

**TARGETED CASE MANAGEMENT PROGRAM
CLIENT APPLICATION**

PLEASE SUBMIT COMPLETED FORM TO:

**Department of Public Welfare
Office of Medical Assistance Programs
Provider and Member Services Section
PO Box 8044
Harrisburg, PA 17015-8044**

REVISED 03/15/04

COMPLETING THE TARGETED CASE MANAGEMENT CLIENT APPLICATION

All items must be completed.

Date of Application: Enter the date the application Case Management Services is initiated.

CLIENT INFORMATION:

Information may be obtained from client's Pennsylvania ACCESS Card.

Recipient Number: Enter the ten-digit recipient number found on the client's Pennsylvania ACCESS Card. Check the Eligibility Verification System to make sure the client is currently eligible and not in a Managed Care Organization. (1-800-766-5387)

Name: Enter the client's last name, first name and middle initial exactly as they appear on the Pennsylvania ACCESS Card.

Phone Number: Enter the area code and telephone number of the client.

Address: Enter the client's current address and social security number.

CASE MANAGER INFORMATION:

Targeted Case Manager's Name: Enter the full name of the targeted case manager.

Provider ID Number: Enter the thirteen (13) digit Provider ID number assigned by the Office of Medical Assistance Programs.

Phone Number: Enter the area code and telephone number of the case manager.

Complete the information about other case managers currently providing services to the client, if applicable.

After the above information is entered on the application, have the client read the authorization or read it to the client. The client's signature on the application authorizes the release of medical information to the Department.

NOTE: Have the client sign application prior to completion by the attending physician.

Client/Parent Guardian's Signature: Signature of the client. If the client is unable to sign the form, a parent or legal guardian may do so.

Date: Date client, parent or legal guardian signs the form.

PHYSICIAN INFORMATION:

Provider ID Number: Enter the thirteen (13) digit provider ID number assigned by the Office of Medical Assistance Programs.

License Number: If not enrolled as a medical assistance provider, enter the nine digit professional license number of the physician.

Physician: Enter the full name of the client's physician.

Phone Number: Enter the area code and telephone number of the physician.

Address: Enter the complete office address of the physician.

NOTE: For an individual to be eligible for the Targeted Case Management Program, he/she must be diagnosed with AIDS or symptomatic HIV disease. The individual need not be currently symptomatic to qualify for the program. A history of at least one HIV related condition is sufficient. It is the responsibility of the attending physician to certify the individual's target group eligibility. In Part A, document either the appropriate condition that defines AIDS (opportunistic infection per CDC criteria), or document in Part B, the symptom(s) related to HIV for which the individual is currently or has been previously treated. Provide the appropriate ICD-9-CM diagnosis code(s) for "Other" only.

Physician's Signature: Signature of the client's physician.

Date: Date physician signs the form.

CASE MANAGEMENT AGREEMENT FORM:

1. Complete the top portion by printing or typing the client's name, address and recipient number.
2. Have the client, a family member, or the client's legal representative read the agreement form.
3. Explain the form and program to the client, a family member, or the client's legal representative.
4. You, or the client, must check the appropriate block in paragraph 3.
5. Have the client, a family member, or the client's legal representative sign and date the agreement form on the bottom left. The case manager signs and dates the agreement form on the bottom right.
6. Give a completed copy to the client, a family member, or the client's legal representative; keep a case manager copy in the client's record, and submit the original to the Department.

TARGETED CASE MANAGEMENT CLIENT APPLICATION

Date of Application: _____

CLIENT INFORMATION:

RECIPIENT #:
NAME:
ADDRESS:
PHONE #:
PHONE #:
SOCIAL SECURITY #:

CLIENT INFORMATION:

TARGETED CASE MANAGER'S NAME:	
PROVIDER ID #:	PHONE #:

Do you currently have a case manager from any program or agency, other than the local County Assistance Office and the Targeted Case Management Program? Yes No

If yes, identify by name: _____ Phone Number: (____) _____

What kind of services are provided? _____

I certify the information contained above on this application is accurate to the best of my knowledge.

I authorize the release of medical information including information pertaining to HIV/AIDS, by my attending physician or case manager to the Department of Public Welfare or its agents, for purposes of determining eligibility for the Targeted Case Management Program and obtaining services of a case manager. The authorization remains revocable until acted upon.

