

These instructions offer guidance for completing the Request for Independent Assessment and Attestation of Medical Need Form for **Personal Care Services (PCS)** and should be read and completed within its entirety before completing. **Expedited Assessment Process** Info: Check Box below. Questions: Email LTSS@Trilliumnc.org

Personal Care Services (PCS) is a Medicaid benefit based on the need for assistance with Activities of Daily Living (ADLs). The ADLs are bathing, dressing, toileting, eating, and transferring/functional mobility in the home. The purpose of the Request for Independent Assessment / Attestation of Medical Need Form (DHB-3051) is to request a PCS Independent Assessment. Requested assessments will be one of the following: New Request, Change of Status (Medical or Non-Medical), or Change of Provider.

Sections A – D: Change of Status: Medical, New Request

Section A: Beneficiary's Demographics. The beneficiary's name should be the same as it appears on their Medicaid card. Beneficiaries living in, and those seeking admission to, an Adult Care Home (ACH) will have the facility address and phone number. Identifies legal guardian or Power of Attorney (POA), submit guardianship/PO documents to LTSS@TrilliumNC.org.

***The RSID # and RSID Date is generated when a beneficiary, being referred or seeking admission to an ACH, is referred to a LME-MCO for the RSVP. Further information can be found below, pg 2. The Alternate Contact should not be a PCS Provider.**

Section D, located on page 2, is a required field for all Medical Change of Status Requests. The date of the beneficiary's last PCP visit must be < 90 days from Received Date by the AE. It is required that the beneficiary's PCP or inpatient practitioner complete this form. If the beneficiary does not have a PCP, the practitioner, currently providing care and treatment for the medical, physical or cognitive condition causing the functional limitation, may complete the form.

PRACTITIONER INSTRUCTIONS ENDS HERE ---

Sections E – F: Non-Medical Change of Status and Change of Provider Requests, located on pg. 3 of the form, shall be completed by the beneficiary, family member, legal guardian, home care provider, or residential provider.

****Note:** Effective 11/1/2018 any Medicaid beneficiary referred to or seeking admission to Adult Care Homes (ACH) licensed under G.S. 131D-2.4 must be referred to a LME-MCO for the Referral Screening Verification Process (RSVP). Adult Care Home providers licensed under G.S. 131D-2.4 shall not receive a PCS assessment or prior approval without verification of a Referral Screening ID (RSID). If you have questions about your status in this process, please contact the Division of Mental Health at 919-981-2580.
DHB-3051



**DMA-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	_____ Expedited Assessment Request

Questions: [Click Here to Submit Questions](#) **Form Submission Email:** LTSS@Trilliumnc.org

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.	_____	<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 Beneficiary 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:

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: _____ **NPI#:** _____

Practice Contact Name: _____

Practice Stamp

Address: _____

Phone: _____ **Fax:** _____

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

Practitioner Signature AND Credentials: _____

Practitioner Signature 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 ---

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:
<input type="checkbox"/> Change of Status: Non-Medical <input type="checkbox"/> Change of Provider	_____ Expedited Assessment Required

Step 2

Questions: [Click Here to Submit Questions](#) **Form Submission Email:** [LTSS @Trilliummc.org](mailto:LTSS@Trilliummc.org)

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: () _____

Step 3

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): ____ / ____ / ____

SECTION E: 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"/> 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 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 F: CHANGE OF PCS PROVIDER

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

Requestor's Contact Name: _____ Phone: _____

Reason for Provider Change (Select One):	<input type="checkbox"/> Beneficiary or legal representative's choice	<input type="checkbox"/> Current provider unable to continue providing services	<input type="checkbox"/> Other: _____
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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):

<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: _____