

N.C. Department of Health and Human Services – Division of Medical Assistance
**PERSONAL CARE SERVICES (PCS) REQUEST FOR SERVICES FORM
INSTRUCTIONS**

These instructions offer guidance for completing the Personal Care Services (PCS) Request for Services Form and should be read in its entirety before completing the PCS Request for Services Form. This form should ONLY be used for New Referral, Change of Status and Change of Provider requests. Please type or print legibly in black or blue ink. Completed Request for Services Forms should be printed and faxed to the Independent Assessment Entity (IAE).

Indicate the date of the request in the outlined format. When selecting the Provider Type indicate the type of provider to be requested for the New Referral or the type of provider that is submitting the Change of Status or Change of Provider request. **Note: Beneficiaries interested in changing the Provider Type from which they currently receive services must have a New Referral submitted on their behalf.**

Example A: If a beneficiary currently receiving PCS assistance in their private residence has a change in their location by being admitted to a residential facility, a NEW referral will need to be completed and submitted.

Example B: If a beneficiary is requesting to change the Home Care Agency from which they receive Personal Care Services to a different Home Care Agency a Change of Provider request must be completed and submitted by the beneficiary or their authorized representative.

Example C: A beneficiary, who was previously residing in a Special Care Unit, was admitted to the hospital. The hospital's Discharge Planner is discharging the beneficiary to their private residence where the beneficiary has requested to continue to receive Personal Care Services. A New Referral will need to be completed and submitted.

SECTION A – BENEFICIARY DEMOGRAPHICS:

1. If submitting a New Referral, Change of Status or Change of Provider, complete section A. Provide information related to beneficiary's demographics to include:
 - Medicaid ID Number (*must be a current Medicaid beneficiary*)
 - Name (i.e., First, Middle Initial, Last)
 - Date of Birth
 - Gender
 - Primary Language
 - Current Physical Address, City, County, Zip Code with the 4 digit extension,
 - Phone Number including the area code
2. Provide the information for the alternate contact, parent or guardian or legal representative in case we have difficulty reaching the beneficiary to schedule the assessment. This should include:
 - Name (First and Last)
 - Phone Number including the area code
3. Indicate the name of the current PCS Provider, their phone number and including area code if submitting a Change of Status or Change of Provider.

SECTION B – BENEFICIARY MEDICAL HISTORY:

1. Complete Section B only if submitting a New Referral or Change of Status request.
2. List both the current medical diagnoses and ICD-9 codes for the corresponding diagnoses that currently limit the beneficiary's ability to independently perform activities of daily living (bathing, dressing, mobility, toileting, and eating).
3. For each medical diagnosis indicate "O" for onset or "E" for exacerbation.
4. If known, indicate the date associated with each medical diagnosis using the indicated format.

SECTION C – NEW REFERRAL REQUESTS:

1. To submit a New Referral request check the box to the left and complete **sections A, B and C** of the form.
2. Select the Referral Entity type.
3. Indicate if the beneficiary is medically stable or has an active Adult Protective Services (APS) case.
4. Provide the date of the last visit to the referring entity in the outlined format. This date should be either the last office visit to the referring primary care physician or the last date the beneficiary was seen by the referring attending, PA, NP or hospitalist MD, if in an inpatient facility.
5. Indicate if, at the time of the New Referral, the beneficiary is receiving services from any of the identified state or federal programs. If unknown, selected the corresponding box.
6. Indicate if 24-hour caregiver availability is required to ensure the safety of the beneficiary.
7. If the beneficiary is currently hospitalized provide the planned discharge date in the outlined format.
8. Provide the following information about the Referring Entity or Medical Practitioner:
 - Name of the Referring Entity or Medical Practitioner
 - NPI number
 - Name of the Practice (if applicable)
 - Provide the name of a Point of Contact (POC) at the Practice with whom questions regarding the information about the New referral can be directed. This information should include the POC's position or title within the practice, phone number, fax number and email address.
9. If the beneficiary is currently in an inpatient facility, the referring practitioner can be an attending physician or hospitalist physician, physician's assistant or nurse practitioner. Enter the name of hospital or nursing facility in the "Practice Name" field. The name of the discharge planner or case manager should be listed as the point of contact.
10. The Referring Entity/Medical Practitioner must sign and date referral as authorization for the Independent Assessment Entity (IAE) to perform a PCS eligibility assessment. If the beneficiary is currently in an inpatient facility, the facility representative may sign the New Referral indicating that a signed physician order is available in the medical records of the beneficiary at the facility.
11. Incomplete New Referrals will be returned to the referring entity via fax with a request for required missing information. PCS eligibility assessments will not be scheduled until all required New Referral information is complete.

