

DMA Instructions for the PCS PACT Form

PACT Page 1	
Field/Category	Instructions
Annual Reauthorization Due	This due date is a minimum of 365 days from the date of the RN assessment being documented on the PACT form. The date is calculated from the certified RN assessment date and not from the date the physician signs the PCS PACT form.
Referral Date	Date provider received the initial referral for services. This date stays the same on all future PACT forms until the patient is discharged. If the patient is discharged and later readmitted for services, a new referral date is entered on the new PACT form.
Date Initial Assessment Completed	Date provider RN completed the initial assessment in the patient's home. This date remains the same on all future PACT forms until the patient is discharged. If the patient is later readmitted for services, a new assessment date is entered on the new PACT form.
Date Last Reassessment Completed	Date provider completed the last reassessment – this date may be the date of the last annual reassessment or the date a reassessment was completed due to a change in the patient's condition or hospitalization that required completion of a new PCS PACT form.
Provider Name	Name of provider agency at this licensed/enrolled site
PCS Provider #	PCS provider # assigned by DMA for this specific licensed/enrolled site
Provider Phone #	Provider agency phone number including area code for this licensed/enrolled site
Provider Address	Provider agency address for this specific licensed/enrolled site – include city, state and zip code. This should be the same address as on your DFS license and your provider enrollment materials, or updates if the address has changed.
Field 1	Patient's first and last name as it appears on the Medicaid card (blue or pink Medicaid card only)
Field 2	Medicaid ID # as it appears on the Medicaid card (blue or pink)
Field 3	Patient's address – include city, state, and zip code
	Patient's phone number – include area code
Field 5	Sex of the patient – male or female
Field 6	Patient's date of birth – month/day/year
Field 7	Indicate with whom the patient lives – check all that apply
Field 8	Contact person's name and relationship to patient, address, phone number at home and work – include area code. The contact is an individual whom the agency would contact for a concern or change in client needs or services.
Field 9	Primary care physician's name – this is the name that must also appear as the authorizer of PCS Services on the PACT form, phone number and address. This is the patient's primary physician . If the Medicaid card indicates Carolina Access/Community Care the primary physician must be the Carolina Access/Community Care

	physician. Note the name of the PA/NP who works for Primary Care Physician, if authorizing services.
Field 10	Address – write the address of the primary care physician, appropriate for mailing Also include the phone number, with area code.
Field 11	Date of most recent exam, month/day/year by primary physician.
Field 12	Vital signs taken by RN at assessment today. Height and weight can be self reported by patient
Field 13	Reason for referral for PCS services, include referral source. The reason for referral should be indicative of the patients need for assistance with activities of daily living qualifying for personal care services. The referral source is specified – such as discharge planner, DSS, social worker, consulting MD, family member.
Field 14	Diagnosis – list the medical diagnosis; specify date of onset of diagnosis and ICD-9 code (s) for the diagnosis/diagnoses. If the client has multiple diagnosis include primary diagnosis and all diagnosis / medical condition (s) supporting the need for PCS. Remember, the date of onset is critical in all surgical/orthopedic diagnoses. If the date is not known, you may give the clients estimate of the date. For example, less than 5 years, more than 5 years etc.
Field 15	Current care – type and source – list informal and formal caregivers, examples: Formal caregivers- Meals on Wheels, Home Health, etc. If the client is a current PCS recipient from the providing (assessor) agency and this is a re-assessment list ongoing PCS here. If it is a client currently receiving PCS from another agency and the CLIENT has chosen to change agencies note this here
Field 16	List all medications – name/dose/frequency/route – remember to include prescribed and over the counter medications. If the client is on oxygen include oxygen flow rate and route.
Field 17	Indicate if medications are self-administered and who assists if applicable by name and relationship. Indicate what they do, such as reminders are needed or other factors for medication administration (such as crushing, mixing with food) Remember: Medical tasks and monitoring which are delegated to the in home aide by the RN are in accordance with NC Laws, practice acts; standards of care and agency policy .The provider agency needs to have policy and procedure in place which identifies the in home aides role in assisting client with self administration of medications. Refer to the NC Board of Nursing Interpretative guide(s) to develop your agency policy. www.ncbon.org
Field 18	Indicate if allergies exist, and if yes, write in all known allergies – include food, medications and environmental allergies
PACT Page 2	
Patient First and Last Name	As it appears on the Medicaid card and page 1 of the PCS PACT Form

