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

☐ **A**	Pregnancy Delivery (Expected) Date	Number of medically verified unborn children
■ **B**	Diagnosis(es) / Treatment plan for this patient	
■ **C**	Chronic ongoing illness ▶ ☐ YES ☐ NO	
■ **D**	Estimated number of office or clinic visits _____ times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify)	Will this change? ☐ YES, When _____ ☐ NO (Date)
■ **E**	Give estimated number of months for the diagnosis in B that medical treatment will be required ☐ Lifetime	
■ **F**	Is the patient non-ambulatory? ☐ YES ☐ NO	If Yes, explain:
■ **G**	Does patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶	
■ **H**	Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶	If yes, who / why?
■ **I**	Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? ▶ ☐ YES ☐ NO Eating, Toileting, Bathing, Grooming, Dressing, Transferring, Mobility, Taking Medications, Meal Preparation, Shopping, Laundry, Housework	Check any complex care services needed. ☐ Specialized Feeding ☐ Suctioning ☐ Catheters or Leg Bags ☐ Bedsore Prevention ☐ Colostomy Care ☐ Range of Motion ☐ Bowel Program ☐ Other _____
■ **J**	Can patient work at usual occupation? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long): Can Patient work at any job? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long):	
■ **K**	Other (Explain)	
■ **L**	Is the spouse or parent of the above disabled individual needed in the home to provide care? ☐ YES ☐ NO Spouse or parent cannot engage in work due to the extent of care required. ☐ YES ☐ NO How long:	

Date patient was last seen	Are you a Medicaid enrolled provider? ☐ YES ☐ 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.

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