**Attention: This checklist may only be used by Home Care Delivered!**

Based on the Request for Proposal (RFP) 2013-01, DMAS awarded a sole contract for the provision of Incontinence and Related Supplies for all Virginia Medicaid fee-for-service members to **Home Care Delivered, Inc.** Effective January 1, 2014, all Virginia Medicaid members will order and receive their incontinence supplies through Home Care Delivered. Please refer to the Virginia Medicaid Web Portal for current Medicaid Memos to providers relating to Incontinence Supplies for additional information at:
<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>

**CMN INFORMATION**

**NOTE** – Beginning 7/1/2010, DMAS will change the Billing units for Incontinence supplies. Requests for these supplies with dates prior to 7/1/2010 will be in Cases. Requests for these supplies with dates **on** **or after 7/1/2010** will be entered as each item/unit. Reference DMAS Memo dated 1-28-2010 and DMAS Memo dated 6/17/2010.

1. Provide Begin Date On CMN:
2. Provide Date of Physician/Nurse Practitioner Signature:
3. Provider Contact Name:
4. Provider Contact Number:
5. Date of Injury/Illness/Surgery:
6. Level of Need:
	1. Acute Need: Yes/No
	2. Chronic or long-term need: Yes/No
7. Is this a Retro Review: Yes / No
8. Describe what level of assistance is required for each impairment:
9. List specialized equipment the patient requires:
10. List Therapeutic Interventions (Medications, Nutrition etc.):
11. List Mobility Impairments:
12. List Endurance Impairments:
13. List Activity Restrictions:
14. Does Patient Have Any Skin Breakdown: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
15. Is Assistance Required With ADL’s: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
16. Are Nutritional Supplements Required: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
17. Is The Item Suitable For Use In The Home: Yes / No

If yes, explain in Atrezzo Connect Clinical Information note box

1. Explain member’s:
	1. Incontinent condition and diagnosis
	2. Frequency of Use
	3. How were needs previously met
	4. Degree of incontinence (if known)

Functional limitations/symptoms

1. Comment box in Atrezzo for entering specific information as noted in numbers 8 through 18e on this document
2. Comment box in Atrezzo for entering specific treatment information noted in numbers 8 through 18e on this document.