



# MassHealth Adult Foster Care Primary Care Provider (PCP) Order Form

This form must be completed by the adult foster care (AFC) provider and reviewed, verified, and signed by the member's PCP in order to receive prior authorization (PA).

## Member Information

Member's Name 035 | Shazia Faizullah

MassHealth ID 100234682761

Member's Address 3 Kaolin Rd., Apt 1, Blandford MA, 01008

Member's Telephone (267) 438-6478

Date of Birth 04-05-1990

AFC Provider Agency Name Star Home Health Solutions LLC

AFC Provider Agency Address 33 Oak Avenue, Suite 2, Worcester MA, 01605

AFC Provider Agency Assessment of Medical Necessity Criteria (130 CMR 408.000, 130 CMR 450.000)

## Section I: To be completed by AFC Provider and reviewed/approved by PCP

### Activities of Daily Living Please refer to AFC Medical Necessity Guidelines Section II.A.2.a-f for Clinical Eligibility Criteria

<input checked="" type="checkbox"/> Bathing	Daily Hands-on (Physical) Assistance Needed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Cueing and Supervision Required During Entire Activity? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Dressing	Daily Hands-on (Physical) Assistance Needed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Cueing and Supervision Required During Entire Activity? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Toileting	Daily Hands-on (Physical) Assistance Needed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Cueing and Supervision Required During Entire Activity? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Transferring	Daily Hands-on (Physical) Assistance Needed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Cueing and Supervision Required During Entire Activity? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Mobility (Ambulation)	Daily Hands-on (Physical) Assistance Needed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Cueing and Supervision Required During Entire Activity? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Eating	Daily Hands-on (Physical) Assistance Needed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Cueing and Supervision Required During Entire Activity? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

## Behaviors

Wandering: moving with no rational purpose, seemingly oblivious to needs or safety	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Verbally abusive behavioral symptoms: threatening, screaming, or cursing at others	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Physically abusive behavioral symptoms: hitting, shoving, or scratching	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Clinician: Clinician, Agency

Signature:

Date: 1/6/2026

Socially inappropriate or disruptive behavioral symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, or causing general disruption

☐ Yes ☒ No

Resisting care

☐ Yes ☒ No

The Member Diagnosis and Signs and Symptoms below should support the need for AFC services.

Member Diagnosis: F333 (Major depressive disorder, recurrent, severe with psychotic symptoms)  
E6601 (Morbid (severe) obesity due to excess calories)  
B9681 (Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere)  
F419 (Anxiety disorder, unspecified)  
F4310 (Post-traumatic stress disorder, unspecified)

Member Signs and Symptoms:

Annual assessment of 35 yr old female originally from the Middle-East. She communicates primarily in Pashto and required use of a translator for this assessment. Member presented with a flat affect and with brief answers through the assessment. The home was clean, neat, and free of obvious safety concerns. Member has dx of Major Depressive disorder with psychotic features, PTSD, Anxiety, Hypertension, GERD, Recurring HPylori infection. She also reports Abdominal pain, headaches, and back pain. Caregivers report that member's mood continues to be depressed and often needs motivation and assistance to initiate and complete tasks. They report that she barely eats but continues to gain weight. Member reports that she does not understand why her mood is always low. She reports difficulty coping with her health status. She reports that her headaches, nausea, dizziness, keep her from being able to care for herself and her family. Caregiver reports that 2 nights ago, member was found on the bathroom floor after they were concerned that she was taking too much time in the bathroom. Member reports that she suddenly felt nausea, dizziness, weakness, and blurred vision causing her to almost lose consciousness. The family is now making sure they remain with her during bathing and toileting. They also assist her to reach her back and lower extremities during bathing and dressing. Member reports fear of falls while ambulating; she supports herself with the walls and furniture, and when outdoors, she is supported by her caregivers. They remain with her during meals to offer encouragement as her appetite has been low and foregoes meals. Member reports feeling drowsy most of the time and feels unsafe if left alone. She is supervised with transfers to ensure safety due to dizziness. Member reports elevated blood pressure on most days, accompanied by blurred vision. Caregivers report that her sleep is also interrupted by thoughts, and as a result, she is drowsy during the day. Member remains at risk for falls without caregiver supervision and assistance. Member has multiple medications requiring assistance with management to ensure compliance and effective treatment. Caregivers also assist with household chores; meal preparation and ordinary housework due to physical and psychiatric limitations. Her caregivers manage her appointments, transportation, and finances due to low literacy, knowledge deficit, and poor insight. She reports memory deficit and gets anxious and overwhelmed trying to manage her care. Due to her current level of care, member requires Level 2 AFC services to ensure continued safety at home and in the community.

Clinician: Clinician, Agency

Signature:

Date: 1/6/2026

**AFC Provider Attestation:**

I certify that I am the requesting AFC provider. I certify that the clinical eligibility/medical necessity information (per 130 CMR 408.416, 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

*Shazia Faizullah* RN

RN, NP

12-17-2025

AFC Provider's Signature

Circle Applicable Credentials

Date

**Section II: PCP Review and Attestation:** Please review Section I information and complete the PCP information and attestation below.

**Ordering Provider (PCP) Information**

MassHealth requires that services be ordered, referred, or prescribed (ORP). ACA Section 6401(b) requires that 1) the billing provider include the ORP provider's **NPI on the claim**; and 2) the ORP provider **be actively enrolled with MassHealth as a fully participating provider** or as a **nonbilling provider**.

Prescribing Provider's Name **Kibathi Vanessa - PA**

Prescribing Provider's Address **26 QUEEN ST, STE 13, Worcester MA, 01610**

Prescribing Provider's Telephone **(508) 860-7800**

Prescribing Provider's MassHealth Provider ID/Service Location

Prescribing Provider's NPI **1740993849**

**Prescribing Provider Attestation:**

I certify that I am the prescribing provider. I certify that the clinical eligibility/medical necessity information (per 130 CMR 408.416 and 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

*Physician  
Signature*

Electronically Signed by [ ] on [ ]

MD, DO, NP, PA

Prescribing Provider's Signature

Circle Applicable Credentials

Date

Clinician: Clinician, Agency

Signature:

Date: 1/6/2026

## List of Medication for 035 | Shazia Faizullah

Star Home Health Solutions LLC

	Name and Dose	Form	Number Taken	Frequency
1	Acetaminophen 325 mg	By mouth (PO)	2 tablets (650mg)	Q6H. Every six hours
2	Amlodipine tablet 5mg tablet	By mouth (PO)	1 tab	QD. Once daily
3	Docusate Sodium tablet 100 mg	By mouth (PO)	1 tablet	BID. Two times daily (includes every 12 hrs)
4	Drospirenone tablet 4 mg	By mouth (PO)	1 tablet	QD. Once daily
5	Ferrous Gluconate 324 mg	By mouth (PO)	1 tab	QOD. Every other day
6	Fluticasone nasal spray 50 mcg/ACT		2 sprays	QD. Once daily
7	Hydroxyzine 25 mg	By mouth (PO)	1	Q6H. Every six hours
8	Ibuprofen 400 mg	By mouth (PO)	1 tab	Q6H. Every six hours
9	Metformin HCl 500 mg	By mouth (PO)	1 tab	QD. Once daily
10	Pantoprazole 40 mg	By mouth (PO)	1	BID. Two times daily (includes every 12 hrs)
11	Sertraline 100 mg	By mouth (PO)	1 tablet	QD. Once daily
12	Trazodone 100 mg	By mouth (PO)	1	QD. Once daily
13	Valsartan- Hydrochlorothiazide tablet 320-12.5 mg	By mouth (PO)	1 tablet	QD. Once daily

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Clinician: Clinician, Agency

Signature:

Date: 1/6/2026

List of Diagnoses for 035 | Shazia Faizullah

Star Home Health Solutions LLC

Diagnosis		ICD 10 Code
1	Major depressive disorder, recurrent, severe with psychotic symptoms	F33.3
2	Morbid (severe) obesity due to excess calories	E66.01
3	Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere	B96.81
4	Anxiety disorder, unspecified	F41.9
5	Post-traumatic stress disorder, unspecified	F43.10
6	Other hypersomnia	G47.19
7	Essential (primary) hypertension	I10
8	Gastro-esophageal reflux disease without esophagitis	K21.9
9	Calculus of gallbladder without cholecystitis without obstruction	K80.20
10	Somnolence	R40.0
11	Headache, unspecified	R51.9
12	Prediabetes	R73.03

Clinician: Clinician, Agency

Signature:

Date: 1/6/2026