

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		Check any complex care services needed.		
	Eating Dressing Meal Preparation Toileting Transferring Shopping Bathing Mobility Laundry Grooming Taking Medications Housework		<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.		

DHS-390, ADULT SERVICES APPLICATION
Michigan Department of Health and Human Services
(Revised 10-21)

Note: If you need help to complete this application, please indicate what kind of help you need.

- Bilingual Interpreter Sign-language interpreter for the deaf
 Other (specify)

FOR DEPARTMENTAL USE ONLY

- | | | |
|--------------|------------------------|------------------------|
| 1. Case Name | 2. Log Number | 3. Recipient ID Number |
| 4. County | 5. Date | |
| 6. Worker | 7. Worker Phone Number | |

CLIENT INFORMATION

8. Full Name of Person Needing or Requesting Services
-
9. Date of Birth (MM/DD/YYYY) 10. Social Security Number
-
11. Address (Number, Street, City, State, Zip Code)
-
12. Phone or Cell Number 13. TTY Number (Teletype for the deaf)

SECTION A – DEPARTMENT PROGRAMS: Below is a brief description of the services provided by the Department. Check the box or boxes which describe the services you need or problems where you desire help.

1. **Home Help**
Services to help pay for someone to assist with personal care and housekeeping.
-
2. **Adult Community Placement**
Services for adults who can no longer remain in their own homes. Includes help finding an adult foster home or home for the aged and services for people living in these settings.
-
3. **Other Services**
Nonpayment services to help adults stay safe in their own homes. Services may include information and referral to other community resources.

**IF YOU OR SOMEONE YOU KNOW IS IN NEED OF PROTECTIVE SERVICES, CONTACT
CENTRALIZED INTAKE FOR ABUSE OR NEGLECT AT 855-444-3911.**

SECTION B – CURRENT SITUATION: Check all boxes that apply to you.

1. Your Status as a Recipient
- a. Medicaid (MA) recipient
 - b. Medicaid application pending
 - c. Supplemental Security Income (SSI) recipient
 - d. MI Choice Waiver recipient
 - e. PACE recipient
 - f. MI Health Link recipient

- g. Community Mental Health (CMH) recipient
- h. Food Assistance recipient
- i. Family Independence Program (FIP) recipient
- j. State Disability Assistance (SDA) recipient
- k. Veteran Affairs recipient
- l. Other

2. Living Arrangement (Check all boxes that apply to you and answer related questions)

- a. Alone
- b. With spouse (If married answer questions below.)
 - Is spouse disabled? Yes No
 - Is spouse working? Yes No
 - Full name of spouse _____
- c. With children under age 18. How many? _____
- d. With others (relatives and non-relatives) How many? _____
- e. Live in adult foster care facility, home for the aged.
- f. Is client in a hospital or nursing home? Yes No
- g. Does the recipient have a guardian? Yes No
 - Name of guardian _____
- h. Is a caregiver/provider already identified? Yes No

Date of Birth

Read the following statement, sign, and date the application.

I wish to apply for one of the adult services programs. I certify that the information I have given is correct. By signing, I acknowledge that I have read and agree to the rights, responsibilities, and important things to know described in Section C of this application.

Signature of Client or Authorized Representative

Date