

DHB-3051
Request for Independent Assessment for Personal Care Services
Attestation of Medical Need

INSTRUCTIONS

These instructions offer guidance for completing the Request for Independent Assessment and Attestation of Medical Need Form for **Personal Care Services (PCS)** and should be read in its entirety before completing. Expedited Assessment Process Info: Contact PARTNERS 1-704-457-5261.

Questions: Call or email PARTNERS at 1-704-457-5261 or Partners_PCSInquiry@PartnersBHM.org.

Personal Care Services (PCS) are Medicaid benefits based on the need for assistance with Activities of Daily Living (ADLs). The ADLs are bathing, dressing, toileting, eating and transferring/functional mobility in the home. The purpose of the Request for Independent Assessment and Attestation of Medical Need Form (DHB-3051) is to request a PCS Independent Assessment. Requested assessments will be one of the following: Disenrollment, New Request, Change of Status (Medical or Non-Medical) or Change of Provider.

Sections A-E: Change of Status: Medical, New Request, and Managed Care Disenrollment (located on pg. 1-2 of the form) shall be completed by a practitioner with section E completed by the PCS Provider if for Managed Care Disenrollment.

Step One: Request Type: Select the type that indicates the reason for the request. Enter the Date of Request in the appropriate field.

Step Two: Section A: Beneficiary's Demographics. The beneficiary's name should be the same as it appears on their Medicaid card. Beneficiaries living in, and those seeking admission to, an Adult Care Home (ACH) will have the facility's address and phone number. If identified as legal guardian or Power of Attorney (POA), submit guardianship/POA documents to PARTNERS.

***The RSID # and RSID Date is generated when a beneficiary, being referred to or seeking admission to an ACH, is referred to an LME-MCO for the RSVP. Further information can be found below, page two.**

The Alternate Contact should not be a PCS Provider.

Step Three: Section B: Beneficiary's Conditions. Enter information regarding current medical conditions that limit the beneficiary's ability to perform, and resulted in a need for assistance with, ADLs. Medical Diagnosis and ICD-10 Code are both required fields.

The Diagnosis and ICD-10 entered must relate to the ADL deficit for this request to be processed.

Step Four: Optional Attestation: This step is optional. Review each statement and initial, only if applicable.

Step Five: Section C: Practitioner Information. Enter Practitioner and Practice information in the appropriate field. You may use the practice stamp if applicable. Sign and date once completed.

Signature stamps are not allowed.

Step Six: Section D: Change of Status: Medical. Complete if requesting a Medical Change of Status. Describe the medical change and its impact on the beneficiary's need for hands-on assistance.

Section D, located on page two, is a required field for all Medical Change of Status Requests. The date of the beneficiary's last PCP visit must be < 90 days from Received Date by the IAE.

It is required that the beneficiary's PCP or inpatient practitioner complete this form. If the beneficiary does not have a PCP, the practitioner, currently providing care and treatment for the medical, physical or cognitive condition causing the functional limitation, may complete the form.

Step Seven: Section E: Managed Care Disenrollment: Medical. Complete if requesting disenrollment from Managed Care. Enter the information regarding the beneficiary's current plan, date of enrollment, effective date of disenrollment, current approved PCS hours and current PCS provider. Completed form should be faxed to PARTNERS prior to disenrollment date.

--- PRACTITIONER FORM ENDS HERE ---

Sections F-G: Non-Medical Change of Status and Change of Provider Requests, located on page 3 of the form, shall be completed by the beneficiary, family member, legal guardian, home care provider or residential provider.

Step One: Request Type. Select the Request Type that indicates the reason for the request. Enter the Date of Request in the appropriate field.

Step Two: Beneficiary's Demographics. The beneficiary's name should be the same as it appears on their Medicaid card. For Beneficiaries living in, and those seeking admission to, an ACH, enter the facility's address and phone number.

The Alternate Contact should not be a PCS Provider.

Step Three: Section F: Change of Status: Non-Medical. Complete if requesting a Non-Medical Change of Status. Enter the Facility License # and Date, if applicable. Describe the specific change in condition and its impact on the beneficiary's need for hands-on assistance.

Section F, found on pg. 3, is a required field for all Non-Medical Change of Status Requests.

Step Four: Section G: Change of PCS Provider. Complete if requesting a Change of Provider.

Fax completed forms to PARTNERS at 1-704-457-5261.

****Note:** Medicaid beneficiaries referred to or seeking admission to Adult Care Homes (ACH) licensed under G.S. 131D-2.4 must be referred to an LME-MCO for the Referral Screening Verification Process (RSVP). Adult Care Home providers licensed under G.S. 131D-2.4 shall not receive a PCS assessment or prior approval without verification of a Referral Screening ID (RSID). If you have questions about your status in this process, please contact the Division of Mental Health at 919-981-2580.

Beneficiary Name: _____

MID: _____

DHB-3051

**Request for Independent Assessment for Personal Care Services
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MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRACTITIONERS COMPLETE PAGES ONE AND TWO ONLY.

