (Print or type)		MA enrolled Provider Signature		
National Provider Identifier (NPI) Number		Signature Date	Telephone Number	
AUTHORITY: Federal 45 CFR of 233.20, CFR 440.10 and CFR 440.20 COMPLETION: Voluntary PENALTY: Benefits may be affected.		The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.		