SECTION C – NEW REFERRAL REQUESTS (continued):

12. If submitting a New Referral **and** requesting an assessment for greater than 80 hours completion of sections A, B, and C are required.
13. The dated signature is verification of the accuracy of the information for the respective beneficiary provided in sections A, B, and C and provides authorization to conduct the PCS eligibility assessment.
14. Upon completion of **sections A, B and C** of the PCS Request for Services form, fax or mail **page 1** to the Independent Assessment Entity (IAE).

SECTION D – CHANGE OF STATUS (COS) REQUESTS:

1. To submit a Change of Status (COS) request check the box to the left and complete **sections A, B, and D**. If the Change of Status is a request for greater than 80 hours of PCS complete **sections A, B, D, and E**. Refer to Section E for the criteria for PCS greater than 80 hours. Refer to the instructions above for completing section A and B.
2. Indicate whether the COS is requested by the:
 - Beneficiary's Primary Care Physician
 - Attending MD
 - Physician Assistant (PA)
 - Nurse Practitioner (NP)
 - Beneficiary's current PCS Provider
 - Beneficiary
 - Beneficiary's Responsible Party.
 - Other (If other, please indicate the individual's relationship to the beneficiary.)
3. Indicate if the beneficiary is medically stable or has an active Adult Protective Services (APS) case.
4. Select the box that most closely describes the reason for change in condition that affects the individual's ability to self-perform or the time required to provide the qualifying ADL assistance. If additional space is required, please attach an additional sheet including the beneficiary's name and MID number. In the box below include supporting documentation describing in detail the:
 - Change in the beneficiary's medical condition
 - Change informal caregiver availability
 - Change in the environmental condition or location

Example A: Beneficiary fell on porch during the week of May 13th. Beneficiary doesn't remember the exact date of fall. Has a fracture to their upper arm and is now unable to lift arm and has limited range of motion changing their current functional status. Beneficiary continues to live alone.

Example B: Beneficiary recently had diagnosis with arthritis in knees with decreased mobility. Needs assistance with ambulation and transfers with toileting.
5. Complete the information fields for the current PCS Provider. Provide the:
 - Name of the agency
 - NPI number
 - Locator Code (3-digit code)
 - Facility License Number (if applicable)
 - Facility License Date (if applicable)

- Provider Contact Name (First and Last name) of the individual completing the Change of Status who may serve as the point of contact regarding the request.
- Provider Contact Position or Title
- Provider Contact Phone number (including area code)
- Provider Contact Fax number (including area code)
- Provider Contact Email address

SECTION D – CHANGE OF STATUS (COS) REQUESTS (continued):

6. If the Change of Status is being submitted by the beneficiary's Primary Care Physician, Attending MD, Physician's Assistant or Nurse Practitioner complete the fields associated with the Referring Entity/Practitioner Information:
 - Referring Entity or Medical Practitioner's Name (First and Last name)
 - NPI number
 - Practice Name (if applicable)
 - Practice Contact's Name (First and Last name) is the name and contact information of the individual within the Practice completing the form who may serve as the point of contact regarding the request.
7. If beneficiary is currently in an inpatient facility or hospital, the referring practitioner can be an attending physician or hospitalist physician, physician's assistant or nurse practitioner. Enter the name of hospital or nursing facility discharge planner or case manager as the contact name. This individual should serve as the point of contact.
8. If submitting a request for a Change of Status, upon completion of **sections A, B, and D** or **sections A, B, D, and E** (for greater than 80 hours) of the PCS Request for Services form, fax or mail **pages 1 and 2** to the Independent Assessment Entity (IAE).
9. If submitting a Change of Status **and** requesting an assessment for greater than 80 hours completion of sections A, B, D & E are required. Section E requires that the Physician (i.e., Primary Care Physician, Attending MD, Physician Assistant, or Nurse Practitioner) attest that the beneficiary meets each of the indicated criteria.

SECTION E – PHYSICIAN ATTESTATION :

1. Session Law 2013-306 requires that a physician attest that the recipient meets each of the criteria below to be eligible for up to 50 additional hours of PCS as determined through the independent assessment.
 - The recipient requires an increased level of supervision.
 - The recipient 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.
 - Regardless of setting, the recipient requires a physical environment that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
 - The recipient has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.
2. If submitting a New Referral or Change of Status (COS) is requesting an assessment for greater than 80 hours the dated signature is verification that information in sections A, B, C, D (if COS) and E are accurate for this recipient and authorization to conduct the PCS eligibility assessment.

3. If submitting a Physician Attestation only the dated signature is verification that information in sections A, B and E are accurate for this recipient and authorization to conduct the PCS eligibility assessment.
4. The referring entity or physician must sign and date the attestation.