Medicaid ID	As it appears on the Medicaid card and page 1 of the PCS PACT Form
Assessment Date	Date this assessment is completed in the patient's home
<p>Limitations in Activities of Daily Living (ADLs)</p> <p>Activities of daily living are activities that we are normally able to perform independently for ourselves. Patients on the PCS program need either hands on assistance with their ADLs or need to have the ADL performed for them.(dependence)</p> <p>There are six universally recognized activities of daily living. They are: bathing, dressing, mobility – consisting of ambulation/transfers, eating, and toileting and bowel/bladder incontinence. To qualify for PCS, the patient must have two ADL deficits requiring hands on assistance with a score of 2 or higher in any of these six ADLs. You would score your hands on assistance with ADL tasks, personal hygiene and delegated medical monitoring. Delegated medical monitoring and personal hygiene alone are not qualifying ADL's to meet the two ADL deficits needed to qualify for PCS. The calculation of time and tasks in these categories can be counted in the ADL category when dividing your time on the Plan of Care in the ADL versus IADL category.</p> <p>The PACT form includes other personal care tasks, such as personal hygiene tasks, that the patient may need assistance with or performed for them. While a personal hygiene task is a covered PCS task, it is not in and of itself an ADL deficit. Hygiene tasks usually associated with the ADL of bathing. A patient only needing personal hygiene tasks and assistance with one other ADL would not qualify for PCS as there are not two ADL deficits. But a patient needing bathing and assistance with one other ADL, such as dressing would qualify for PCS. Field 25, personal hygiene needs can identify time needs for the plan of care when referring to the time and tasks guidance only.</p> <p>IADL's are instrumental activities of daily living. IADL's are meal preparation, home management tasks and simple errands. (Note: do not confuse ADLs with IADL's) For example, a patient that cannot eat independently and must be fed orally or by a tube has an ADL deficit in eating. A patient, who can feed himself/herself, but needs a meal prepared, does not have an ADL deficit in eating. Rather, the patient has an identified need for an IADL, a home management task to be performed. Meal preparation is not an ADL deficit. Meal preparation can not be used as one of the two ADL deficits needed to qualify for PCS as it is a home management task and not an ADL deficit.)</p> <p>Rate the individual's "ADL Self-Performance" and "ADL Support Provided" using the scoring system provided.</p> <p>Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task.</p> <p>M= Mon, T=Tues, W=Wed, Th=Thurs, F=Fri, S=Sat, Sun=Sunday</p>	

Completion of the assessment areas in each ADL field/category also includes completing scoring for column A “ADL Self-Performance” and column B “ADL Support Provided.” The last column provides a space for the assessor to check if PCS assistance is needed based on the assessment and scoring of columns A. and B. Be careful that the fields/category numbers where you have indicated assistance is needed match up to the category numbers and are included in the POC.

The “ADL Self Performance Scores” are briefly defined on the PCS PACT tool. More information on this scoring is available in the MDS scoring research.

- 0 - Independent: No help needed or oversight needed
- 1 - Supervision: Oversight, encouragement, or cueing needed
- 2 - Limited Assistance: Individual highly involved in activity, **receives hands-on assistance** in guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and/or other non-weight bearing assistance.
- 3 - Extensive Assistance: While individual performs part of activity, **substantial or consistent hands-on assistance** with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and/or weight bearing assistance is needed.
- 4 - Full Dependence: Full performance of activity by another

The “ADL Support Provided Scores” are also defined on the PCS PACT tool.

- 0 - No set-up or physical help needed
- 1 - Set-up help only
- 2 - One person physical assist
- 3 - Two+ persons assist and/or one person assist w/ assistive equipment

ADL Self-Performance Scores

Lists Scores 0-4 which correspond with the patient’s level of independence and/or dependence. The provider will place the applicable score - 0, 1, 2, 3 or 4 - under column A - by each of the fields/categories 19-24 on the PCS PACT form. Score how the patient appears most of the time. (A seven day look back) as observed in the nursing assessment, self reported by patient in the interview and caregivers input. Document accurately the patients condition(s) and functional health status with ADL deficits on the PACT to demonstrate clients self performance and services needed **Remember –supervisory visits and nursing review of the aide service logs provide the opportunity for ongoing assessment and evaluation of the clients ADL needs and self performance.** Include in field 46 clear and concise documentation indicating when and why additional time is needed.

