AmeriHealth Caritas North Carolina

Request for Assessment for Personal Care Services (PCS) Attestation of Medical Need

Complete all applicable sections of the form and fax to AmeriHealth Caritas North Carolina Long Term Services and Supports at **1-833-893-2262**. For questions, call **1-833-900-2262**.

Step 1 Please select one: ☐ New Request ☐ Change of Status: Medical Date of Request:

Step 2

Section A. Beneficiary Demographics

Beneficiary's name: First:	MI:	Last:	Date of birth:
Medicaid ID number:	PASRR number (For ACHs Only):	PASRR Date:	
Gender: ☐ Male ☐ Female	Language: ☐ English ☐ Spanish ☐ Other:		
Address:			
City:	County:	ZIP:	Phone number:
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18) Name:			
Relationship to Beneficiary:			Phone number:
Active Adult Protective Services Case? ☐ Yes ☐ No			

Beneficiary currently resides:

☐ At home ☐ Hospitalized/medical facility ☐ Group Home ☐ Other:

☐ Adult Care Home ☐ Skilled Nursing Facility ☐ Special Care Unit (SCU) D/C date (Hospital/SNF):

Enter RSVP Service ID #:

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 ICD-10 code for each.

Medical Diagnosis	ICD-10 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

In your clinical judgment, the ADL limitations are: ☐ Short Term (3 Months) ☐ Intermediate (6 Months)
☐ Expected to resolve or improve (with or without treatment) ☐ Chronic and stable ☐ Age Appropriate

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

Step 4

Attestation: Practitioner identifies change in need for current PCS services, if applicable:

The beneficiary requires an increased level of supervision.	Initial if Yes:
The **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 if Yes:
Regardless of setting, the **beneficiary requires a physical environment 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 if Yes:
The **beneficiary has a history of safety concerns** related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial if Yes:

Beneficiary Name:_____ MID number:_____

Step 5

Section C. Practitioner Information		
Attesting Practitioner's name:	Practitioner NPI number:	
Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner Practice		
Name:		Practice Stamp:
Practice NPI number:		
Practice contact name:		
Address:		
Phone number:	Fax number:	
Date of last visit to practitioner (Must be < 90 days from request date):		

Sign here

Practitioner signature and credentials:	Date:

Signature stamp is 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."

Change of Status Medical

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 for all reasons):

Practitioner Form Ends Here

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Beneficiary Name:_____ MID number:_____

For non-medical change of status or change of provider requests, complete this page only.

Step 1 Please select one: ☐ New Request ☐ Change of Status: Non-Medical Date of Request:

Step 2

Beneficiary's name: First:	MI:	Last:	Date of birth:
Medicaid ID number:	Gender: ☐ Male ☐ Female	Language: ☐ English ☐ Spanish ☐ Other:	
Address:			
City:	County:	ZIP:	Phone number:
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18) Name:			
Relationship to Beneficiary:			Phone number:

Beneficiary currently resides:

☐ At home ☐ Hospitalized/medical facility ☐ Group Home ☐ Other:
☐ Adult Care Home ☐ Skilled Nursing Facility ☐ Special Care Unit (SCU) D/C date (Hospital/SNF):

Change of Status Non-Medical

Section E. Change of Status: Non-Medical

Requested by (select one): ☐ PCS Provider ☐ Beneficiary

Responsible Party: ☐ Guardian ☐ Legal Power of Attorney (POA) ☐ Family (Relationship):

Requestor name:

PCS Provider NPI number:	PCS Provider Locator Code number (three-digit code):
Facility License number (if applicable):	License date (if applicable): (mm/dd/yyyy)
Provider contact name:	Contact's position:
Provider phone number:	Provider fax number:
Email:	

Reason for Change in Condition Requiring Reassessment:

☐ Change in beneficiary's location affecting ability to perform ADLs ☐ Change in days of need
☐ Change in caregiver status ☐ Other:

Describe the specific change in condition and its impact on the beneficiary's need for hands-on assistance (required for all reasons):

Beneficiary Name:_____ MID number:_____

Change of Provider

Section F. Change of PCS Providers	
Requested by (select one): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship to Beneficiary)	
Requestor contact's name:	Phone number:
Reason for Provider Change (select one): ☐ Beneficiary or legal representative's choice ☐ Current provider unable to continue providing services ☐ Other:	
Status of PCS Services (select one): ☐ Discharged/Transferred on _____(mm/dd/yyyy) ☐ Scheduled for discharge/transfer on _____(mm/dd/yyyy) ☐ Continue receiving services until beneficiary is established with a new provider agency; no discharge/transfer is planned	
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 number:
PCS Provider NPI number:	PCS Provider Locator Code number (three-digit code):
Facility License number (if applicable):	License Date (if applicable): (mm/dd/yyyy)
Physical address:	