Office of Aging and Adult Services (OAAS)

STATEMENT OF MEDICAL STATUS (SMS)

For Home and Community Base Services (HCBS) Programs Use Only

The purpose of this form is to verify medical information reported by the patient for home and community-based services. Please return the completed form to the patient's support coordinator, or applicable OAAS designee.

I. PATIENT INFORMATION

Name:		Date of Birth:	Gender:
SS#:	Medicaid #:	Medicare #:	
Street Address:			Telephone #:
City:		State:	Zip Code:

II. MEDICAL INFORMATION

A. Diagnoses (**include ICD9):	a. Primary:	b. Secondary:	c. Other:

B. Physician Involvement:

a. Physician Visits: In the last 14 days, how many days has a physician (or authorized assistant or practitioner) examined the patient? Do not count emergency room exams or hospital in-patient visits.
Enter "0" if none. ☐

b. Physician Orders: In the last 14 days, how many days has the physician, or authorized assistant or practitioner, changed the patient's orders? Do not include drug or treatment order renewals without change.
Enter "0" if none. ☐

C. Treatments and Conditions:

Has the patient received any of the following health treatments, or been diagnosed with any of the following health conditions? **Enter "0" for No, "1" for Yes, and "2" for Unknown:**

a. Stage 3-4 pressure sores in the last 14 days? ☐

b. Intravenous or parenternal feedings in the last 7 days? ☐

c. Interavenous medications in the last 14 days? ☐

d. Tracheostomy care, ventilator/respirator, suctioning in the last 14 days? ☐

e. Pneumonia in the last 14 days? ☐

f. Daily respiratory therapy in the last 14 days? ☐

g. Daily insulin injections with 2 or more order changes in the last 14 days? ☐

h. Peritoneal or hemodialysis in the last 14 days? ☐

D. Skilled Rehabilitation Therapies

Record the total minutes each of the following therapies was administered or scheduled (for at least 15 minutes a day).
Enter "0" if none or less than 15 minutes daily. Enter "999" if unknown:

a. Total number of minutes provided in the last 7 days
b. Total number of minutes scheduled for next 7 days, but not yet administered

Therapy	a.	b.
Speech Therapy		
Occupational Therapy		
Physical Therapy		

E. **Physician's Name** (type or print):	**Phone:**
Address:	
Signature: (Physician or Physician's PA, NP, RN, LPN)	**Date:**

Office of Aging and Adult Services (OAAS)
STATEMENT OF MEDICAL STATUS (SMS)

Instructions for OAAS Form: Statement of Medical Status (OAAS-PF-06-009)
for Home and Community Based Programs Use Only

The SMS may be used by Home and Community Based Program support coordinators/assessors when there is no supporting documentation available to verify that an individual meets level of care eligibility under Pathway 3 – Physician Involvement, Pathway 4 – Treatments and Conditions, and/or Pathway 5 – Skilled Rehabilitation Therapies, **AND** the individual meets no other Level of Care (LOC) Pathway.

*The SMS may be completed and signed by the applicant's physician, by a qualified licensed professional (i.e., Physician's Assistant [PA], Nurse Practitioner [NP], Registered Nurse [RN], or Licensed Practical Nurse [LPN]) in the physician's office**. The SMS information may also be obtained from the physician's office per telephone by the agency's RN, LPN, assessor, or support coordinator**. Information obtained per telephone must be clearly documented on the SMS as verbal information and signed by the RN, LPN, assessor or support coordinator who obtained the information. Information obtained verbally is not considered a verbal order, and is considered part of the assessment gathering process.

The SMS is **not** to be used for physician orders to home and community based programs.

The SMS, if completed, should be submitted with the Plan of Care (POC) packet to the appropriate OAAS office, or OAAS designated review staff.

Please note: If additional space is needed for any section of this form, the reverse side may be used or an additional page attached.

I. Patient Information:

a. **Applicant's Name:** Enter the applicant's legal name
b. **Date of Birth:** Enter the year as a 4 digit number (e.g., 2/14/1927)
c. **Gender:** Enter gender (e.g., M/F)
d. **SS# / Medicaid / Medicare #:** Enter the applicant's SS#, Medicaid # and Medicare # if known
e. **Home Address:** Enter the applicant's address including zip code
f. **Telephone #:** Enter the applicant's or personal representative's telephone number, including area code

II. Medical Information:

A. Diagnoses:

a. Identify applicant's primary diagnoses from physician's medical records; hospital records; from the individual; include ICD-9 codes if available
b. Identify applicant's secondary diagnoses from physician's medical records; hospital records; from the individual; include ICD-9 codes if available
c. Identify all other diagnoses

B. Physician Involvement:

a. Physician Visits: Enter the number of days the patient has been examined by the physician

(or authorized assistant of practitioner) within the last 14 days. **Do not count emergency room exams or hospital visits.** Enter "0" if none.

b. **Physician Orders:** Enter the number of **new** orders that were written for the patient by the physician identified below, within the last **14 days**. Do not include in-patient order changes for the applicant; Do not include renewal orders that do not involve a change. The following are considered examples of **new** orders:

- Physician orders in the emergency room
- New orders written by primary physician for specialist consultation
- New medications
  - New dosage, route, or frequency
  - New sliding scale with different parameters for insulin administration
- New procedures/treatments
  - New frequency, sites, routes, dosage
- New services
  - Home Health; initial order and subsequent changes
  - Physical therapy, occupational therapy, speech therapy; initial order and subsequent changes
- New equipment

The following are **NOT** considered new orders

- Drug renewal orders with no change in dosage, route or frequency
- Renewal of continued skin care treatments (etc) which are no different from previous orders

C. Treatments and Conditions:

Has the patient received any of the following health treatments, or been diagnosed with any of the following health conditions? **Enter "0" for No, "1" for Yes, and "2" for Unknown:**

a. Stage 3-4 pressure sores in the last 14 days?

b. Intravenous or parenternal feedings in the last 7 days?

c. Interavenous medications in the last 14 days?

d. Tracheostomy care, ventilator/respirator, suctioning in the last 14 days?

e. Pneumonia in the last 14 days?

f. Daily respiratory therapy in the last 14 days?

g. Daily insulin injections with 2 or more order changes in the last 14 days?

h. Peritoneal or hemodialysis in the last 14 days?

D. Skilled Rehabilitation Therapies:

- Record the total minutes each of the following therapies was administered or scheduled (for at least 15 minutes a day). **Enter "0" if none or less than 15 minutes daily. Enter "999" if unknown:**

a. Total number of minutes provided in the last 7 days
b. Total number of minutes scheduled for next 7 days, but not yet administered

E. Physician's Name Address/Phone Number:

- Identify the name, address, etc. of the physician/physician's office that is completing/providing the SMS information.

- **Signature on SMS:** The SMS may be signed by the physician, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or the assessor/support coordinator completing the SMS (*refer to page one, second paragraph of this document for further clarification regarding who may sign the SMS form) . This signature does not attest to having completed an assessment. It indicates that the information entered on the SMS was extracted from the applicant's medical record by the signer.