UnitedHealthcare Community Plan

Personal Care Services (PCS) Practitioner's Statement of Need

PCS FORM 008
HHSC/DSHS
09-2018

Member Name (Last, First, MI):	Medicaid Number (PCN):
	Date of Birth:

The Practitioner's Statement of Need (PSON) must be signed by a practitioner (physician, advanced practice nurse, or physician assistant) who has personally examined the Member in the last twelve (12) months and reviewed all appropriate medical records.

For questions about the PCS benefit for the Member listed on this form, please contact the United Health Care Community Plan Star Kids Service Coordinator listed at the bottom of this page.

Step 1: To be completed by Practitioner

A. PROVIDE ICD codes for the Member's active (within the last 12 months) medical or behavioral health diagnosis/diagnoses.

ICD code	ICD code	ICD code	ICD code	ICD code

B. DECLARE Member's physical, cognitive or behavioral limitation(s) related to medical or behavioral diagnosis/diagnoses.

*This Member **HAS** physical, cognitive or behavioral limitation(s) related to the medical or behavioral diagnosis/diagnoses listed in Section A:*

☐ *YES. (Complete All Sections)*
☐ *NO. (Skip Section C and Complete Section D & E.)*

C. CHECK all symptoms or limitations related to diagnosis/diagnoses listed above.

Limitations	✓	Limitations	✓	Limitations	✓	Limitations	✓
Bed-Fast or Chair-Bound		Difficulty Swallowing		Weakness / Tremors		Impairment of Executive Functions	
Contractures / Spasticity		Recurrent Aspiration		Hearing Impairment		Memory Impairment	
Paralysis / Limited Mobility or ROM		Requires Special Diet		Visual Impairment		Cognitive Impairment	
Seizures / Blackouts		Incontinence		Sensory Impairment		Repetitive Behaviors	
Resistance to Assistance		Wandering / Elopement		Verbal/Physical Aggression		Other	

D. SIGN

I have personally examined this Member in the last twelve (12) months and reviewed all appropriate medical records.

By signing this form I certify that I am a Texas Medicaid enrolled provider and the information provided above is accurate. I understand I am not prescribing personal care services.

Signature of Practitioner:		Date:
Printed name of Practitioner:	TPI:	License Number:

E. RETURN the Practitioner Statement of Need:

- Fax the completed form to the UHC Service Coordinator at the fax number listed.
- A signed and dated Statement of Need must remain in the Member's UHC file.

Step 2: To Be Completed by UHC Service Coordinator

UHC Service Coordinator:	Date:
Service Coordinator Phone number:	Service Coordinator FAX number: