Vaya Health

Request for Independent Assessment for Personal Care Services and Attestation of Medical Needs Form

Personal Care Services (PCS) is a Medicaid benefit that helps people with disabilities perform Activities of Daily Living (ADLs), such as bathing, dressing, mobility, toileting, and eating. NC Medicaid requires an independent assessment to determine PCS program eligibility.

To request an assessment or to notify Vaya Health (Vaya) of a change of provider, complete this form and fax it to Vaya's PCS Assessment Team at 828-707-9349. To request an expedited assessment, fax the completed form as described above and call Vaya's PCS Assessment Team at 1-877-290-6315.

For more information or help completing this form, call Vaya's PCS Assessment Team at the number above.

FULLY COMPLETE REQUIRED SECTIONS.

Request type

What type of assessment are you requesting?

☐ New/initial (complete sections 1 and 3)

Is this request for an expedited assessment process? ☐ Yes (If yes, complete Section 2) ☐ No

☐ Change of status: Medical (complete sections 1, 3, and 4)

☐ Change of status: Non-medical (complete sections 1 and 5)

☐ Request for change of provider (complete section 1 and 6)

Date of request *(use two digits for both the month and day and four digits for the year)*: ____ / ____ / ____

Please note: The following applies for initial requests and change in status: medical: The member's primary care provider or inpatient provider must complete sections 1-3 (as applicable). If the member does not have a primary care provider or inpatient provider, the provider treating them for the condition(s) causing the limitation(s) that prompted the assessment request may complete sections 1-3. The provider must be an MD, a DO, an NP, or a PA.

1. Member Information

Name: _____ ____ _____
First *MI* *Last*

Date of birth *(use two digits for both the month and day and four digits for the year)*: ____ / ____ / ____

Medicaid ID #: _____

Is member seeking admission to an Adult Care Home (ACH)? ☐ Yes ☐ No

Referral Screening Identification (RSID) number
(only required for members living in or seeking admission to an ACH): _____

Gender:
☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐ Other: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____

Address: *(for members living in or seeking admission to an ACH, enter the facility address)*

Facility name (If applicable): _____

Street address: _____

City: _____ County: _____ ZIP Code: _____

Phone: _____

Alternate contact (may not be a PCS provider):
☐ Parent ☐ Legal guardian (required if member is under age 18) ☐ Other: _____

Name: _____

Relationship to member: _____ Phone: _____

Is the member involved in an active Adult Protective Services case? ☐ Yes ☐ No

Current living arrangements: ☐ Private residence ☐ Hospital/medical facility ☐ ACH
☐ Group home ☐ Skilled nursing facility (SNF) ☐ Special care unit
☐ Other: _____

If the member is currently in a hospital or SNF, what is their expected discharge date? _____

2. For Expedited Requests Only

Expedited requests must meet items 1 and 2 OR 3:

1. To qualify for an expedited assessment process, the person requesting the assessment must be one of the following. Please check which applies:
   - ☐ Hospital discharge planner
   - ☐ Skilled Nursing Facility discharge planner
   - ☐ Adult Protective Services (APS) worker
   - ☐ Vaya Transition Coordinator

2. To qualify for an expedited assessment process, the member must meet one of the following criteria. Please check which applies:
   - ☐ Member is in process of being discharged from a Skilled Nursing Facility or a hospital following a qualifying stay (e.g., not an emergency department visit)
   - ☐ Member is in the care of NCDHHS APS
   - ☐ Member is served through the transition to community living program

3. FOR MEMBERS SEEKING PCS IN CONGREGATE SETTINGS ONLY: To qualify for a Fast Track expedited process, the member must be at risk of harm, institutionalization, injury, or loss of function without immediate access to PCS. The physician making the initial request must include detailed information about this need:

3. Medical Information

(For "New/initial" and "Change of status: Medical" assessment requests only)

Identify the current medical diagnoses (including ICD-10 code) related to the member's need for help with qualifying ADLs (bathing, dressing, mobility, toileting, and eating).

Diagnosis	ICD-10 Code	Does this impact ADLs?	Date of onset
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

In your clinical judgment, the member's ADL limitations are (check all that apply):

☐ Short term (three or fewer months) ☐ Chronic and stable ☐ Likely to resolve or improve (with or without treatment)

☐ Intermediate (approximately six months) ☐ Age appropriate

Is the member medically stable? ☐ Yes ☐ No

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

Attestation: Review the following and initial if applicable.

Initial: _____ **Member requires an incre ased level of supervision.**

Initial: _____ **Member requires caregivers with training or experience in caring for individuals with 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 learning, and loss of language skills.

Initial: _____ **Member requires a physical environment, regardless of setting, that includes modifications and safety measures** due to the member's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skills.

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

Name of the provider attesting to the information above: _____

Attesting provider's National Provider Identifier (NPI) #: _____

Attesting provider's relationship to the member (select one):

☐ Primary care provider ☐ Outpatient specialist ☐ Inpatient provider

Attesting provider's practice/facility name: _____

Practice/facility's NPI#: _____

Enter the following information about the above practice/facility:

Primary contact name: _____

Address: _____

Phone: _____ Fax: _____

Date of member's last visit to provider
(use two digits for both month and day and four digits for year): ____ / ____ / _____

Please note: The date of the member's last visit must be within 90 days of the assessment request date.

The provider must attest to the following:

"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."

Please note: Signature stamps are not permitted on this form.

Provider signature: _____

Date of attestation *(use two digits for both month and day and four digits for year)*: ____ / ____ / _____

4. Change in Medical Status Information

***(For "Change of status: medical" assessment requests only.** This section does not require a provider signature.)*
Describe the specific change in medical condition and its impact on the member's need for assistance (required):

5. Change in Non-Medical Status Information

*(**For "Change of status: non-medical" assessment requests only**. This section does not require a provider signature.)*

Name of person making this request: _____

Relationship to member: _____

PCS provider agency NPI#: _____ PCS provider agency locator code #: _____

PCS provider agency license number (if applicable): _____

PCS contact name: _____ PCS contact title: _____

PCS contact phone: _____ PCS contact fax: _____

PCS contact email: _____

Select the type of change that requires reassessment:

☐ Change in days of need ☐ Change in caregiver status ☐ Other: _____

☐ Change in member location that affects ability to perform ADLs

Describe the change in condition and its impact on the member's need for assistance:

6. Change in Provider

Requested by (select one): ☐ Care facility ☐ Member ☐ Other (Relationship):

Requestor's Contact Name: _____ Phone: _____

Status of PCS (select one):

☐ Discharged/transferred Date: ____ / ____ / ____

☐ Scheduled discharge/transfer Date: ____ / ____ / ____

New provider name: _____ New provider phone: _____