State of Alaska • Department of Health • Division of Senior and Disabilities Services

Personal Care Services/CFC Personal Care Services
Request for Passive Range of Motion
Personal Care Activity/CFC Personal Care Activity

Patient name _____ Medicaid number _____

Date of patient's most recent visit _____

Personal Care Services may be authorized for Medicaid recipients who need physical assistance with basic personal activities and other activities related to independent living. Passive range of motion is a service that requires **medical documentation of a physical condition associated with a risk of contracture(s) or existing contracture(s)**, from a medical professional before SDS can authorize payment for the service. Your recommendation for passive range of motion must be based on personal knowledge of your patient's medical or functional condition; consequently, you should not sign a form pre-filled by a Personal Care Services agency. Please provide in the space below, the affected extremity(ies), the number of minutes of movement for each affected extremity (not to exceed 15 minutes per day), the number of times a day, the number of days per week, and the length of time (not to exceed one year) passive range of motion should be provided. **Attach a written plan of care with detailed guidance for the movement of extremities for the PCA to follow and medical documentation that will support your recommendation.**

Diagnosis that puts patient at risk of contractures_____

Plan of Care for Passive Range of Motion

Extremity	Number of minutes	Number of times per day	Number of days per week
_____	_____	_____	_____
Extremity	Number of minutes	Number of times per day	Number of days per week
_____	_____	_____	_____
Extremity	Number of minutes	Number of times per day	Number of days per week
_____	_____	_____	_____
Extremity	Number of minutes	Number of times per day	Number of days per week
_____	_____	_____	_____

Treatment is to continue for _____ weeks (not to exceed 52 weeks)

Prescriber assurances *I understand that, although I may recommend passive range of motion, the decision to authorize the service will be made by Senior and Disabilities Services on the basis of a review of current medical documentation and a functional assessment of the patient's capacity to perform the activity. I recommend passive range of motion for the named patient based on personal knowledge of his/her medical or functional condition, and have attached a plan of care and medical documentation supporting the need for passive range of motion. I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.*

Prescriber's signature

Date

Prescriber's printed name

☐MD ☐DO ☐PA ☐ANP ☐PT ☐OT

Prescriber's telephone number

Prescriber's Medicaid ID or AK license number