Kentucky Medically Frail Provider Attestation v5

This Attestation is to be completed by an enrolled Medicaid Provider whose scope of expertise qualifies them to assess the Member for "medical frailty." Kentucky HEALTH is the Commonwealth of Kentucky's Section 1115 proposed demonstration project approved by CMS, and focused on "Helping to Engage and Achieve Long Term Health (HEALTH)."

In accordance with 42 CFR §440.315(f), Members in the Medicaid expansion population who are medically frail will be required to enroll in Kentucky HEALTH, but will not be required to enroll in an alternative benefit plan. The determination of medical frailty considers whether an individual is homeless, has a disabling mental disorder (including serious mental illness), or chronic substance abuse disorder (SUD), or serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs ability to perform one or more activities of daily living.

Please provide the following information to help assess the possible medical frailty of the Member's conditions, including Activities of Daily Living (ADLs). For additional detail regarding the medical conditions included with each level of frailty, refer to the page number of the supplemental "Kentucky Medically Frail Medical Condition Guide" for each corresponding condition group. You may also include additional commentary at the end of this form.

Part I. Member Information

Last Name:	**First Name, Middle Initial:**	**Date of Birth: MM/DD/YYYY**
Residential Street Address (if homeless, write "N/A"):	**City, State, Zip Code**	**Phone Number:** **( )**
Medicaid ID Number:	**Gender: M F**	**Managed Care Organization (MCO):**

Part II. Chronic Homelessness

Is the member Chronically Homeless? - circle **Y** or **N**

To meet the criteria for "Y', a member must:

1. Have been continuously homeless 90 days or more, ("homeless" 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). OR

2. Have been homeless on at least four (4) occasions in the last three (3) years where those occasions cumulatively total at least ninety (90) days.

Provider Notes: ____

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Part III. Activities of Daily Living (ADLs)

Rate Level of Help Needed as **"0":** Person is independent in completing the activity safely

Rate Level of Help Needed as "**1**": Help is needed to complete task safely but helper **DOES NOT** have to be physically present throughout task. "Help" can be supervision, cueing or hands-on assistance.

Rate Level of Help Needed as "**2**": Help is needed to complete task safely and helper **DOES** need to be physically present throughout task. "Help" can be supervision, cueing or hands-on assistance.

Please select Level of Help Needed and provide additional comments supporting selected level to identify the Member's ability to perform the following ADLs:

Activities of Daily Living		
1) Dressing: Is member independent with the ability to dress and undress safely as necessary and choose appropriate clothing? Includes the ability to put on prostheses, braces, anti-embolism hose (For example, "TED" stockings) with or without assistive devices, and includes fine motor coordination for buttons and zippers. Includes choice of clothing appropriate for the weather. *Difficulties with a zipper or buttons* ***at the back*** *of a dress or blouse do not constitute a functional deficit.*	Circle Level of Help Needed 0 1 2	Circle all that apply: • Requires supervision or verbal cues • Requires hands on assistance • Requires total assistance Comments:

Activities of Daily Living

2) Bathing: Is member independent with the ability to shower, bathe, or take sponge baths for the purpose of maintaining adequate hygiene? This also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash, and dry fully.	Circle Level of Help Needed 0 1 2	Circle all that apply: • Requires grab bars, shower chair or tub bench • Requires mechanical lift • Requires total assistance Comments:
3) Toileting: Is member independent with the ability to use the toilet, commode, bedpan, or urinal? This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes.	Circle Level of Help Needed 0 1 2	Circle all that apply: • Uses grab bars, commode, or other adaptive equipment • Bladder/bowel incontinence • Requires urinary catheter-related skilled services • Requires ostomy-related skilled services • Occasionally requires hands-on assistance • Always requires hand-on assistance • Requires total assistance Comments:
4) Eating: Is member independent with the ability to eat and drink using routine or adaptive utensils, including ability to cut, chew and swallow food?	Circle Level of Help Needed 0 1 2	Circle all that apply: • Partial/occasional help • Totally fed (by mouth) • Tube feeding (type and location) Comments:

Activities of Daily Living		
5) Mobility in Home: Is member able to move independently among locations in the living environment? Areas are defined as kitchen, living room, bathroom, and sleeping area. *This excludes basements, attics, yards, and any equipment used outside the home.*	Circle Level of Help Needed 0 1 2	Circle all that apply: • Dependent on device: wheelchair, scooter, cane, prosthesis, quad-cane, crutches, walker • Needs assistance with wheelchair • Number of falls in last 12 months: ____________________ • Bed-bound Comments:
6) Transferring: Does member have the physical ability to move between surfaces? From bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping position. The ability to use assistive devices for transfers. *Excludes toileting transfers.*	Circle Level of Help Needed 0 1 2	Circle all that apply: • Uses grab bars, transfer board, trapeze, or mechanical lift (excluding lift chair) • Bedfast Comments:

Provider Notes: ____

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Part IV: Medical Conditions

Please check all conditions in the table rows "A through N" below which apply to the Member.

If the Member has had conditions indicating medical frailty in the last 12 months, place a checkmark for the condition in the corresponding row and specify the disease code(s) that apply. Disease codes corresponding to each table row are defined in "Kentucky Medically Frail Medical Condition Guide." Only "Kentucky Medically Frail Medical Condition Guide" codes will be accepted for entries in the table. ICD10, DSM IV or other substitutions will not be accepted.

For any other significant Medical Condition, not otherwise classified, please check category "N" and provide details in the 'Additional Commentary' section below the table.

	Condition Group	**Check All that Apply Below**	**Specify Disease Code(s) Example: B4, N7**
A	Substance Use Disorder (excludes tobacco and cannabis)		1. Substance(s): ______________________ 2. Treatment Program Name, or NA: ______________________ 3. If member treatment in progress" OR "completed": ______________________ 4. Dates of Treatment Program: ______________________ 5. If overdose, date: ______________________
B	Mental Disorder		
C	Cancer		
D	Cardiac and Circulatory System		
E	Digestive System		
F	Endocrine System		
G	Genitourinary System		
H	Hematological Disorder		
I	Infectious Disease		
J	Musculoskeletal System		

	Condition Group	Check All that Apply Below	Specify Disease Code(s) Example: B4, N7
K	Nervous System		
L	Respiratory System		
M	Skin Disorder		
N	Other: Gangrene Hospice Ostomy Transplant		

Additional Commentary: Please provide other relevant information regarding the Member's health relevant to possible status as Medically Frail, including any significant conditions as denoted in "N – Other."

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Part V: Health Care Professional Attestation

As the enrolled Medicaid Provider caring for this Member, I attest to the truth of the information presented in this document. If necessary, I can provide supporting information regarding the information. I understand this information will be used to assist in the determination of medical frailty status for this Member.

Provider Name: ______________________________

Medicaid ID Number: ______________________________

Provider Signature: ______________________________

Contact Phone Number: ______________________________

NPI / Provider ID# : ______________________________

Date: ______________________________

Should you have questions regarding this form or the completion of this form, please contact the Member's specific Managed Care Organization (MCO), at:

Mail:	WellCare Health Plans Attention Kentucky Frail Clinical Attestations P.O. Box 31497 Tampa, FL 33631-3497
Fax:	(813) 283-3665
E-Mail:	kyfrail@wellcare.com
Online:	https://provider.wellcare.com/
Help Line:	1-877-389-9457

This form will be reviewed by the Member's Managed Care Organization (MCO), as directed by the Kentucky Department of Medicaid Services.