



MassHealth Adult Foster Care Primary Care Provider (PCP) Order Form

This form must be completed by the adult foster care (AFC) provider and signed by the member's PCP in order to receive prior authorization (PA) for re-evaluations, significant changes, and transfers. For initial PA requests, providers must complete the *Physician Summary Form (PSF)*.

Member Information

Member's Name

MassHealth ID

Member's Address

Member's Telephone

Date of Birth

AFC Provider Agency Name

AFC Provider Agency Address

AFC Provider Agency Assessment of Medical Necessity Criteria (130 CMR 408.000, 130 CMR 450.000)

Activities of Daily Living

Bathing
 Daily Hands-on (Physical) Assistance Needed? Yes No Cueing and Supervision Required During Entire Activity? Yes No

Dressing
 Daily Hands-on (Physical) Assistance Needed? Yes No Cueing and Supervision Required During Entire Activity? Yes No

Toileting
 Daily Hands-on (Physical) Assistance Needed? Yes No Cueing and Supervision Required During Entire Activity? Yes No

Transferring
 Daily Hands-on (Physical) Assistance Needed? Yes No Cueing and Supervision Required During Entire Activity? Yes No

Mobility (Ambulation)
 Daily Hands-on (Physical) Assistance Needed? Yes No Cueing and Supervision Required During Entire Activity? Yes No

Eating
 Daily Hands-on (Physical) Assistance Needed? Yes No Cueing and Supervision Required During Entire Activity? Yes No

Behaviors

Wandering: moving with no rational purpose, seemingly oblivious to needs or safety Yes No

Verbally abusive behavioral symptoms: threatening, screaming, or cursing at others Yes No

Physically abusive behavioral symptoms: hitting, shoving, or scratching Yes No

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

Resisting care Yes No

Member Diagnosis:

Member Signs and Symptoms:

Prescribing Provider (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 **nonbilling 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. I certify that the clinical eligibility/medical necessity information (per 130 CMR 408.416 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.

MD, NP, PA

Prescribing Provider's Signature

Circle Applicable Credentials

Date