

**Practitioner Statement of Need for Personal Care/
Consumer Directed Personal Assistance Services
For Adults 18 and Over (for Immediate Needs)**

This form is intended for adult patients (age 18 or older) who have an immediate need for personal care and/or consumer directed personal assistance services. This includes care in the home to ensure continued patient safety through aide assistance with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).

For patients under age 18, practitioners cannot use this form and instead must continue to complete the Physician's Order for Personal Care/Consumer Directed Personal Assistance Services form (DOH-4359 or HCSP-M11Q).

Complete All Items

Incomplete forms will be returned to the practitioner

1. Patient Identifying Information

Last Name		First Name	
Date of Birth	Medicaid CIN	Social Security Number	Telephone Number
Address: Street			
Address: City		State	ZIP Code

2. Practitioner Information

Last Name		First Name	
License #	Profession (MD, DO, NP, PA, SA)		Telephone Number
Address: Street			
Address: City		State	ZIP Code

I, the undersigned practitioner, certify I have direct knowledge of the patient's condition and it is my opinion that they are in need of personal care and/or consumer directed personal assistance services.

Practitioner Signature

Date Signed

Instructions

Complete all items. Incomplete forms will be returned to the practitioner. Incomplete or missing information may delay services to this patient.

1. Patient Identifying Information

- **Last Name.** Enter the patient's last name.
- **First Name.** Enter the patient's first name.
- **Telephone Number.** Enter the patient's telephone number.
- **Date of Birth.** Enter the patient's date of birth.
- **Medicaid CIN.** Found on the patient's Medical Assistance ID card.
- **Social Security Number.** Enter the patient's social security number.
- **Address.** Enter the patient's address.

2. Practitioner's Information.

Enter information for the practitioner signing the order. The medical professional must be a physician licensed in accordance with article 131 of the Education Law, a physician assistant or a specialist assistant registered in accordance with article 131-B of the Education Law, or a nurse practitioner certified in accordance with article 139 of the Education Law. Enter the practitioner's license number as issued by the New York State Department of Education.

3. Practitioner's Signature/Date Signed.

The signature of the practitioner identified in item 2. Note that by signing this document, the practitioner certifies that they have direct knowledge of the patient's condition and that the patient is in need of personal care and/or consumer directed personal assistance services.

4. Return Form To:

- A. The Patient.** The practitioner may provide the form directly to the patient to include with the other information required for immediate need of personal care and/or consumer directed personal assistance services to be submitted to their Local Department of Social Services.
- B. The Local Department of Social Services.** This form may be faxed directly to the Local Department of Social Services if the form is provided to the practitioner with the information filled out below:

County Name

Fax Number