Step One:	REQUEST TYPE (SELECT ONE):			DATE OF REQUEST:	
	☐ Change of Status (Medical) ☐ New Request ☐ Managed Care Disenrollment				
	Form Submission for PCS: Fax PARTNERS at 1-704-457-5261				
	Form Submission for Expedited Assessment: Fax PARTNERS at 1-704-457-5261				
Step Two:	Questions or Expedited Assessment Process Info: Email PARTNERS at Partners_PCSInquiry@partnersbhm.org				
	SECTION A. BENEFICIARY DEMOGRAPHICS				
	Beneficiary's Name:		First:	MI:	Last:
	Medicaid ID:		RSID# (ACH Only):		RSID Date:
	Gender: ☐ Male ☐ Female		Language: ☐ English ☐ Spanish ☐ Other:		
	Address:			City:	
	County:		Zip:	Phone:	
	Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary under 18) ☐ Other				
	Relationship to Beneficiary (NON-PCS Provider):				
	Name:			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 Three:	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 COMPLETE ICD-10 Code.					
Medical Diagnosis		ICD-10 Code	Impacts ADLs		Date of Onset (mm/yyyy)
1.		_____	☐ Yes ☐ No		
2.		_____	☐ Yes ☐ No		
3.		_____	☐ Yes ☐ No		
4.		_____	☐ Yes ☐ No		
5.		_____	☐ Yes ☐ No		
6.		_____	☐ Yes ☐ No		
7.		_____	☐ Yes ☐ No		
8.	_____	☐ Yes ☐ No			
9.	_____	☐ Yes ☐ No			
10.	_____	☐ Yes ☐ No			
In your clinical judgement, 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					

MID: _____

OPTIONAL ATTESTATION: <i>Practitioner should review the following and initial <u>only</u> if applicable:</i>	
Beneficiary requires an increased level of supervision.	Initial:
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:
Beneficiary requires a physical environment, regardless of setting, 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:
Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial:

SECTION C. PRACTITIONER INFORMATION			
Attesting Practitioner's Name:		Practitioner NPI:	
Select One:			
☐ Beneficiary's Primary Care Practitioner		☐ Outpatient Specialty Practitioner	
		☐ Inpatient Practitioner	
Practice Name:		NPI:	
Practice Contact Name:		Practice Stamp:	
Address:			
Phone:	Fax:		
Date of last visit to Practitioner:		**Note: Must be < 90 days from Received Date	
Practitioner Signature AND Credentials **Note: Signature stamp not allowed		Date	
<i>"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."</i>			

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):	

SECTION E: MANAGED CARE DISENROLLMENT	
Disenrolling from (Select One): ☐ AmeriHealth Caritas NC, Inc. ☐ Carolina Complete Health, Inc. ☐ Blue Cross Blue Shield of NC, Inc. ☐ UnitedHealthcare of NC, Inc. ☐ WellCare of NC, Inc.	
Disenrollment Effective Date:	Current PCS Hours:
BENEFICIARY'S CURRENT PROVIDER	
Agency Name:	Phone:
Provider NPI:	Provider Locator Code:
Facility License Number (if applicable):	Date:
Physical Address:	

MID: _____

Step One:	REQUEST TYPE (SELECT ONE):		DATE OF REQUEST:	
	☐ Change of Status (Non-Medical) ☐ Change of Provider			
	Form Submission for PCS: Fax PARTNERS at 1-704-457-5261 Questions or Expedited Assessment Process Info: Email PARTNERS at Partners_PCSInquiry@partnersbhm.org			
Step Two:	SECTION A. BENEFICIARY DEMOGRAPHICS			
	Beneficiary's Name:		First:	MI: Last: Date of Birth:
	Medicaid ID:			
	Gender: ☐ Male ☐ Female		Language: ☐ English ☐ Spanish ☐ Other:	
	Address:		City:	
	County:		Zip:	Phone:
	Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary under 18) ☐ Other			
	Relationship to Beneficiary (NON-PCS Provider):			
	Name:		Phone:	
	Beneficiary currently resides:			
Step Three:	☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility			
	☐ Group Home ☐ Special Care Unit (SCU) ☐ Other:		☐ D/C Date (Hospital/SNF):	
	SECTION F: CHANGE OF STATUS: NON-MEDICAL			
	Requested by (Select One):		☐ PCS Provider ☐ Beneficiary ☐ Legal Guardian ☐ Responsible Party	
			☐ Power of Attorney (POA) ☐ Family (Relationship):	
	Requestor Name:			
	PCS Provider NPI:		PCS Provider Locator Code:	
	Facility License:		Date:	
	Contact's Name:		Contact's Position:	
	Provider Phone:		Provider Fax:	Email:
	Reason for Change in Condition Requiring Reassessment (Select One):			
	☐ Change in Days of Need ☐ Change in Caregiver Status ☐ Other:			
	☐ Change in Beneficiary location affects ability to perform ADLs			
	Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (Required):			
	Step Four:	SECTION G: CHANGE OF PCS PROVIDER		
Requested by (Select One): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship):				
Requestor's Contact Name:		Phone:		
Status of PCS Services (Select One): ☐ Discharged/Transferred (Date: _____)				
☐ Scheduled Discharge/Transfer (Date: _____)				
☐ No Discharge/Transfer Planned (Continue receiving services until established with a new provider.)				
BENEFICIARY'S CURRENT PROVIDER				
☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ SLF-5600a ☐ SLF-5600c				
☐ Adult Care Bed in Nursing Facility ☐ Special Care Unit				
Disenrollment Effective Date:		Current PCS Hours:		
Agency Name:		Phone:		
Provider NPI:		Provider Locator Code:		
Facility License Number (if applicable):		Date:		
Physical Address:				