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 NC LIFTSS 1-833-522-5429. Questions: Call or Email NC LIFTSS at 1-833-522-5429 or, NCLIFTSS@Kepro.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 NC LIFTSS.

***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 NC LIFTSS 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 NC LIFTSS- via fax at 1-833-521-2626 (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.

Beneficiary Name: _____ MID#: _____

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

REQUEST TYPE: (select one) | **DATE OF REQUEST:**

£ **Change of Status: Medical** £ **New Request** £ **Managed Care Disenrollment** | ___/___/___

Form Submission for PCS: Fax NCLIFTSS at 1-833-521-2626 (toll free).
Form Submission for Expedited Assessment: Fax NCLIFTSS at 1-833-551-2602 (toll free).
Questions or Expedited Assessment Process Info: Contact NCLIFTSS at 1-833-522-5429.

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.	_ _ _._ _ _ _	Yes ☐ No ☐	
3.	_ _ _._ _ _ _	Yes ☐ No ☐	
4.	_ _ _._ _ _ _	Yes ☐ No ☐	
5.	_ _ _._ _ _ _	Yes ☐ No ☐	
6.	_ _ _._ _ _ _	Yes ☐ No ☐	
7.	_ _ _._ _ _ _	Yes ☐ No ☐	
8.	_ _ _._ _ _ _	Yes ☐ No ☐	
9.	_ _ _._ _ _ _	Yes ☐ 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

Beneficiary Name: _____ MID#: _____

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: _____ **N P I#:** _____

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:

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:**
£ **Change of Status: Non-Medical** £ **Change of Provider**	____/____/____

Form Submission: Fax NC LIFTSS at 1-833-521-2626 (toll free).
Questions: Call NC LIFTSS at 1-833-522-5429.

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: ( ) _____

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 F: CHANGE OF STATUS: NON-MEDICAL

Requested by (Select One):	£ PCS Provider	£ Beneficiary	£ Legal Guardian	£ Power of Attorney (POA)	£ Responsible Party	£ 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):

£ Home Care Agency	£ Family Care Home	£ Adult Care Home	£ Adult Care Bed in Nursing Facility	£ SLF-5600a	£ SLF-5600c	£ Special Care Unit

Agency Name: _____ Phone: ( ) _____ Provider NPI#: _____ Provider Locator Code# _____

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

Physical Address: _____