

Member Name: _____

MID#: _____

NC LTSS-3051

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

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

Step 1

REQUEST TYPE: (select one)	DATE OF REQUEST:
<input type="checkbox"/> Change of Status: Medical <input type="checkbox"/> New Request	____/____/____

Form Submission: Contact UHC C&S North Carolina Provider Call Center at 1-800-638-3302. (toll free).
Expedited Assessment Process Info: Contact UHC C&S North Carolina Provider Call Center at 1-800-638-3302.
Questions: Call United HealthCare C&S North Carolina Provider Call Center at 1-800-638-3302.

Step 2

SECTION A. MEMBER DEMOGRAPHICS

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

UHC ID#: _____ **RSID#(ACH Only):** _____ **RSID Date:** ____/____/____

Gender: Male Female **Language:** English Spanish Other _____

Address: _____ **City:** _____

Zip: _____ **Phone:** (____) _____

County: _____

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

Relationship to Member (NON-PCS Provider): _____

Name: _____ **Phone:** (____) _____

Active Adult Protective Services Case? Yes No

Member 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. MEMBER'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS

Identify the current **medical diagnoses related to the member'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 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 ~Member Medically Stable? Yes No

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

Step 4

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

Member requires an increased level of supervision.

Initial: _____

Member 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: _____

Member requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the Member because of the member's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the 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.

Initial: _____

Step 5

SECTION C. PRACTITIONER INFORMATION

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

Select one: Member's Primary Care Practitioner Outpatient Specialty Practitioner Inpatient Practitioner

Practice Name: _____ **NPI#:** _____

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):

--- PRACTITIONER FORM ENDS HERE ---

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

Step 1

REQUEST TYPE: (select one)	DATE OF REQUEST:
<input type="checkbox"/> Change of Status: Non-Medical <input type="checkbox"/> Change of Provider	____ / ____ / ____

Form Submission: Contact UHC C&S North Carolina Provider Call Center at 1-800-638-3302.(toll free).
Questions: Call UHC C&S North Carolina Provider Call Center at 1-800-638-3302.

Step 2

MEMBER DEMOGRAPHICS

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

UHC ID#: _____ **Gender:** Male Female **Language:** English Spanish

Address: _____ **City:** _____ Other _____

County: _____ **Zip:** _____ **Phone:** (____) _____

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

Relationship to Member (NON-PCS Provider): _____

Name: _____ Phone: (____) _____

Step 3

Member 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

Requested by (Select One):	<input type="checkbox"/> PCS Provider	<input type="checkbox"/> Member	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Power of Attorney (POA)	<input type="checkbox"/> Responsible Party	<input type="checkbox"/> Family (Relationship): _____
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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 Member location affects ability to perform ADLs
 Other: _____

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

Step 4

SECTION F: CHANGE OF PCS PROVIDER

Requested by (Select One): Care Facility Member Other (Relationship): _____

Requestor's Contact Name: _____ Phone: (____) _____

Reason for Provider Change (Select One): Member or legal representative's choice Current provider unable to continue providing services Other: _____

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

MEMBER'S PREFERRED PROVIDER (Select One):

<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Family Care Home	<input type="checkbox"/> Adult Care Home	<input type="checkbox"/> Adult Care Bed in Nursing Facility	<input type="checkbox"/> SLF-5600a	<input type="checkbox"/> SLF-5600c	<input type="checkbox"/> Special Care Unit
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Agency Name: _____ Phone: (____) _____

Provider NPI#: _____ Provider Locator Code#: _____

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

Physical Address: _____