



Dear Physician:

Your patient has applied for Home and Community Based Services in order to receive services and support in their home instead of receiving assistance in an institutional setting (nursing facility, ICF/ORC, or other institutional setting). The enclosed Physician Certification Form is a required part of the eligibility determination for these programs. The application requires that this form be completed in its entirety and **signed by an MD or DO**. On the form, please indicate your patient's 'level of care' using the definitions provided. For patient's meeting ICF/ORC page 2 of this form must also be completed.

To prevent delays with your patient's application, please complete, sign and return the form at the fax number or address below within **five (5) business days** of receipt.

If you have questions, please call us at **1-877-550-4227**.

Thank you,
PA Independent Enrollment Broker

Fax number: 1-888-349-0264

Address: P.O. Box 61560
Harrisburg, PA 17106

Note: The commonwealth contracts with the PA Independent Enrollment Broker to facilitate the overall eligibility application for older adults and people with physical disabilities seeking Medicaid funded home and community-based services.



P.O. Box 61560
Harrisburg, PA 17106



Call us toll free at
1-877-550-4227
(TTY: 1-877-824-9346)



Send a fax to
1-888-349-0264



Email us at
paieb@maximus.com

Level of Care Definitions:

Nursing Facility Clinically Eligible (NFCE) – The individual has an illness, injury, disability or medical condition diagnosed by a physician; and as a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board; and a physician certifies that the individual is NFCE; and the care and services are either a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

Nursing Facility Ineligible (NFI) – Individuals who do not meet the definition of Nursing Facility Clinically Eligible are considered NFI.

Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) – Has a diagnosis of Other Related Condition (ORC), a severe, chronic disability - other than a mental illness or an intellectual disability – **that manifested before age 22**, is likely to continue indefinitely, results in an impairment of either general intellectual functioning or adaptive behavior, and results in substantial functional limitations in at least three of these areas: self-care, understanding and use of language, learning, mobility, self-direction, and capacity of independent living, and Requires active treatment – a continuous program that aggressively, consistently gives specialized and generic training, treatment, health services and related services; that focuses on the client acquiring behaviors necessary to function with as much self-determination and independence as possible ; and that aims to prevent or slow regression or loss of current optimal functional status.



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This form is intended for the sole use of the individual or entity to whom it is addressed and contains protected health information (PHI) subject to provision under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). Providers may not submit false information to obtain authorization to furnish services or items under Medical Assistance.

PATIENT NAME	
PATIENT ADDRESS:	
PATIENT SSN:	PATIENT DATE OF BIRTH:

DIAGNOSIS

Please list all diagnoses with ICD codes related to patient's need for care. Please ensure that you include diagnoses of brain injury and/ or developmental disability if present.

ICD 10 CODE:	PHYSICIAN DIAGNOSIS:

LEVEL OF CARE

For individuals 60 years of age or older, please only select between NFCE or NFI.

- Nursing Facility Clinically Eligible (NFCE)** – This individual has an illness, injury, disability or medical condition diagnosed by a physician; and as a result of the illness, injury, disability or medical condition, the individual requires the level of care and services provided in a nursing facility above the level of room and board.
- Nursing Facility Ineligible (NFI)** – This individual does not meet the definition of NFCE.
- Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)** – This individual requires services at the level of an ICF/ORC, because the individual requires active treatment and has a diagnosis of an ORC.

ORC – A severe chronic disability (other than mental illness or an intellectual disability) that: (1) manifested before age 22; (2) is likely to continue indefinitely; (3) results in the impairment of either general intellectual functioning or adaptive behavior; and (4) results in substantial functional limitations in at least three of the following areas of major life activities: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. ORCs may include, but are not limited to: cerebral palsy, spina bifida, epilepsy, severe physical disabilities, and autism.

Active Treatment – A continuous program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

LENGTH OF CARE REQUIRED

Please indicate length of care required related to the diagnosis listed.

- Long Term** – Condition or disability is anticipated to last 12 months or longer.
- Short Term** – Condition or disability is anticipated to last less than 12 months.

PHYSICIAN INFORMATION

PHYSICIAN NAME (MUST BE MD OR DO):	PHYSICIAN LICENSE # OR MA ID #:
PHYSICIAN PHONE:	PHYSICIAN FAX:
PHYSICIAN SIGNATURE:	DATE:



PATIENT NAME: _____

THIS SECTION MUST BE COMPLETED IF YOUR PATIENT'S IDENTIFIED LEVEL OF CARE IS ICF/ORC

INSTRUCTIONS: Please check **Yes** or **No** to indicate whether or not the patient has a substantial limitation in any of the six areas below. In addition, for those areas checked "**Yes**," please provide comments to substantiate your response.

1. **Self-Care:** A long-term condition which requires the patient to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance with at least one-half of all activities normally required for selfcare.

Yes No **Comments:** _____

2. **Receptive and Expressive Language:** A patient is unable to effectively communicate with another person without the aid of a third person, a person with special skills or with a mechanical device, or a condition which prevents articulation of thoughts.

Yes No **Comments:** _____

3. **Learning:** A patient that has a condition which seriously interferes with cognition, visual, or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

Yes No **Comments:** _____

4. **Mobility:** A patient that is impaired in his/her use of fine motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the patient to move from place to place.

Yes No **Comments:** _____

5. **Self-Direction:** A patient that requires assistance in being able to make independent decisions concerning social and patient activities and/or in handling personal finances and/or in protecting his/her own self-interest.

Yes No **Comments:** _____

6. **Capacity for Independent Living:** A patient that is limited in performing normal societal roles or it is unsafe for the patient to live alone to such an extent that assistance, supervision, or presence of a second person is required more than one-half the time (during waking hours).

Yes No **Comments:** _____