Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MassHealth
PACE Bulletin 1
October 2002

TO: PACE (Program for All-Inclusive Care of the Elderly) Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: **Request for Services Form**

Revision to* Request for Services *Form

The *Request for Services* form (formerly called the *MassHealth Long Term Care Assessment* form for PACE providers) has been revised in an effort to facilitate communication between providers and the Division. Effective October 1, 2002, the Division or its agent will accept only the revised *Request for Services* form. To determine the applicant's or member's clinical eligibility, PACE providers must complete this form and submit it with the Minimum Data Set (MDS-HC) to their local Aging Services Access Points (ASAPs), the Division's agent.

Completing the Form

A nurse, licensed by the Massachusetts Board of Registration in Nursing as a registered nurse, must complete the *Request for Services* form.

Obtaining the Form

A copy of the *Request for Services* form is attached. You may photocopy the form as needed. To obtain supplies of the form, mail or fax a written request to the following address or fax number.

MassHealth
Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 617-576-4087

Effective Date

You must begin using this form by **October 1, 2002**. Please discard all previous versions of this form.

Questions

If you have any questions about this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

MassHealth Request for Services

Date _____

Type of clinical eligibility determination all requested services.

Service(s) requested

- ☐ Pre-admission nursing facility (NF)
- ☐ Adult day health (ADH)
- ☐ Adult foster care (AFC)
- ☐ Group adult foster care (GAFC)
- ☐ Home and community based services (HCBS) waiver
- ☐ Program for All-inclusive Care for the Elderly (PACE)
- ☐ Other _____

Nursing facility use only

- ☐ Conversion
- ☐ Continued stay
- ☐ Short term review
- ☐ Transfer NF to NF
- ☐ Retrospective

Member information

Member/applicant

Last name	First name	Telephone	
Address		City	Zip

Check one

- ☐ MassHealth member — MassHealth ID number _____
- ☐ MassHealth application pending — Date application filed _____
- ☐ GAFC/ Assisted living residence — Date SSI-G application filed _____

Next of kin/Responsible party

Last name	First name	Telephone	
Address		City	Zip

Physician

Last name	First name	Telephone	
Address		City	Zip

Screening for mental illness, mental retardation, and developmental disability

Does the member/applicant have any of the following diagnoses/conditions? Check all that apply.

- ☐ Mental illness Specify: _____
- ☐ Mental retardation without related condition
- ☐ Developmental disability with related condition that occurred prior to age 22. **Check all that apply.**
  - ○ Autism
  - ○ Blindness/severe visual impairment
  - ○ Cerebral palsy
  - ○ Cystic fibrosis
  - ○ Deafness/severe hearing impairment
  - ○ Epilepsy/seizure disorder
  - ○ Head/brain injury
  - ○ Major mental illness
  - ○ Multiple sclerosis
  - ○ Muscular dystrophy
  - ○ Orthopedic impairment
  - ○ Speech/language impairment
  - ○ Severe learning disability
  - ○ Spina bifida
  - ○ Spinal cord injury

Name of member/applicant _____

Community services recommended

Check all that apply.

○ Skilled nursing	○ HCBS waiver	○ Rest home	○ Homemaker
○ Physical therapy	○ Personal emergency response system	○ Elderly housing	○ Meals
○ Occupational therapy	○ Adult foster care	○ Adult day health	○ Transportation
○ Speech therapy	○ Group adult foster care	○ PACE	○ Chore service
○ Mental health services	○ Assisted living	○ Home health aide	○ Grocery shopping/delivery
○ Social worker services	○ Congregate housing	○ Personal care/homemaker	○ Other: _____

Additional information

1. Is the home or apartment available for the member or applicant?	○ yes	○ no
2. Is there a caregiver to assist the member in the community?	○ yes	○ no
3. Has the member or applicant experienced unexplained weight gain in the last 30 days?	○ yes	○ no
4. Does the member or applicant receive personal care/homemaker services?	○ yes	○ no

If yes: days per week _____ hours per week _____

5. Has the member or applicant experienced a significant change in condition in the last 30 days?	○ yes	○ no

If yes: ☐ improvement ☐ deterioration

Indicate the changes below. _____

_____

_____

_____

For nursing facility requests only

1. Does the nursing facility member/applicant express an interest to remain in or return to the community?	○ yes	○ no
2. Is the nursing facility stay expected to be short-term (up to 90 days)?	○ yes	○ no
3. Is the nursing facility stay expected to be long-term (more than 90 days)?	○ yes	○ no

Referral source Name of registered nurse completing this form

Signature	Print name	Title	
Name of organization		Telephone	
Address		City	Zip

For community providers: Attach the MDS-HC and Physician's Summary form according to provider's regulations/guidelines.

For nursing facility providers: Attach the most recent comprehensive MDS, current quarterly MDS, and current physician orders.