SECTION F – CHANGE OF PROVIDER (COP) REQUESTS:

1. To submit a Change of Provider (COP) Request check the box to the left and complete **sections A and F**. Refer to the instructions above for completing section A.
2. Select the corresponding box to indicate by whom the COP is being requested.
3. Home Care Agencies and Licensed Residential Facilities should have beneficiaries or the beneficiary's legal representatives to call the IAE to facilitate a change of provider (COP) request. Home Care Agencies and Licensed Residential Facilities may assist the beneficiary or legal representative in placing the call.
4. Indicate the reason for the provider change. If the reason is not one of the choices listed describe the reason in the "Other" text field.
5. Indicate if the beneficiary has been discharged/transferred and date of discharge/transfer, the beneficiary's scheduled date for discharge/transfer or if the current provider will continue to provide services until the beneficiary is established with a new PCS Provider agency and no discharge/transfer is planned.
6. Select the Provider Type of the Preferred Provider Agency/Agencies. **NOTE: Beneficiaries interested in changing from one Provider Type from which they currently receive services to another must have a New Referral submitted on their behalf and not a Change of Provider.**

Example A: If a beneficiary currently receiving PCS assistance in their private residence has a change in their location by being admitted to a residential facility, a NEW referral will need to be completed and submitted.

Example B: If a beneficiary is requesting to change the Home Care Agency from which they receive Personal Care Services to a different Home Care Agency a Change of Provider request must be completed and submitted.

7. List information about the beneficiary's preferred Provider of choice and an alternate Provider. Include the:
 - Agency Name
 - Phone Number including the area code
 - Three digit Locator Code
 - Facility License number, if applicable
 - License Date, if applicable in month and year format,
 - Physical address for the PCS Provider(s).
8. If an Alternate Preferred Provider agency is not indicated assistance can be provided to select an alternate provider.
9. If submitting a request for a Change of Provider, upon completion of **sections A and F** of the PCS Request for Services form, fax or mail **pages 1, 2 and 3** to the Independent Assessment Entity (IAE).

Completed Request for Services Forms should be printed and faxed to: Liberty Healthcare Corporation-NC at 484-434-1571 or 855-740-0200 (toll free)

For questions, email NC-IAsupport@libertyhealth.com

Copies of forms and fax confirmations should be maintained by the Referring and Requesting Entities.

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PERSONAL CARE SERVICES (PCS) REQUEST FOR SERVICES FORM

Completed form should be sent to Liberty Healthcare Corporation-NC via fax at 919-307-8307 or 855-740-1600 (toll free) or mail: ATTN: Liberty Healthcare Corporation, PCS Program 5540 Centerview Dr. Suite 114, Raleigh, NC 27606-3386. For questions, contact 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@libertyhealth.com. **DISCLAIMER: Adherence to the INSTRUCTIONS for the Request for Services Form is REQUIRED. If a request for services form is submitted incomplete, an unable to process notification will be issued and a new request for services form will be required. For the Expedited Assessment Process contact Liberty Healthcare Corporation at 1-855-740-1400**

PROVIDER TYPE (select one)	DATE OF REQUEST: _____(mm/dd/yyyy)
<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 (stand-alone Special Care Unit or SCU bed)	

SECTION A. RECIPIENT DEMOGRAPHICS

Medicaid ID#: _____

Recipient's Name (as shown on Medicaid Card) First: _____ MI: _____ Last: _____

Date of Birth: _____(mm/dd/yyyy)
 Gender: Male Female
 Primary Language: English Spanish Other

Address: _____ City: _____

County: _____ Zip: _____ (zip code + 4 digit extension) Phone: _____

Alternate Contact/Parent/Guardian (required if patient under 18): First: _____ Last: _____

Relationship to Patient: _____ Phone: _____

Provider Name (if applicable) _____ Provider Phone: _____

SECTION B. RECIPIENT'S MEDICAL HISTORY – complete this section only if submitting a NEW REFERRAL or CHANGE OF STATUS request.

List **both** the current **medical diagnoses** and **ICD-9 codes** that currently limit patient's ability to independently perform Activities of Daily Living (bathing, dressing, mobility, toileting, and eating), prepare meals, and manage medications.

Medical Diagnosis	ICD-9 Code	Enter "O" for Onset or "E" for Exacerbation	Date (mm/yyyy)

SECTION C. NEW REFERRAL REQUEST complete this section if submitting a New Referral.

Check the box to the left and complete sections A, B, and C if submitting a New referral.