Signature of applicant/guardian

Date

PHYSICIAN INFORMATION:

PROVIDER ID #:	LICENSE #:
PHYSICIAN:	
ADDRESS:	
PHONE #:	

**BEFORE COMPLETING, PLEASE READ THE ACCOMPANYING INSTRUCTIONS
FOR THIS SECTION.**

CLIENT'S NAME:

Physician's Statement for Target Group:

I certify that the client identified on this application is eligible for the Targeted Case Management Program based on a positive HIV test and either a diagnosis of AIDS (see "A" below) or symptomatic HIV disease (see Part "B" on the following page).

Please check Part A or B as appropriate

A. DIAGNOSIS OF AIDS	
<input type="checkbox"/> 042.1 Candidiasis (excluding lung)	<input type="checkbox"/> 042.2 Lymphoma
<input type="checkbox"/> 042.0 Cervical cancer, invasive	<input type="checkbox"/> 031.0 Mycobacterium avium intracellular
<input type="checkbox"/> 042.0 Cryptococcal meningitis	<input type="checkbox"/> 043.3 Peripheral neuropathy
<input type="checkbox"/> 042.0 Cryptosporidiosis	<input type="checkbox"/> 042.0 Pneumocystis carinii pneumonia (PCP)
<input type="checkbox"/> 042.1 Cytomegalovirus infection (CMV)	<input type="checkbox"/> 042.1 Pneumonia recurrent bacterial
<input type="checkbox"/> 043.1 Dementia/HIV encephalopathy	<input type="checkbox"/> 042.0 Progressive multifocal leukoencephalopathy (PML)
<input type="checkbox"/> 042.1 Herpes simplex	<input type="checkbox"/> 042.1 Salmonella septicemia, recurrent
<input type="checkbox"/> 042.1 Herpes zoster, chronic or recurrent	<input type="checkbox"/> 043.0 Toxoplasmosis
<input type="checkbox"/> 042.0 Histoplasmosis	<input type="checkbox"/> 042.1 Tuberculosis
<input type="checkbox"/> 042.0 Isosporiasis	<input type="checkbox"/> 043.3 Wasting syndrome due to HIV
<input type="checkbox"/> 042.2 Kaposi sarcoma (KS)	
Other (include diagnosis code)	

SYMPTOMATIC HIV DISEASE	
<input type="checkbox"/> 043.3 Persistent diarrhea (at least 2 loose stools per day for at least 30 days duration)	<input type="checkbox"/> 043.3 Soaking night sweats (present for more than 2 weeks).
<input type="checkbox"/> 043.3 Chronic fatigue (at least 30 days duration)	<input type="checkbox"/> 043.0 Persistent generalized lymphadenopathy (PGL)
<input type="checkbox"/> 043.3 Chronic fever (unexplained of at least 30 days duration)	<input type="checkbox"/> 043.3 Persistent, recurrent dermatologic disorders which are HIV related
Other (include diagnosis code)	

Most recent CD4 Count _____ Date _____

Lowest CD4 Count _____ Date _____

Physician Signature Date

TARGETED CASE MANAGEMENT PROGRAM

CASE MANAGEMENT AGREEMENT FORM

NAME:	RECIPIENT #:
ADDRESS:	

With the signing of this agreement, I voluntarily agree to participate in the Department of Public Welfare's Targeted Case Management Program. I understand that I have the right to choose any enrolled case manager to be the provider of my case management services, and I have chosen the person indicated below. Further, I agree to:

1. Work with my case manager to develop a plan of service,
2. Use the services as outlined in my care plan to achieve the goals set for me,
3. Communicate with my case manager, at least monthly and as needed, to review my plan of services, to make any changes to the stated activities and follow through on those changes.

I also realize that enrollment in the Case Management Program does not limit my freedom to choose providers of other medical services that I may need.

I give my case manager the right to act on my behalf to arrange for the activities stated in my plan of services. In addition, I

(check one) agree do not agree

to the release of information regarding my medical condition or plan of services by my case manager, when the information is necessary to coordinate needed services.

My case manager explained to me that if, at any time, I am not satisfied with him/her, I have the right to apply for a change of case manager or discontinue case management services by submitting a written request to the Department giving 30 days notice for such action. My case manager may discontinue providing case management services to me by giving me a 30 day notice to request a transfer to another case manager.

I hereby certify that this agreement has been explained to me by my case manager.

Client's Signature

Date

Case Manager's Signature

Date