

**DHB-3051**  
**REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES**  
**ATTESTATION OF MEDICAL NEED**

**INSTRUCTIONS**

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 in its entirety before completing. Expedited Assessment Process Info: Contact Liberty Healthcare Corporation at 1-855-740-1400. Questions: Call or Email Liberty Healthcare at 855-740-1400, 919-322-5944, or [nc-iasupport@libertyhealth.com](mailto:nc-iasupport@libertyhealth.com).

**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: Disenrollment, New Request, Change of Status (Medical or Non-Medical), or Change of Provider.

**Sections A – E:** Change of Status: Medical, New Request, and Managed Care Disenrollment (located on pg. 1-2 of the form) shall be completed by a practitioner with section E completed by the PCS Provider if for Managed Care Disenrollment.

**Step 1**

**Request Type:** Select the type that indicates the reason for the request. Enter the Date of Request in the appropriate field.

**Step 2**

**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's address and phone number. If identified as legal guardian or Power of Attorney (POA), submit guardianship/POA documents to Liberty Healthcare.

**\*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.**

**Step 3**

**Section B:** Beneficiary's Conditions. Enter information regarding current medical conditions that limit the beneficiary's ability to perform, and resulted in a need for assistance with, ADLs. Medical Diagnosis and ICD-10 Code are both required fields.

**The Diagnosis and ICD-10 entered must relate to the ADL deficit for this request to be processed.**

**Step 4**

**Optional Attestation:** This step is optional. Review each statement and initial, only if applicable.

**Step 5**

**Section C:** Practitioner Information. Enter Practitioner and Practice information in the appropriate field. You may use the practice stamp if applicable. Sign and date once completed.

**Signature stamps are not allowed.**

**Step 6**

**Section D:** Change of Status: Medical. Complete if requesting a Medical Change of Status. Describe the medical change and its impact on the beneficiary's need for hands on assistance.

**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 IAE.**

**It is required that the beneficiary's PCP or inpatient practitioner complete this form. If 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.**

**Step 7**

**Section E:** Managed Care Disenrollment: Medical. Complete if requesting disenrollment from Managed Care. Enter the information regarding the beneficiary's current plan, date of enrollment, effective date of disenrollment, current approved PCS hours, and current PCS provider. Completed form should be faxed to Liberty Healthcare prior to disenrollment date.

--- PRACTITIONER FORM ENDS HERE ---

**Sections F – G:** 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.

**Step 1** Request Type. Select the Request Type that indicates the reason for the request. Enter the Date of Request in the appropriate field.

**Step 2** Beneficiary's Demographics. The beneficiary's name should be the same as it appears on their Medicaid card. For Beneficiaries living in, and those seeking admission to, an ACH, enter the facility's address and phone number.

**The Alternate Contact should not be a PCS Provider.**

**Step 3** Section F: Change of Status: Non-Medical. Complete if requesting a Non-Medical Change of Status. Enter the Facility License # and Date, if applicable. Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance.

**Section F, found on pg 3, is a required field for all Non-Medical Change of Status Requests.**

**Step 4** Section G: Change of PCS Provider. Complete if requesting a Change of Provider.

**Completed Request Forms should be submitted to Liberty Healthcare Corporation-NC via fax at 919-307-8307 or 855-740-1600 (toll free).**

**\*\*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  
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

<b>REQUEST TYPE:</b> (select one)	<b>DATE OF REQUEST:</b>
<input type="checkbox"/> Change of Status: Medical <input type="checkbox"/> New Request <input type="checkbox"/> Managed Care Disenrollment	_ / _ / _

**Form Submission:** Fax Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).  
**Expedited Assessment Process Info:** Contact Liberty Healthcare Corporation at 1-855-740-1400.  
**Questions:** Call Liberty Healthcare at 855-740-1400 or 919-322-5944.

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.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes No	
2.	_ . _ . _ . _ . _ . _ . _ . _ .	<input type="checkbox"/> Yes No	
3.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes No	
4.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes No	
5.	_ . _ . _ . _ . _ . _ . _ . _ .	<input type="checkbox"/> Yes No	
6.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes No	
7.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes No	
8.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes No	
9.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes <input type="checkbox"/> No	
10.	_ . _ . _ . _ . _ . _ . _ . _ .	Yes 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: \_\_\_\_\_

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):

Step 7

**SECTION E: Managed Care Disenrollment****Disenrolling from; Plan name** (Select One):  AmeriHealth Caritas NC, Inc.  Carolina Complete Health, Inc. Blue Cross Blue Shield of NC, Inc.  UnitedHealthcare of NC, Inc.  WellCare of NC, Inc.

Disenrollment Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Current PCS Hours: \_\_\_\_\_

**BENEFICIARY'S CURRENT PROVIDER)**

Agency Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Provider NPI#: \_\_\_\_\_

Provider Locator Code# \_\_\_\_\_

Facility License # (if applicable): \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Physical Address: \_\_\_\_\_

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

Step 1

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

**Form Submission:** Fax Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).  
**Questions:** Call Liberty Healthcare at 855-740-1400 or 919-322-5944.

Step 2

**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 F: CHANGE OF STATUS: NON-MEDICAL**

<b>Requested by</b> (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): _____
--------------------------------------	---------------------------------------	--------------------------------------	---	--	--	---

**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 G: CHANGE OF PCS PROVIDER**

**Requested by** (Select One):  Care Facility  Beneficiary  Other (Relationship): \_\_\_\_\_

Requestor's Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**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
---	---	--	---	------------------------------------	------------------------------------	--

Agency Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Provider  
NPI#: \_\_\_\_\_ Provider Locator Code# \_\_\_\_\_  
Facility License # (if applicable): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Physical Address: \_\_\_\_\_