ADL Support Provided Scores	Lists scores 0-3 which corresponds to the type of support the recipient needs with the task(s). The provider will place the applicable score - 0, 1, 2, or 3 - under column B - by each of the fields indicated (19-24)
Agency Assistance is needed	The third column is where you would place a check in the box if hands on assistance with an ADL will be needed and will be provided in the plan of care
Field 19 ADL Mobility	Ambulation – Moving in the recipient’s residence: To and from bathroom, bedroom, kitchen and dining area, living/sitting area, outside (porch, deck, yard). May use assistive devices including cane, walker, and wheelchair. Check all that apply. Note assistive equipment patient is to use while ambulating and the score for assistance needed If another device is used the RN should specify in the “other “category.
Field 19 ADL mobility	Non-ambulatory/transfer. This is moving to and between surfaces - bed, chair, toilet, tub, shower, wheelchair and standing position. Circle all transfers the client needs assistance with and the rating. Note: A simple transfer on and off the toilet/shower is included in the transfer score and not apart of the toileting/bathing score. Indicate if the individual is bed or chair bound. This includes moving recipient to and from a lying position, turning side-to-side and positioning recipient in bed. Indicate assistive equipment patient is to use during transfer and check all that apply. Note self sufficiency once transferred: If wheelchair bound consider if the recipient’s self-sufficiency to perform other ADLs once in wheelchair. <u>Indicate pressure relief devices used or if the patient is turned and positioned.</u>
Field 20 Eating	Eating – Taking in food by any method. Check whether the patient is fed orally, parenterally or by tube. Indicate in the blank beside tube what type of tube the patient has. Check whether patient is fed. An ADL deficit in eating occurs in this field if you are either feeding the patient or if you are replacing a part of eating such as chopping, pureeing or grind the food for the patient. Also note if a thickener is used for food or liquids. Physician orders for a therapeutic diet and modifications are needed for qualification. (chop ,grind ,puree) Remember Meal preparation and serving the food only is considered an IADL deficit. Write in the dietary restrictions. Write in any supplements the patient may be using. Write in the diet ordered. Write in if food is chopped, ground, pureed or thickened as ordered by the primary care physician.
Field 21	Bathing – Indicate the days and type of bath needed by writing in the days

ADL Bathing	<p>of the week by full body bath, partial bath, shower, and sponge bath assistance. Score the patient needs with the ADL bathing and on what day the assistance is needed. Note the time differs for a full bath or a partial bath. A partial bath may be done on limited days recognizing a full bath/shower daily is not needed for the aging and non-ambulatory patient (see time and task guidance)</p> <p>Write in the day(s) of the week the patient needs help with shampooing hair, foot care and with special skin care .(see time and task guidance)</p> <p>Check the devices the patient needs, if applicable, to assist with the bath. Remember the ADL self-performance score indicates the client's ability to self perform the identified task most of the time. Bathing would be an ADL deficit if the patient requires hands on assistance with the bathing process, not just supervision of the self-performance of the bath or prompting to bathe.</p> <p>Please note that foot care, washing back, hands or face alone does not meet the bathing description. Foot care and /or a shampoo alone does not indicate a deficit in the ADL of bathing, but can provide additional time in this category. (see time and task guidance for description and time)</p>
Field 22 ADL Dressing	<p>Dressing - place a check in the boxes indicating if the patient needs hands on assistance with dressing. To qualify for an ADL deficit, the patient needs to have hands on assistance. Indicate the areas where the client has needs with dressing, such as putting clothes on and off, putting stockings, socks and shoes on and off, assisting with buttons, fasteners, and zippers. Write in the blank(s) the days of the week assistance is needed with dressing activities. Assistance with therapeutic stockings, prosthetic devices is noted.</p>
Field 23 ADL Toileting	<p>Toileting -How the individual uses the toilet.</p> <p>Rating should consider assistance needed and frequency. Note: A simple transfer on and off the toilet/shower is included in the transfer score and not a part of the toileting/bathing score.</p> <p>Bladder – Indicate the patient's urinary status and method by placing a check in the applicable boxes. Note the frequency of assistance needed. Check the devices/supplies needed. If a patient needs assistance with toileting, such as hands on assistance on/off the toilet, assistance with undergarments or perineal care after going to the bathroom, a patient would have an ADL deficit in toileting.</p>
	<p>Bowel - Indicate the patient's bowel status and method by placing a check in the applicable boxes. Check the frequency of assistance needed. Check the devices/supplies needed. Write in the days of the week the patient needs an enema and/or assistance with a bowel program.</p>
Field 24 ADL Continence	<p>Continence status - Indicate patient's continence status by placing a check in the appropriate box describing incontinence - day/night urinary incontinence, uses diapers, disposable underwear, daily bowel</p>

