North Carolina Department of Health and Human Services - Division of Medical Assistance

REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS) ATTESTATION OF MEDICAL NEED

PCS is a Medicaid benefit based on an unmet need for assistance with Activities of Daily Living (ADLs), which means bathing, dressing, toileting, eating, and mobility in the setting of care.

Completed form should be faxed to Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).
For the Expedited Assessment Process contact Liberty Healthcare Corporation at 1-855-740-1400.
For questions, call 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@libertyhealth.com.

Step 1

Please select one: ☐ New Request ☐ Change of Status: Medical **Date of Request:** ___/___/___

Step 2

SECTION A. BENEFICIARY DEMOGRAPHICS

Beneficiary's Name: First:_____ **MI**:___ **Last**:_____ **DOB:** ____/____/_____

Medicaid ID#: _____ **PASRR#***(For ACHs Only)*: _____ PASRR Date: ___/___/_____

Gender: ☐ M ☐ F **Language:** ☐ English ☐ Spanish ☐ Other_____

Address: _____ **City:** _____

County: _____ **Zip:** _____ **Phone:** _____

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____

Relationship to Beneficiary: _____ Phone: _____

Active Adult Protective Services Case? ☐ Yes ☐ No

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility ☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF) : ___/___/___

Step 3

SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS

Identify the current **medical diagnoses related to the beneficiary's need for assistance with** qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List *both* the diagnosis and the ICD-10 code for each.

Medical Diagnosis	ICD-10 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
	_ _ _ . _ _ _ _	☐Yes ☐No	
	_ _ _ . _ _ _ _	☐Yes ☐No	
	_ _ _ . _ _ _ _	☐Yes ☐No	
	_ _ _ . _ _ _ _	☐Yes ☐No	
	_ _ _ . _ _ _ _	☐Yes ☐No	

In your clinical judgment, the ADL limitations are: ☐ Short Term (3 Months) ☐ Intermediate (6 Months)
☐ Expected to resolve or improve (with or without treatment) ☐ Chronic and stable ☐ Age Appropriate

Is Beneficiary Medically Stable? ☐ Yes ☐ No

Is 24-hour caregiver availability required to ensure beneficiary's safety? ☐ Yes ☐ No

Optional Step 4

OPTIONAL ATTESTATION: *Practitioner should review the following and initial only if applicable*:

The **beneficiary requires an increased level of supervision.** Initial if Yes: _____

The **beneficiary requires caregivers with training or experience** in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

Regardless of setting, the **beneficiary requires a physical environment that includes modifications and safety measures** to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

The **beneficiary has a history of safety concerns** related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls. Initial if Yes: _____

Beneficiary Name: _____ MID#:_____

Step 5

SECTION C. PRACTITIONER INFORMATION

Attesting Practitioner's Name: _____ Practitioner NPI#:_____

Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name: _____

Practice NPI#:_____

Practice Contact Name: _____

Address:_____

Practice Stamp:

Phone (_____) _____ Fax (_____) _____

Date of last visit to Practitioner : ____/____/____ ****Note:** Must be < 90 days from request date

Sign Here

Practitioner Signature AND Credentials: _____ **Date:** ____/____/____

Signature stamp not allowed

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Change of Status - Medical

SECTION D. CHANGE OF STATUS: MEDICAL

Complete for medical change of status request only.

Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (required for all reasons):

- PRACTITIONER FORM ENDS HERE -

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Beneficiary Name: _____ MID#:_____

FOR NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE THIS PAGE ONLY.

Step 1

Please select one: ☐Change of Status: Non-Medical ☐Change of PCS Provider **Date of Request:**___/___/___

Step 2

Beneficiary's Name: First:_____ **MI**:___ **Last**:_____ **DOB:** ____/____/_____

Medicaid ID#: _____ Gender: ☐ M ☐ F Language: ☐ English ☐ Spanish ☐ Other _____

Address: _____ **City:** _____

County: _____ **Zip:** _____ **Phone:** _____

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name:_____

Relationship to Beneficiary: _____ Phone: _____

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility ☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF): ___/___/___

SECTION E. CHANGE OF STATUS: NON-MEDICAL

Change of Status: Non-Medical

Requested By (select one): ☐ PCS Provider ☐ Beneficiary

Responsible Party: ☐ Guardian ☐ Legal Power Of Attorney (POA) ☐ Family (Relationship): _____

Requestor Name: _____

PCS Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Provider Contact Name: _____ Contact's Position: _____

Provider Phone_____ Provider Fax: _____

Email: _____

Reason for Change in Condition Requiring Reassessment:

☐ Change in beneficiary's location affecting ability to perform ADLs ☐ Change in caregiver status

☐ Change in days of need ☐ Other: _____

Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (required for all reasons):

SECTION F. CHANGE OF PCS PROVIDER

Change of Provider

Requested By (select one): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship to Beneficiary): _____

Requestor Contact's Name: _____ **Phone:** _____

Reason for Provider Change (select one)**:**

☐ Beneficiary or legal representative's choice

☐ Current provider unable to continuing providing services

☐ Other:_____

Status of PCS Services (select one)**:**

☐ Discharged/Transferred on _____(mm/dd/yyyy)

☐ Scheduled for discharge/transfer on _____(mm/dd/yyyy)

☐ Continue receiving services until beneficiary is established with a new provider agency; no discharge/transfer is planned

Beneficiary's Preferred Provider (select one):

☐ Home Care Agency	☐ Family Care Home	☐ Adult Care Home	☐Adult Care Bed in Nursing Facility	☐ SLF-5600a	☐ SLF-5600c	☐ Special Care Unit

Agency Name:_____ Phone: _____

PCS Provider NPI#: _____ PCS Provider Locator Code#: _____(3 digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Physical Address: _____