AmeriHealth Caritas VIP Care Plus
4000 Town Center
Suite 1300
Southfield, MI 48075

Care for Older Adults Form – Provider Form

***Please save a copy of the completed form in your patient chart or EMR.**

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 a completed copy of this form via fax to our Quality Dept.: **1-248-663-7363** or by email **QualityAHCVIPCarePlus@amerihealthcaritas.com**. If you have questions, please call our provider services at 1-888-667-0318.

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

Pain Assessment

Does the patient have pain? ☐ Yes ☐ No (If 'No,' stop Pain assessment, if 'Yes,' complete remainder of Pain questions.)

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 enjoy?

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

Functional Status

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

If NO, patient needs help with:

☐Bathing	☐Taking Medications	☐Dressing	☐Shopping
☐Using Toilet	☐Meal Prep/Cooking	☐Transfers	☐Housework/Laundry
☐Grooming	☐Using the Phone	☐Feeding	☐Driving or transportation
☐Climbing Stairs	☐Home Repair	☐Handling Finances	

Additional information: _____

_____

Please add the patient identifiers for page 2.

Patient Name:	Date of Birth:	Member ID:

Advance Care Planning

- The presence of an advanced care plan in the medical record?: ☐ Yes ☐ No
- 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 Medication Review and list *(Date is Required)*: _____
**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 pain, functional status and advanced care planning assessed and medication review submitted:	Signature of Provider: