DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL ASSISTANCE PERSONAL CARE SERVICES LTSSMaryland AUTHORIZATION FORM – DHMH 302B

I. ASSESSMENT INFORMATION

A. Date of Assessment: _____ **B.** Initial_____ Annual_____ Re-Assessment_____

II. APPLICANT INFORMATION

A. Applicant's Name: Last_____ First_____ M.I.____

B. Date of Birth: _____ M.A.#: _____

C. Responsible Relative/Guardian or Emergency Contact

Name: _____
Address: _____
Telephone #: _____Relationship: _____

D. Is there any person currently assisting the applicant with activities of daily living? ☐ Yes ☐ No If yes,

Name: _____
Address:_____
Telephone #: _____Relationship:_____

E. Is there any person the applicant recommends as a personal care provider? ☐ Yes ☐ No If yes,

Name: _____
Address: _____
Telephone #: _____Relationship:_____

F. Other services received and frequency:

1.

☐ Medicaid Waiver Services_____	☐ Nutrition Program for the Elderly _____
☐ Homemaker/Chore Service _____	☐ Adult Evaluation Service (AERS)_____
☐ Senior Care Program (MDOA)_____	☐ Adult Day Care Program_____
☐ Multipurpose Senior Centers_____	☐ Social Work Services (DSS)_____
☐ Sheltered Housing_____	☐ Meals On Wheels_____
☐ Home Health_____	☐ Mental Hygiene Administration (MHA)_____
☐ Foster Care for Adults _____	☐ Developmental Disabilities Admin. (DDA)_____
☐ Other, Specify_____	☐ None _____

2. Contact: _____ Contact: _____ Contact: _____
Agency: _____ Agency: _____ Agency: _____
Telephone #: _____Telephone #:_____ Telephone #:_____

III. MEDICAL INFORMATION

Physician's Name: _____Phone Number: _____
Physician's Address: _____

IV. REFERRALS TO OTHER SERVICES: _____

_____
_____

V. APPLICANT CERTIFICATION

This is to certify that I am requesting personal care services and that the above information is true, accurate and complete to the best of my knowledge and belief. I understand that services under the Personal Care Services Program will be paid for by the federal and State governments and that any false claims, statements, documents or concealment of material facts will be prosecuted under applicable federal and State laws.

Signature:_____ Date: _____
(APPLICANT OR APPLICANT'S REPRESENTATIVE)

Witness:_____ Date: _____

VI. CASE MONITOR'S INFORMATION AND CERTIFICATION

A. Case Monitor's Name: _____ Agency:_____
B. Jurisdiction: _____
C. Telephone Number: _____
D. Assessed Level of Service and Frequency: _____

E. This is to certify that the above information is accurate and complete to the best of my knowledge and professional judgment.

Case Monitor's Signature: _____ Date: _____

VII. AUTHORIZATION OF SERVICE:

☐ Approved ☐ Disapproved

Justification (Level is based on the complexities of ADL and IADL, frequency of services, degree of dependency of recipient and lack of support system):

Level _____ Frequency_____

Signature of Coordinator or Supervisor:_____ **Date:**_____