	incontinence or bowel program. Note if the client is on a bowel/ toileting program
Field 25 Hygiene-care plan time and task indicators	Hygiene are activities such as brushing teeth, denture care and shaving- (Refer to Time and Task Guidance)This tasks category is usually associated with the bathing ADL, however patient needs in this area do not constitute an ADL deficit. For clarification and care planning purposes DMA has separated the tasks. The agency in care planning could indicate the needs and additional time, if needed for these activities. Some single and simple hygiene activities, such as comb hair or oral care, are often easily done within the bathing time allotted. However, more time intensive tasks, such as braiding and setting hair or shaving may need additional time in the care plan.
Field 26 Delegated medical monitoring , includes treatments	Document patient ability in the self administration of medications. Remember: Medical tasks and monitoring which are delegated to the in home aide by the RN are in accordance with NC Laws, practice acts ; standards of care and agency policy . The provider agency needs to have policy and procedure in place which identifies the in home aides role in assisting client with self administration of medications. Refer to the NC Board of Nursing Interpretative guide(s) for your agency policy (www.ncbon.org). Indicate delegated medical monitoring tasks. The RN should identify for the aide the parameters to report. Complete all applicable boxes. If vital sign monitoring, self monitoring and/or weights are identified as needed, the nurse should indicate the frequency of the task on the Plan of Care and the parameters for the aide to report to the agency. If the caregiver (s) will be responsible for these tasks they are not included in the POC. These tasks and time, for care planning time purposes may be calculated as an ADL time, since they are a medical care task. HOWEVER please remember they are not qualifying ADL activities. Please specify other medical treatments as approved NA 1 and or NA II tasks as per NC Board of Nursing regulations and adopted by reference
Field 27 IADL Meal Preparation	Home Management - Meal Preparation - Indicate whether 1 or 2 meals are prepared, the patient needs assistance with meal set up only – which includes serving, opening packages and or simple cut to bite size, not included in an ordered therapeutic diet. Related kitchen home management is noted in this section
Field 29 IADL Bathroom	Home Management – Bathroom. “Tidy “bathroom after bath – which usually consist of wipe off counter, sink, basin and rinse equipment. Clean bathroom indicates a scrub of toilet, shower/tub and sink. Note the difference between clean and tidy.
Field 29 IADL Bedroom and Living areas	Home management for bedroom and living areas. Check tasks to be done, and indicate frequency in line to indicate frequency and day to be done. Some tasks, such as make bed, tidy, sweep (wood floor) are commonly done daily. Other tasks such as mop, vacuum and dust are commonly done weekly.

