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

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

This form must be completed by the adult foster care (AFC) provider and reviewed, verified, and signed by the member's PCP in order to receive prior authorization (PA).

Member Information

Member's Name

MassHealth ID

Member's Address

Member's Telephone

Date of Birth

AFC Provider Agency Name EPIC NURSING SERVICES LLC.

AFC Provider Agency Address 420 WASHINGTON ST STE 306, BRAINTREE, MA 02184

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

Section I: To be completed by AFC Provider and reviewed/approved by PCP

Activities of Daily Living Please refer to AFC Medical Necessity Guidelines Section II.A.2.a–f for Clinical Eligibility Criteria

☐ 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

Member Name:	MassHealth ID #:

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

The Member Diagnosis and Signs and Symptoms below should support the need for AFC services.

Member Diagnosis:

Member Signs and Symptoms:

AFC Provider Attestation:

I certify that I am the requesting AFC provider. I certify that the clinical eligibility/medical necessity information (per 130 CMR 408.416, 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.

AFC Provider's Signature	RN, NP Circle Applicable Credentials	Date

Section II: PCP Review and Attestation: Please review Section I information and complete the PCP information and attestation below.

Ordering 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

Member Name: MassHealth ID #:

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, DO, NP, PA	
Prescribing Provider's Signature	Circle Applicable Credentials	Date