

Beneficiary Name: _____

MID: _____

DHB-3051

**Request for Independent Assessment for Personal Care Services
Attestation of Medical Need**

MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRACTITIONERS COMPLETE PAGES ONE AND TWO ONLY.

Step One:	REQUEST TYPE (SELECT ONE):	DATE OF REQUEST:
	<input type="checkbox"/> Change of Status (Medical) <input type="checkbox"/> New Request <input type="checkbox"/> 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	
	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: _____ RSID# (ACH Only): _____	RSID Date: _____
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
	Address: _____	City: _____
	County: _____ Zip: _____	Phone: _____
	Alternate Contact (Select One): <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian (required if beneficiary under 18) <input type="checkbox"/> Other	
	Relationship to Beneficiary (NON-PCS Provider):	
	Name: _____	Phone: _____
	Active Adult Protective Services case? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Beneficiary currently resides:	
	<input type="checkbox"/> At home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Hospitalized/medical facility <input type="checkbox"/> Skilled Nursing Facility	
	<input type="checkbox"/> Group Home <input type="checkbox"/> Special Care Unit (SCU) <input type="checkbox"/> Other:	<input type="checkbox"/> 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.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	2.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	3.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	4.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	5.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	6.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	7.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	8.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	9.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	10.	-----
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	In your clinical judgement, ADL limitations are: <input type="checkbox"/> Short Term (3 Months) <input type="checkbox"/> Intermediate (6 Months)	
	<input type="checkbox"/> Expected to resolve or improve (with or without treatment) <input type="checkbox"/> Chronic and Stable <input type="checkbox"/> Age Appropriate	
	Is beneficiary Medically Stable? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is 24-hour caregiver availability required to ensure beneficiary's safety? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Beneficiary Name: _____

MID: _____

Step One:	REQUEST TYPE (SELECT ONE):			DATE OF REQUEST:			
	<input type="checkbox"/> Change of Status (Non-Medical) <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
	Address:				City:		
	County:			Zip:		Phone:	
	Alternate Contact (Select One): <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian (required if beneficiary under 18) <input type="checkbox"/> Other						
	Relationship to Beneficiary (NON-PCS Provider):						
	Name:				Phone:		
	Beneficiary currently resides:						
	<input type="checkbox"/> At home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Hospitalized/medical facility <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Group Home <input type="checkbox"/> Special Care Unit (SCU) <input type="checkbox"/> Other: <input type="checkbox"/> D/C Date (Hospital/SNF):						
	Step Three:	SECTION F: CHANGE OF STATUS: NON-MEDICAL					
Requested by (Select One):		<input type="checkbox"/> PCS Provider <input type="checkbox"/> Beneficiary <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Responsible Party					
		<input type="checkbox"/> Power of Attorney (POA) <input type="checkbox"/> 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):							
<input type="checkbox"/> Change in Days of Need <input type="checkbox"/> Change in Caregiver Status <input type="checkbox"/> Other: <input type="checkbox"/> 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): <input type="checkbox"/> Care Facility <input type="checkbox"/> Beneficiary <input type="checkbox"/> Other (Relationship):						
	Requestor's Contact Name:				Phone:		
	Status of PCS Services (Select One): <input type="checkbox"/> Discharged/Transferred (Date: _____) <input type="checkbox"/> Scheduled Discharge/Transfer (Date: _____) <input type="checkbox"/> No Discharge/Transfer Planned (Continue receiving services until established with a new provider.)						
	BENEFICIARY'S CURRENT PROVIDER						
	<input type="checkbox"/> Home Care Agency <input type="checkbox"/> Family Care Home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> SLF-5600a <input type="checkbox"/> SLF-5600c <input type="checkbox"/> Adult Care Bed in Nursing Facility <input type="checkbox"/> 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:						