**Please note. This document has been formatted for use with screen readers.**

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

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

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: Enter Member's Name Here

MassHealth ID: Enter MassHealth ID Here

Member’s Address: Enter Member’s Address Here

Member’s Telephone: Enter Member’s Telephone (XXX) XXX-XXXX Here

Date of Birth: Enter Date of Birth (MM/DD/YYYY) Here

AFC Provider Agency Name: Enter AFC Provider Agency Name Here

AFC Provider Agency Address: Enter AFC Provider Agency Address here

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

AFC Provider Agency Assessment of Medical Necessity Criteria

## 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

Member Name: Enter Member Name Here MassHealth ID #: Enter MassHealth ID # Here

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

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

Member Diagnosis: Enter Member Diagnosis Here

Member Signs and Symptoms: Enter Member Signs and Symptoms Here

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 Enter AFC Provider’s Signature Here Date:

Circle Applicable Credentials: RN, NP

Member Name: Enter Member Name Here MassHealth ID #: Enter Masshealth ID # Here

## 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: Enter Prescribing Provider’s Name Here

Prescribing Provider’s Address: Enter Prescribing Provider’s Address Here

Prescribing Provider’s Telephone: Enter Prescribing Provider’s Telephone Here

Prescribing Provider’s MassHealth Provider ID/Service Location:

Enter Prescribing Provider’s MassHealth Provider ID/Service Location Here

Prescribing Provider’s NPI: Enter Prescribing Provider’s NPI Here

### 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.

Prescribing Provider’s Signature: Enter Prescribing Provider’s Signature Here Date:

Circle Applicable Credentials MD, DO, NP, PA

(Form code) AFC-PCP-2-0421