Field 30 IADL General tasks	Home Management, General - and IADL tasks are laundry, specify day and frequency, change bed linens, and check smoke alarm. Note if any of tasks, such as laundry are done outside the home (ex Laundromat).
Field 31 IADL Errands	IADL- Errands/Misc. - Indicate essential errands for the recipient such as grocery shop pick up medicine and medical supplies, pay utility bills. Indicate the frequency of the errand. The assessor may identify additional miscellaneous tasks in home management, such as reading and writing tasks, and observing and reporting symptoms of abuse, neglect and illness to the RN.
PACT Page 3	
Patient First and Last Name	As it appears on the Medicaid card and page 1 of the PCS PACT Form
Medicaid ID	As it appears on the Medicaid care and page 1 of the PCS PACT Form
Assessment Date	Date this assessment is completed in the patient's home
	Other patient information, These sections document the physical observations which indicate patient general condition.
Field 32 Respiration	Respiration – place a check in the box by the patient's respiratory status – check all that apply. Place a check in the applicable box to indicate the patient's frequency of oxygen use and whether or not the patient utilizes a nebulizer. If the patient utilizes a nebulizer, write in the blank the days of the week assistance is needed through PCS.
Field 33 Endurance	Endurance – place a check in the applicable box indicating the patient's breathing status for how the patient appears most of the time. Then place a check in the box indicating whether or not the patient has generalized weakness. Note – if the patient is high risk for falls, see risk assessment under safety.
Field 34 Pain	Pain – This is a 7 day look back- indicate the location of the pain and severity of the pain using a scale of 0-10, with 0 being no pain and 10 being the worst pain. Indicate with a check pain frequency or pain control. Remember a PCS PLUS criteria indicates the client has consistent and substantial pain which interferes with daily activities, and indicates a need for additional time.
Field 35 Cognitive skills for Daily decision making	Cognitive Skills for Daily Decision Making – Check the box that describes the patient most of the time. If client is MR/DD note level or score. For example, mild; moderate; severe MR. These assessment indicators are reviewed considering the patient's chronological age. Remember – PCS PLUS criteria indicates the patient has significant cognitive deficits which interfere with daily activities and may indicate needs for additional time.

Field 36	Behavior – Check all that apply to best describe the patient most of the time
Field 37	Vision – Check the patient’s vision status and indicate if the patient uses glasses or contacts.
Field 38	Hearing - Check the patient’s hearing status and indicate if the patient uses a hearing aid.
Field 39	Speech - Check the patient’s speech status. Note the primary language the patient speaks.
Field 40	Communication Method - Check the patient’s method of communication and indicate if the patient is unable to write. If so, the client must make a mark on this form and it be followed by the nurse assessor’s initials. This is only required if the patient will be making a mark on the in-home aide service log. (If telephony or electronic time verification is used – refer to these criteria in the policy.)
Field 41	Write in the patient’s perception of what he or she needs, in their own words . This should reflect the patient’s perception that they need hands on assistance with ADL’s – and provides an excellent screening and teaching opportunity. If the client does not believe they need help with personal care and indicate a need and/or preference for home management only the RN would have to review eligibility and compliance with the plan of care. Remember: this would be an on going assessment done at supervisory visits and in reviewing the aide service logs.
Field 42	Indicate if the patient has an advanced directive and if so the location of the document.
Field 43	Indicate if there is a DNR order and check all that apply. Remember that Hospice recipients are not eligible for in-home PCS.
Field 44	Safety Assessment – Note if the home is adequate or suitable for the agency staff to carry out the plan of care according to the agency’s policies. Note if they have a water source, telephone, heating, cooling and electric capacity to support the medical devices to carry out the plan of care. Note if there is a smoke alarm, fire extinguisher and O2 safety precautions when O2 is in use in the home. Note DME supplier and contact information .Indicate the equipment used in the home and other DME which has been ordered. Patient choice is to be upheld as related to coordination of DME. Remember - if the home is not adequate or suitable to complete the plan of care, the primary physician and/or other applicable resources should be notified. Do not admit the patient to PCS services if there are safety issues. (you may refer to the APS/DSS for follow up)
Field 45	Indicate if there are any other sources as listed available to meet the patient’s needs at the times the services have been requested. These are family members, in and outside the home, friends, other programs/agencies- such as certified home health, mobile meals. If yes please explain their role and what is done. If no, please explain reason they are unable to assist. .

Nurse Assessor/Certification – legibly print name, the RN completing the assessment signs and dates the PACT. The nurse certification and signature indicates that you completed this assessment and it accurately reflects the patient’s condition and needs. The nurse is to document on the PCS PACT form the patient needs hands on assistance with personal care indicating whether or not the PCS services are needed. Record the time in and out of the home. The falsification statement indicates the nurses understanding of implications in falsification of any of the information in the PACT. Your printed name will be used to verify that you have completed the certification training.

