

MEDICAID PRIVATE DUTY NURSING APPLICATION FORM

Please print legibly or type. Please attach pertinent medication documentation

I. Informational Section

Submitter's Name: _____ Phone: (____) _____ Title: _____ Agency: _____

Medicaid ID #: _____ Social Security Number: _____

Client Name: _____ Age: _____ Phone: (____) _____

Address: _____ Date of Birth: ____/____/____

City: _____ State: _____ Zip: _____ County of Residence: _____

Medicaid eligibility established through: _____ Date Verified: _____

Diagnosis:

Technologies: _____

Frequency Technologies are used:

PDN Hours Requested Indicate planned shifts or hours /// Total per week: _____

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
Total	Total	Total	Total	Total	Total	Total	

Primary Care Physician: _____ Phone: (____) _____

Address: _____

Currently Hospitalized? No: Yes: Hospital Name: _____ Phone: (____) _____

In Home Caregiver Information	Primary Caregiver	Secondary Caregiver	Alternate Caregiver
Name			
Address			
Relationship to Client			
Phone #'s	Home: ()	Home: ()	Home: ()
	Work: ()	Work: ()	Work: ()
Hours available to provide Care			

Family members present in the home (include relationship and ages): _____

Family members living in the area: _____

Health or care issues with family members: _____

Home Health Agency: _____ Medicaid Provider #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: () _____ Case Coordinator: _____

II. Certification Section
A. Physician Certification

.....
I certify that _____ is medically stable and appropriate for home care, and requires private duty nursing services at home.
.....

Physician Signature

Date

II. Certification Section continued
B. Client/Family in Home Caregiver Requirements

I certify that all client/family in home caregiver requirements at 8.540.6.A.11a-h. have been met:

Signature Date

Affiliation of certifying person: _____
.....

C. Home Environmental Requirements

I certify that all home environmental requirements at 8.540.6.A.12.a-e. have been met:

Signature Date

Affiliation of certifying person: _____
.....

D. Home Health Agency Provider Requirements

I certify that all home health agency provider requirements at 8.540.6.A.1-12. have been met:

Signature Date

Affiliation of certifying person: _____
.....
.....

Additional Information

PRIVATE DUTY NURSING
Insurance Information

Pt. Name:	Medicaid State ID #:
Date of Birth (mo/day/yr) / /	Social Security #: - -

SECTION I

Do you (policyholder) or any covered family member have other group health insurance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is any health coverage provided by spouse's employer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you have checked **NO** to **both** of the above questions, please go to SECTION II. If **YES** to **either** question, please complete all the information below regarding health insurance.

Policyholder Name:	Policyholder Birthday (mo/day/yr) / /
Policyholder Employer:	Work Phone #: ()
Insurance Company Name:	Policy #/Soc. Sec. #:
Insurance Company Phone #: ()	Group #:
Address:	Coverage End Date (mo/day/yr) / /
	Term Date of Coverage (mo/day/yr) / /
City:	State: Zip:

List family member names who are covered by the other insurance policy:

1.	2.	3.
4.	5.	6.

If there is court-ordered coverage (other than above) for dependent children, give name and address of other coverage (see miscellaneous). If applicable, please provide a copy of the portion of your divorce decree which states who must carry insurance on the dependent children.

PDN USE ONLY

Private Insurance Company Name:	
Contact Person (claims processor):	Date Contacted (mo/day/yr): / /
Last Name:	First Name:
Phone #: ()	

SECTION II

Case Manager Name:
Phone #: ()

MISCELLANEOUS (court order information):