AmeriHealth Caritas
VIP Care Plus

2019 Care for Older Adults Form – Provider Form

***Keep completed record in patient's chart/medical record.**

Care for Older Adults includes a group of assessments intended to serve as additional preventive screenings for adults age 66 and over. AmeriHealth Caritas VIP Care Plus tracks these services as part of our ongoing Quality Improvement Program. We encourage your practice to document completion of these screenings by including appropriate codes on your claims or by returning this form via secure fax to our Quality Department at 1-248-663-7363. If you have questions, please call provider services at 1-888-667-0318. Please save a copy of the completed form in your patient chart or electronic medical record.

Patient Name:	Date of Birth:	Member ID:
Member Phone:	Provider Name:	Provider Phone/Fax:

Functional Status

Can the patient perform all the activities of daily living (ADL) and instrumental activities of daily living (IADLS) independently? ☐ **Yes** ☐ **No**

If NO, patient needs help with:

☐Bathing ☐Taking Medications
☐Dressing ☐Shopping
☐Using Toilet ☐Meal Prep
☐Transfers (e.g., getting in/out of chair or bed)
☐Walking ☐ Laundry
☐Grooming ☐Using the Phone
☐Eating ☐Driving or transportation
☐Other _____

Check the most appropriate:

Cognitive Status:	☐Excellent	☐Good	☐Fair	☐Poor
Ambulation Status:	☐Excellent	☐Good	☐Fair	☐Poor
Hearing:	☐Excellent	☐Good	☐Fair	☐Poor
Vision:	☐Excellent	☐Good	☐Fair	☐Poor
Speech:	☐Excellent	☐Good	☐Fair	☐Poor
Other:	☐Excellent	☐Good	☐Fair	☐Poor

(e.g., ability to exercise, ability to perform job)

Additional information:

Pain Assessment

Does the patient have pain? ☐**Yes** ☐**No**

If yes, patient rates current intensity of pain between 0 - 5:

☐0 – No Pain ☐1- Slight Pain ☐2- Minimal Pain ☐3-Moderate Pain ☐4-Significant Pain ☐5- Severe Pain

Is the pain constant? ☐Yes ☐No

Does the pain limit daily activities? ☐Yes ☐No

How often during the past three months has the pain kept the patient from doing activities he/she enjoys?

☐Not at all ☐some days ☐most days ☐every day

Additional Information:

Patient Name:	Date of Birth:	Member ID:

Advance Care Planning

- Advance directives – Instructions about treatment preferences and designation of who can make medical decisions for the patient if they are unable to make decisions themselves. Does the patient have an Advance Directive? □ Yes □ No
- Living will – A legal document denoting preferences for life-sustaining treatment and end-of-life care. Does the patient have a living will?: □ Yes □ No
- Surrogate decision maker – A written document designating someone other than the patient to make future medical treatment choice. Does the patient have a surrogate decision maker? □ Yes □ No
- Has the patient talked with his/her family, caregiver or other doctor about how they want to be treated if he/she were too sick and could not talk or communicate with anyone? Has patient discussed with anyone?

  □ Yes □ No

  Discussed with or additional information:

Medication Review (You may attach a medication list from chart.)

Date of review and list: _____

Medication review and list of medications must be submitted on the same date. This may be completed by the prescribing practitioner or a clinical pharmacist. ***You can attach a copy of your patient's medication list from their chart.***

Medication name and strength	Quantity/days' supply	Prescriber	Notes

Date Functional Status, Pain, Advanced Directive and Medication Review Assessments completed: **DATE:**	Signature of Provider: