471-000-69 Instructions for Completing Form MS-82, "Adult Day Care Assessment/ Authorization"

Use: Form MS-82, "Adult Day Care Assessment/Authorization" is used by the Adult Day Care provider to assess the client for skilled nursing and/or aide services. The HHS worker uses Form MS-82 to authorize Medicaid payment to the provider for skilled nursing and/or aide services.

Number Prepared: Form MS-82 is completed in duplicate.

Completion: Form MS-82 is completed by the Adult Day Care personnel who retain the pink copy. If payment is requested for skilled nursing services, the form must be completed by an RN/LPN. It is forwarded to HHS staff for authorization of Medicaid payment for skilled nursing and/or aide services.

Adult Day Care personnel complete the following Sections:

1. Enter the client's Medicaid number. The provider is responsible to assure that the client has current Medicaid eligibility.
2. Enter the client's date of birth.
3. Circle the appropriate sex.
4. Enter the client's name, current address, and phone number.
5. Enter the provider's name, address, and phone number.
6. Enter the client's current living arrangement. Check the appropriate box and enter the living arrangement if it is "Other."
7. Enter the client's principal diagnosis.
8. Staff Interventions:
   Circle the days that care was provided for each specific service. Indicate the types of injections or treatments given.
   For Personal Care, check each applicable box.
9. Enter the specific current physician orders for care being provided by the Adult Day Care staff.
10. Check the appropriate box to indicate whether the client is currently receiving any home health agency service. If so, indicate specifically services being received, i.e., daily aide visit to assist the client every a.m.; weekly RN visit to pre-fill insulin syringes, etc.
11. Enter the physician's name and address.
12. Enter signature of provider and the date.
13. HHS staff will authorize or deny skilled nursing and/or aide services in this box. Enter the To and From dates of the approval period. Enter the number of days per week for RN services or the number of days of aide services. If the client needs both RN and aide services, then the RN service is authorized.

The number of days approved per week cannot exceed the number of days that the center is open.

The approval period cannot exceed six months.

If services are denied, check the appropriate box.

Sign and date.

Distribution:

1. White copy of Form MS-82 is retained in client's HHS case record.
2. Yellow copy of Form MS-82 is returned to the Adult Day Care Provider.

Retention:

Form MS-82 is retained in the client's case record and by the provider for six years.

To view printable form click here: Adult Day Care Assessment/Authorization

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Health and Human Services System

ADULT DAY CARE ASSESSMENT/AUTHORIZATION

1. Client Case No ID No: 2. Date of Birth 3. Sex M F

4. Client's Name, Address and Telephone Number

5. Provider's Name, Address and Telephone Number

6. Living Arrangement
❑ House / Apt ❑ Other _____ Specify

7. Principal Diagnosis

8. Staff Interventions

RN/LPN (Circle days provided)

1. Medication Administration
M - T - W - T - F - S
2. Complete Med Set-up
M - T - W - T - F - S
3. Injections
Type_____
M - T - W - T - F - S
4. Catheter Irrigations/Care
M - T - W - T - F - S
5. Vital Signs
M - T - W - T - F - S
6. Lab Draws
M - T - W - T - F - S
7. Dressing Changes
M - T - W - T - F - S
8. Treatments
Type _____
M - T - W - T - F - S

Aide (Circle days provided)

1. Bath given at Center
M - T - W - T - F - S
2. Personal Care Given
❑ Shaving ❑ Skin Care
❑ Hair Care ❑ Nail Care
❑ Other
M - T - W - T - F - S
3. Assistance with
❑ Eating
❑ Toileting
❑ Ambulation
❑ Transfers
❑ Alzheimer & Related Behavior
❑ Other
M - T - W - T - F - S
4. ❑ Arranging Appointments
Frequency _____

9. MD orders for Care and Treatments (specify type/duration)

10. Client is currently receiving
Home Health Agency Personal Assistance Services
❑ Yes ❑ No
If yes - describe type and amount.

11. Physician's Name and Address

13. Services Approved: From _____To_____
Number of Days Per Week:
RN_____
Aide_____
Service Denied _____

12. Provider Signature Date

Case Manager Signature Date