NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Heritage Health Adult

Medically Frail Attestation Form

Purpose:
Nebraska DHHS Medicaid and Long Term Care (MLTC) uses this Attestation form to determine if the Heritage Health Adult (HHA) Medicaid Expansion member is Medically Frail. Submission of this form or a Medically Frail determination does not affect underlying Medicaid eligibility. Members who are determined Medically Frail by DHHS will be enrolled in the HHA Prime benefit tier. Medically Frail determinations are effective for 12 or 36 months before a redetermination is required.

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. Forms signed by the member will not be accepted.

Provider Instructions:
If you are a provider with diagnosing capabilities within your scope of practice and have a patient whom you believe meets the Medically Frail criteria as defined in the categories below, please complete this form and check the certification box. Incomplete forms will not be accepted.

Upload this form to: https://dhhs.ne.gov/pages/accessnebraska.aspx
For instructions on uploading forms please reference the following document
https://dhhs.ne.gov/Documents/Med%20Frail%20ACCESSNebraska.pdf

If you cannot use the ACCESSNebraska website, mail or email this form to:

Nebraska DHHS
ATTN: Heritage Health Adult Medically Frail Determinations
PO Box 95026
Lincoln, NE 68509
E-Mail: dhhs.AndiCenter@nebraska.gov

Patient Information (REQUIRED)

Date Assessment Completed:	Medicaid ID: (if known)
Patient Name (First, Middle Initial, Last):	
Address:	
City, State, Zip Code:	Date of Birth:

PLEASE ATTACH MEDICAL DOCUMENTATION TO SUPPORT THIS MEDICALLY FRAIL ATTESTATION.
Documentation must be from the last 12 months.

1. (a) Serious and Complex Medical Conditions

Medical conditions which significantly impair the individual's ability to function independently in an appropriate and effective manner in the functional areas of (1) Vocational/ Educational, (2) Social Skills, or (3) Activities of Daily Living.

Medically Frail:	**Yes ☐ No ☐**
Diagnosis	**ICD-10 Codes**
1.	
2.	
3.	
4.	

Please describe severity of illness:

Activities of Daily Living: Mark below if help is needed to complete the task safely and helper **MUST** be physically present throughout the task for **each occurrence**.

Dressing	**Bathing**	**Continence**	**Toileting**	**Eating**	**Mobility in Home**	**Transferring**	**No Assistance needed for ADLs**
☐	☐	☐	☐	☐	☐	☐	☐

1. (b) Other Serious and Complex Medical Conditions

Patient's Medical Condition	**Yes / No**	**Diagnosis for Hospice or Long Term Care/Residential Facility**	**ICD-10 Codes**
The patient is in Hospice	☐ ☐		
The patient meets hospice criteria, however chooses not to be in hospice.	☐ ☐		
The patient is in a long-term care facility or residential facility.	☐ ☐		

2. Disabling Mental Disorder

Medically Frail:	**Yes ☐ No ☐**
Diagnosis	**ICD-10 Codes**
1.	
2.	
3.	

Please describe severity of illness:

3. Chronic Substance Use Disorder

Medically Frail:	Yes ☐ No ☐
Diagnosis	**ICD-10 Codes**
1.	
2.	
3.	
Please describe severity of illness:	

4. Physical Disability <u>Requiring ADL Assistance</u> (ADL section must be completed)

Medically Frail:	Yes ☐ No ☐
Diagnosis	**ICD-10 Codes**
1.	
2.	
3.	
Please describe severity of illness:	

Activities of Daily Living: Mark below if help is needed to complete the task safely and helper **MUST** be physically present throughout the task for **each occurrence**.

Dressing	Bathing	Continence	Toileting	Eating	Mobility in Home	Transferring	No Assistance needed for ADLs
☐	☐	☐	☐	☐	☐	☐	☐

5. Developmental or Intellectual Disability <u>Requiring ADL Assistance</u> (ADL section must be completed) The patient has an intellectual or developmental disability as defined in Title 404 NAC 2.

Medically Frail:	Yes ☐ No ☐
Diagnosis	**ICD-10 Codes**
1.	
2.	
3.	
Please describe severity of illness:	

Activities of Daily Living: Mark below if help is needed to complete the task safely and helper **MUST** be physically present throughout the task for **each occurrence**.							
Dressing	**Bathing**	**Continence**	**Toileting**	**Eating**	**Mobility in Home**	**Transferring**	**No Assistance needed for ADLs**
☐	☐	☐	☐	☐	☐	☐	☐

6. Social Security Determination Beneficiary has a current disability designation based on Social Security Administration criteria.

Medically Frail:	**Yes ☐ No ☐**
Diagnosis	**ICD-10 Codes**
1.	
2.	
3.	
4.	

7. Chronic Homelessness

Member meets ONE of the following criteria	**Yes / No**
1. Has been continuously homeless for a year or more, (HUD defines "homelessness" is defined as "a person sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter).	☐ ☐
2. Has had four (4) episodes of homelessness in the last three (3) years that total 12 months.	☐ ☐

Provider Attestation (REQUIRED)

Name of Provider (First, Middle Initial, Last):	
Provider **Specialty**:	
Provider **NPI** (National Provider Identification Number):	
Clinic **Telephone**:	Clinic **Email**:

CERTIFICATION ☐ I certify that by signing this document and checking this box I am a provider with diagnosing capabilities within my scope of practice, and I understand that any false statement, omission, or misrepresentation may result in prosecution under state and federal laws. I agree to submit, if requested by Nebraska DHHS MLTC, any additional information in support of this attestation. I also certify that I have obtained the member's written consent to provide the Nebraska DHHS MLTC this information.

_____ **Signature**	_____ **Date**