Beneficiary Name: _____ MID#: _____

ALLIANCE HEALTH
REQUEST FOR PERSONAL CARE SERVICES (PCS) ASSESSMENT

MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRACTITIONERS COMPLETE PAGES 1 & 2 ONLY

Step 1

REQUEST TYPE: (select one) | **DATE OF REQUEST:**

☐ **Change of Status: Medical** ☐ **New Request** ☐ **Managed Care Disenrollment** | ___/___/___

Form Submission for PCS: Email Alliance Health at MedicaidPCS@alliancehealthplan.org.
Form Submission for Expedited Assessment: Email Alliance Health at MedicaidPCS@alliancehealthplan.org.
Questions or Expedited Assessment Process Info: Contact Alliance Health Provider Service Line at 855-759-9700.

Step 2

SECTION A. BENEFICIARY DEMOGRAPHICS

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

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

Is Beneficiary Medically Stable? ☐ Yes ☐ No

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

Beneficiary Name: _____ MID#: _____

Step 4

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

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:_____

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: _____ **N P I#:** _____

Practice Contact Name: _____

Address: _____

Phone: (___) _____ Fax: (___) _____

Practice Stamp

Date of last visit to Practitioner: ___/___/___ ****Note:** Must be < 90 days from Received Date

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."

Step 6

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):

BENEFICIARY'S CURRENT PROVIDER)

Agency Name: _____ Phone: (___) _____

Provider NPI#: _____ Provider Locator Code# _____

Facility License # (if applicable): _____ Date: ___/___/___

Physical Address:

Beneficiary Name: _____ MID#: _____

NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE PAGE 3 ONLY

Step 1

REQUEST TYPE: (select one)	**DATE OF REQUEST:**
☐ **Change of Status: Non-Medical** ☐ **Change of Provider**	___/___/___

Form Submission: Email Alliance Health at MedicaidPCS@alliancehealthplan.org.
Questions: Call Alliance Health Provider Service Line at 855-759-9700.

Step 2

BENEFICIARY DEMOGRAPHICS

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

Medicaid ID#:_____ **Gender:** ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish **Address:**

_____ **City:**___ ☐ Other ___ **County:**

_____ **Zip:**_____ **Phone:** (___)_____

Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary < 18) ☐ Other

Relationship to Beneficiary (NON-PCS Provider):_____

Name:_____ 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):___/___/___

Step 3

SECTION F: CHANGE OF STATUS: NON-MEDICAL

Requested by (Select One):	☐ PCS Provider	☐ Beneficiary	☐ Legal Guardian	☐ Power of Attorney (POA)	☐ Responsible Party	☐ Family (Relationship):

Requestor Name: _____

PCS Provider NPI#: _____ PCS Provider Locator Code# _____

Facility License # (if applicable): _____ 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 ☐ Change in Beneficiary location affects ability to perform ADLs

☐ Other:_____

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

Step 4

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 ☐ Scheduled Discharge/Transfer ☐ No Discharge/Transfer Planned.

Date:___/___/___ Date:___/___/___ Continue receiving services until established with a new provider.

Step 5

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: (___)_____ Provider

NPI#:_____ Provider Locator Code# _____

Facility License # (if applicable):_____ Date: ___/___/___

Physical Address: _____