Special Touch CDPAP
A CONSUMER DIRECTED PERSONAL ASSISTANCE COMPANY

1569 Flatbush Avenue
2nd Floor
Brooklyn, NY 11210

Facsimile Transmittal

To: Special Touch C.R.P.U.	Fax: 718-907-3377
From:	Date:
Re:	Pages:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

FAX THE COMPLETED FORM TO 718-907-3377.
If you have any questions call 718-736-2344 and ask to speak with our Intake Department.

Your patient's insurance WILL deny/reject CDPAP services for your client if this form is not completed 100% in accordance with the guidelines below.
To avoid slowing down the process, please read through the following guidelines carefully.
You are also welcome to call us with any questions.
Thank you for your assistance – we greatly appreciate the opportunity to work together to better serve your patient(s)!

TIPS ON HOW TO ACCURATELY COMPLETE THE (DOH-4359) PHYSICIAN'S ORDER FOR CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

1. The client's name, address, telephone #, DOB, and CIN number **MUST** be provided (PG 1).
2. The medical professional **MUST** complete the DOH-4359 by accurately describing the patient's current medical/ physical condition (PGS 1 & 2) and providing ICD-10CM diagnosis codes (PG 1).
3. The medical professional **MUST NOT** recommend or request the number of hours of personal care services.
4. The date of the examination (PG 1) **MUST** be provided.
5. The DOH-4359 **MUST** be signed by a NY State licensed physician. If the patient was examined by a Physican's Assistant, Specialist's Assistant, or Nurse Practioner, complete the required information (PG 1). The name, license number, and the complete business address **MUST** be indicated.
6. The medical professional whom completed the form must sign and date it (PG 2). The date must be within 30 days of the exam date (PG 1).
7. The completed signed copy of the DOH-4359 **MUST** be faxed to Special Touch **(Fax: 718-709-8867)** within 30 calendar days after the date of examination (PG 1).

Notes: Is there anything else you would like us to know? Tell us here....

CONFIDENTIAL

DOH-4359 (2010)

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

COMPLETE ALL ITEMS *INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN*

1. Patient Identifying Information *(Use Additional Paper If Necessary)*

PATIENT NAME		CIN	DATE OF BIRTH	SEX
ADDRESS: APT/STREET		CITY	STATE	ZIP CODE
TELEPHONE NO. ( )	MEDICARE NO.	IF CURRENTLY HOSPITALIZED: Name of Hospital	DATE OF ADMISSION:	ANTICIPATED DATE OF DISCHARGE

TO ABOVE ADDRESS? ☐ YES ☐NO IF NO EXPLAIN:____________________

2. General Information

PHYSICIAN NAME		LICENSE #	TELEPHONE NO. ( )
ADDRESS: STREET	CITY	STATE	ZIP CODE

If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify:
Name __________ Profession: __________ License # __________

PLACE OF EXAMINATION: __________

DATE OF EXAMINATION: __________

3. Medical Findings

NOTE: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

Height: __________ Weight: __________

For the condition(s) requiring personal care:

Primary Diagnosis __________ ICD-9-CM Code __________

Secondary Diagnosis __________ ICD-9-CM Code __________

Describe the patient's current medical/physical condition __________

Is the patient's condition stable? ☐ Yes ☐ No

Is the patient appropriate for Hospice care? ☐ Yes ☐ No

Describe the current treatment plan and therapeutic goals including the prognosis for recovery: __________

Describe any prohibited activities or functional limitations: __________

Is the patient self-directing? ☐ Yes ☐ No

Is the patient able to summon help by any means? ☐ Yes ☐ No

If no, explain __________

Is the patient able to ambulate independently? ☐ Yes ☐ No With devices? ☐ Yes ☐ No Other Assistance? ☐ Yes ☐ No

Describe: __________

Is the patient continent of bowel? ☐ Yes ☐ No of bladder? ☐ Yes ☐ No

Catheter/Colostomy Needs: __________

List all current medications (prescription and OTC) and note dosage and frequency and any special instructions (attach additional sheet if necessary):

Can the patient self-administer medications: ☐ Yes ☐ No

If the patient requires a modified diet or has other special nutritional or dietary needs, describe: ______

______

______

Please indicate any task, treatments or therapies currently received, or required by the patient: ______

______

______

______

Does the patient require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)?

☐ Yes ☐ No

If Yes, please indicate:

______

______

______

Based on the medical condition, do you recommend the provision of service to assist with skilled tasks, personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Contributing Factors:

Describe contributing factors including but not limited to the social, family, home or medical (e.g. muscular/motor impairments, poor range of motion, decreased stamina, etc.) situation that may affect the patient's ability to function, or may affect the need for home care or that may affect the patient's need for assistance with skilled tasks, personal care tasks and/or light housekeeping. Please include any other information that may be pertinent to the need for assistance with home care services.

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IT IS MY OPINION THAT THIS PATIENT CAN BE CARED FOR AT HOME. I HAVE ACCURATELY DESCRIBED HIS OR HER MEDICAL CONDITION. NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PARTS 515, 516, 517 AND 518 OF TITLE 18 NYCRR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM, PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES WHEN MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature ______ Date ______

PLEASE SIGN AND RETURN COMPLETED FORM WITHIN 30 CALENDAR DAYS OF EXAMINATION TO:

Special Touch CDPAP

1569 Flatbush Avenue 2nd Floor

Brooklyn, NY 11210

Fax: 718-907-3377

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New York State Department of Health