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Patient First and Last Name	As it appears on the Medicaid card and page 1 of the PCS PACT Form
Medicaid ID	As it appears on the Medicaid card and page 1 of the PCS PACT Form
Assessment Date	Date this assessment is completed in the patient’s home
Field 46	<p>Additional Time Needed - Check all the boxes that support the need for additional time 32 – Respiration 33- Endurance 34- Pain 43- Cognitive skills for daily living 36- Behavior 37- Vision 38- Speech 39- Hearing 40- Communication method</p> <p>The assessment information supports the need to exceed the time and task guidance. In the box below the indicators concisely describe the client needs and condition, specific to plan of care when additional time is needed.</p>
Plan of Care	<p>Plan of Care – If the assessment indicates that the patient has medically-related personal care needs requiring hands on assistance with ADLs indicating a need PCS, develop the plan for providing the care beside the day(s) services are needed.</p> <p>Note the plan is divided into 2 sections- ADL activities and IADL activities which will help you tabulate your time and tasks, and insure ADL tasks and time exceed IADL tasks and time on a weekly basis. Write in the category # of the assigned task(s) that is designated on the</p>

	<p>assessment and by the category # indicate the amount of time to be allocated to that specific task. Home management categories also are lettered to assist in care planning. Follow the DMA time guidance for time allotments. The category numbers on the POC should match up with the field/categories on the assessment that indicated that the patient needed assistance. Remember the tasks and time allotted should be individualized and person centered based on identified needs.</p> <p>The time allotted is based on the time guidance and any documented exceptions, is summarized in field 46. The time allotted for personal care (ADL's) should exceed the IADLs (home management) on a weekly basis. For time calculation purposes delegated medical monitoring is included in ADLs activities. Please remember delegated medical monitoring is NOT an ADL or a qualifier for PCS services. DMA expects an economy of tasks when there are multiple recipients in the same home. DMA expects staff to multi-task – for example, the aide may be preparing a meal while he/she is washing the clothes. Remember many tasks are not required daily such as mopping, laundry etc.</p> <p>Home management tasks should not exceed or equal the time allotted for personal care on a weekly basis.</p> <p>Remember – for PCS services the patient can have no more than 3 ½ hours per day and no more than 60 hours per month.</p> <p>If PCS PLUS is requested and prior approved – the patient can have no more than 80 hours per month, no daily limit is specified.</p> <p>The time total should be indicated in the third column and no sliding hours are allowed (e.g. 2-3 hours /day)</p>
Field 47	Goals/Objectives: Complete all.
Field 48 Assessment order	<p>Assessment authorization may be received in a verbal order. Indicate if a verbal order was obtained to assess the patient for hands on assistance with ADL's and personal care and determine eligibility for PCS per the PCS policy and indicate the date. The order communicates to the primary physician who is the appointed gatekeeper of the service. The RN will be assessing the patient for hands on assistance needs with: mobility, eating bathing, dressing, toileting and continence. Check the ADL categories indicated by the physician or authorized representative the client may need hands on assistance with.</p> <p>Indicate who conveyed and received the order and date. . This means you would document who in the physician's office conveyed the verbal order and then the nurse's name in your agency who took the verbal order. The provider agency should develop policy and procedure for who can convey and receive verbal orders. Please refer to the NC Board of Nursing Interpretative guide for who may convey and receive an order (www.ncbon.org).</p> <p>If a written order was received, separately, for example on a physician's prescription pad, incorporate this written order into the clinical record. This is required for an initial assessment, not an annual re-assessment or</p>

	re-assessment for a change. If this PACT assessment is a re-assessment indicate n/a or continuing services in this field.
Field 49 Start or continue service order	Specify the date of the verbal order to start and /or continue PCS for hands on assistance needs with: mobility, eating, bathing, dressing, toileting and continence. Check which you received an order for and note the number of days a week. Document who conveyed the verbal order and who received the verbal order. This means you would document who in the physician's office, for example, conveyed the verbal order and then the nurse's name in your agency who took the verbal order. This follows NC BON interpretative guides.
Physician Certification	The patient's primary physician, PA or NP must sign and date prior to PCS services beginning unless a verbal order to begin services was obtained. Follow your agency policy and/or have the order signed within 60 days of obtaining the verbal order. If in a returned order, the physician failed to date his signature, the agency may stamp or note the date received in the agency. This is to note the date received only. Stamp or write in "Received" and then the date. The agency cannot predate or date the form for the physician. Indicate Carolina Access Number