MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HEALTHCARE INFORMATION REQUEST

TO: PHYSICIAN'S NAME:

ADDRESS:

ADDRESS:

CITY, STATE, ZIP:

Your patient below has requested Home and Community Based Services (HCBS). HCBS are authorized for reimbursement through Medicaid for participants who require nursing facility level of care. The services provide assistance with activities of daily living and/or instrumental activities of daily living as an alternative to nursing facility placement.

Your patient has authorized the Division of Senior and Disability Services (DSDS) to contact you to obtain information to assist in determining program eligibility. Please complete the information below within 10 days and return this form to the staff listed on page 2. If you have additional information, please include.

PATIENT'S NAME:	DOB:	DCN:

Your Patient provided the information below regarding their eligibility for Medicaid HCBS		**Is this information accurate according to your records?** IF NO, PLEASE EXPLAIN ON PAGE 2	
BATHING		☐ YES	☐ NO
BEHAVIORAL		☐ YES	☐ NO
COGNITION		☐ YES	☐ NO
DRESSING & GROOMING		☐ YES	☐ NO
EATING		☐ YES	☐ NO
MANAGING MEDICATIONS		☐ YES	☐ NO
MEAL PREP		☐ YES	☐ NO
MOBIILTY		☐ YES	☐ NO
REHABILITATION		☐ YES	☐ NO
SAFETY		☐ YES	☐ NO
TOILETING		☐ YES	☐ NO
TREATMENTS		☐ YES	☐ NO

MO 580-3211 (8-2025)

DSDS STAFF COMMENTS

PHYSICIAN COMMENTS

PHYSICIAN or HEALTH CARE PROFESSIONAL SIGNATURE	DATE

DSDS STAFF SIGNATURE	DSDS STAFF NAME (**PLEASE PRINT**)	DATE
ADDRESS	FAX NUMBER	