Referral Entity (select one): Primary Care Physician Attending MD Physician Assistant (PA) Nurse Practitioner (NP)

Is Recipient Medically Stable: Yes No
 Is there an active Adult Protective Services (APS) case: Yes No

Date of last visit to Referring Entity: _____(mm/dd/yyyy)

Other state/federal programs recipient is currently receiving (select all that apply): Medicare Home Health Private Duty Nurse
 CAP Hospice Unknown

Is 24-hour caregiver availability required to ensure recipient's safety? Yes No (e.g., Does patient have unscheduled ADL needs or require safety supervision or structured living, or is patient unsafe if left alone for extended periods?)

Is recipient currently hospitalized or in a medical facility: Yes No If yes, planned discharge date: _____(mm/dd/yyyy)

Is recipient currently in a Skilled Nursing Facility (SNF): Yes No if yes, planned discharge date: _____(mm/dd/yyyy)

Referring Entity's Name: _____ NPI#: _____

Practice Name: _____(if applicable)

Name of Practice Point of Contact: _____ Position: _____

Phone (including area code): _____ Fax (including area code): _____

Point of Contact's Email Address: _____

Referring Entity/Practitioner Signature: _____ Date: _____(mm/dd/yyyy)

NOTE: Dated signature is verification that the information in sections A, B, and C is accurate for this recipient and authorization to conduct a PCS eligibility assessment. If requesting an assessment for greater than 80 hours of PCS completion of **sections A, B, C, and E with a second signature is REQUIRED on page 2. If not stop here and submit to Liberty.**

SECTION D. CHANGE OF STATUS REQUEST – complete this section if submitting a Change of Status (COS).

Check the box to the left and complete sections A, B, and D if submitting a Change of Status. If the Change of Status

Requested By (select one): Primary Care Physician Attending MD PA NP PCS Provider Recipient
 Responsible Party Other (Relationship to Recipient): _____

Is Recipient Medically Stable: Yes No **Is there an active Adult Protective Services (APS) case:** Yes No

Reason for Change in Condition Requiring Reassessment:

- Change in medical condition Change in recipient's location affecting ability to perform ADLs
 Change in caregiver status Hospitalization Discharge Date: _____(mm/dd/yyyy)
 Other: _____

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

Provider Name: _____
PCS Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)
Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)
Provider Contact Name: _____ Contact's Position: _____
Practice Phone _____ Practice Fax: _____
Email: _____

Referring Entity/Practitioner Information (Complete if change of status is submitted by the recipient's PCP, Attending MD, PA, or NP).
Practitioner First Name: _____ Last Name: _____ NPI#: _____
Practice Name: _____(if applicable)
Practice Contact's Name: _____ Contact's Position: _____
Practice Phone _____ Practice Fax: _____
Email: _____

SECTION E. PHYSICIAN ATTESTATION: Session Law 2013-306 requires that a physician attest that the recipient meets each

- The **recipient** requires an increased level of supervision.
- The **recipient** 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.
- Regardless of setting, the **recipient** requires a physical environment that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- The **recipient** has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Referring Entity/Practitioner Signature: _____ **Date:** _____(mm/dd/yyyy)

NOTE: If submitting a **New Referral or Change of Status (COS)** is requesting an assessment for greater than 80 hours the dated signature is verification that information in sections A, B, C, D (if COS) & E are accurate for this recipient and authorization to conduct the PCS eligibility assessment. If submitting a **Physician Attestation only** the dated signature is verification that information in

sections A, B and E are accurate for this recipient and authorization to conduct the PCS eligibility assessment.

SECTION F. CHANGE OF PROVIDER REQUEST – complete this section if submitting a Change of Provider (COP).

Check the box to the left and complete sections A and F only.

Requested By (select one): Primary Care Physician Attending MD Physician Assistant Nurse Practitioner
 Recipient Responsible Party

NOTE: Home Care Agencies and Licensed Residential Facilities should have beneficiaries or the recipient's legal representatives to call the Liberty Healthcare Corporation-NC Call Center for Change of Provider (COP) requests at 855-740-1400 or 919-322-5944. Home Care Agencies and Licensed Residential Facilities may assist the recipient or legal representative in placing the call.

Reason for Provider Change (select one):

- Recipient or legal representative's choice
- Current provider unable to continuing 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 recipient is established with a new provider agency; no discharge/transfer is planned

Recipient'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 (stand-alone Special Care Unit or SCU bed)

Agency Name: _____ Phone: _____
Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)
Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)
Physical Address: _____

Recipient's Alternate 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 (stand-alone Special Care Unit or SCU bed)

Agency Name: _____ Phone: _____
Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)
Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)
Physical Address: _____

Contact Information for Questions about Change of Provider Request (if not recipient or alternate contact listed in section A).

Contact's Name: _____ **Relationship to Recipient:** _____
Phone: _____ **Fax:** _____ **Email:** _____