New York State Medicaid Fee-for-Service Program
Private Duty Nursing Member Demographic Information Form

Instructions

- This form must be completed by the Private Duty Nursing (PDN) billing provider submitting the prior approval request OR the member's case (care)manager.
- This form must be submitted with new PDN cases and with 12-month documentation renewal requests, along with the required documentation detailed in **Section 6.1** of the PDN Policy Manual.
- This form is required any time there has been a change to the information provided, submitted via change request to eMedNY per **Section 9.1** of the PDN Policy Manual.
- The form must be dated no more than 90 days before the prior approval start date.
- Incomplete forms will not be accepted and may delay the prior approval process.

Member Information

Member Name _____

Medicaid ID Number _____

Home Safety Attestation

YES ☐ NO ☐ The member's current home environment has been deemed appropriate to receive private duty nursing services.

Member School Information (for members 22 and under):

YES ☐ NO ☐ The member will attend in-person school instruction during any portion of the requested period of service.

If YES, provide the information below:

- Indicate preschool ☐ or school age ☐
- Schedule indicating days of the week and times of day (including transportation time)

- YES ☐ NO ☐ The requested PDN hours from Medicaid will be serviced outside of in-person school instruction.
- YES ☐ NO ☐ The school is **NOT** approved by the New York State Education Department **AND** the nurse is requested to attend school with the member.
  - If YES, submit the required school letter detailed in **Section 6.11.2.1** of the PDN Policy Manual.

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Member Day Program Information (for members 18 and over):

YES ☐ NO ☐ The member will attend a day program during any portion of the requested period of service.

If YES, provide the information below:

- Schedule indicating days of the week and times of day (including transportation time)

_____

- YES ☐ NO ☐ The Medicaid funded nurse is requested to attend a day program with the member.
  - If Yes, submit the required day program letter detailed in **Section 6.11.3** of the PDN Policy Manual.

I attest the information provided is true, accurate, and was completed by the member's PDN provider or case/care manager.

Name _____ **Date** _____

Title _____

Agency Name or Independent PDN _____

Questions may be directed to the Bureau of Medical Review, PDN Prior Approval Unit at:
1(800) 342-3005, Option 4 or PDNDirectory@health.ny.gov