Annual Reauthorization Due _________

PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

Referral Date:_________ Date Initial Assessment Completed:____________________ Date Last Reassessment Completed:_______________

Provider Name: ____________________________ PCS Provider #: _____________________ Provider Phone #: ____________________

Provider Address: ____

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME: ____
2. MEDICAID ID # (MID):____
3. PATIENT ADDRESS: ____
4. PATIENT PHONE:____________________________ 5. SEX: ☐Male ☐ Female 6. DATE OF BIRTH (mm/dd/yy):______________
7. PATIENT LIVES: *Check all that apply* ☐ Alone ☐w/Spouse ☐w/Adult Child(ren) ☐w/Parent(s) ☐w/others
8. CONTACT PERSON'S NAME:_________________________________ RELATIONSHIP TO PATIENT:_______________

   ADDRESS:____ PHONE: (H) ___________(W)_______________
9. PRIMARY PHYSICIAN'S NAME:________________________________ PA/NP FOR PCP (If applicable): __________________
10. ADDRESS: ____ PHONE: (___)______________
11. DATE OF MOST RECENT EXAM (mm/dd/yy): ________ 12. Vital Signs @ Assessment: B/P ______ T _____ P____ R ___ Wt ____ Ht___
13. REASON FOR REFERRAL: ____

    Referral Source: ____
14. DIAGNOSIS (Specify date of onset and ICD-9 code):____

____

____

____

15. CURRENT CARE (Type and Source): ____

____

ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (Name/Dose/Frequency/Route)

17. Self-Administered? ☐ Yes ☐ No If no, who assists/what needed? ____________________

18. Does the individual have any allergies?: ☐ No Known Allergies ☐ Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

Limitations in Activities of Daily Living (ADLs)

Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below. Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task. M=Mon T=Tues W=Wed Th=Thurs F=Fri S=Sat Sun=Sunday

A. ADL Self-Performance Scores

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** *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.

B. ADL Support Provided Scores

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

			A. ADL Self-Performance	B. ADL Support Provided	Place a check in the box if agency assistance is needed (unmet needs)
19. ADL Mobility	Ambulation:	Note assistive equipment patient is to use while ambulating: ☐ Cane ☐ Quad cane ☐ Walker ☐ other ______________________			
	Non-ambulatory/ Transfer	Moving to and between surfaces (circle): bed, chair, wheelchair, toilet, tub, shower, and standing. ☐ Bed/chair bound Assistive equipment needed during transfer: ☐ Hoyer lift ☐ Transfer board ☐ Trapeze bar ☐ Hospital bed ☐ other ____________________ Note self sufficiency once transferred ______________ ☐ Pressure relief device ☐ Turn & position Wheelchair: ☐ Manual ☐ Electric			
20. *ADL Eating*		☐ Oral ☐ Parenteral ☐ Tube________ ☐ Feed patient Dietary Restrictions______________________________________ Supplements_________________________ Diet Ordered__________________________________ ☐ Chop ☐ Grind ☐ Puree ☐ Thicken			
21. *ADL Bathing*		☐ Full body bath__________ ☐ Partial bath________ ☐ Shower___________ ☐ Sponge bath_________ ☐ Shampoo hair_____________ ☐ Foot care______________ ☐ Special skin care_______________ *Devices used:* ☐ Shower bench/chair ☐ Bath safety bars ☐ Detachable shower head			
22. *ADL Dressing*		☐ Retrieve clothes ☐ Put clothes on and take clothes off ☐ Don/remove therapeutic stockings ☐ Don/remove prosthesis ☐ Assists with buttons, fasteners, & zippers ☐ Put stockings/socks & shoes on/off			
23. ADL Toileting	Toileting *Bladder*	Rate assistance and frequency needed : ☐ Normal ☐ Ostomy ☐ Indwelling catheter ☐ Condom catheter ☐ I/O cath ☐ Occasional incontinence (less than daily) ☐ Clean perineum ☐ Changing______________ *Devices/supplies used:* ☐ Bedside commode ☐ Elevated toilet seat ☐ Bedpan ☐ Urinal ☐ Pads ☐ Cath care_________ ☐ Ostomy Care ______________			
	Toileting *Bowel*	Rate assistance and frequency needed : ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Ostomy ☐ Ostomy Care ___________ *Devices/supplies used:* ☐ Bedside commode ☐ Elevated toilet seat ☐ Bedpan ☐ Pads ☐ Constipation ☐ Use of laxatives ☐Enemas ☐ Clean perineum___________ ☐ Changing_________			
24. *ADL Continence*		☐ Daily urinary incontinence ☐ Day/night urinary incontinence ☐ Diapers ☐ Disposable underwear ☐ Daily bowel incontinence ☐ Bowel/Toileting program __________			
25. **Personal hygiene**		☐ Comb hair ☐ Brush teeth ☐ Clean dentures ☐ Wash/dry face and hands ☐ Braid or set hair_____________ ☐ Shave_________________ ☐ Oral care _________________			
26. **Delegated medical monitoring and treatments**		☐ Assistance with self-administration of: ☐ a. Pre-poured medications ☐ Reminders needed ☐ b. BP: _____ Notify agency RN if BP is > ______ or < _____ c. Blood Sugars: ______ Notify agency if BS is > _____ or <_____ ☐ d. ROM ______ ☐ e. Other monitoring/treatment (specify) ____ ☐ Delegated medication task(s) ____			
27. IADL	Meal Preparation	Meal prep: ☐ a. 1 meal _____________ ☐ b. 2 meals ___________ ☐ c. Set-up only ☐ d. Take out trash _______ ☐ e. Wash dishes & tidy after meal ☐ f. Clean kitchen ________ ☐ g. Other ______________			

IADL Home Mgt.	28. Bathroom	29. Bedroom/Living areas	30. General	31. Errands/Misc
	☐ a. Tidy after Bath ☐ b. Clean Bathroom ___________	☐ a. Make bed __________ ☐ b. Sweep _______ ☐ c. Dust ___________ ☐ d. Keep free of clutter ___________ ☐ e. Tidy __________	☐ a. Laundry ______ ☐ b. Change bed linens ______ ☐ c. Mop ______ ☐ d. Vacuum _________ ☐ e. Check smoke alarm ______	☐ a. Grocery shop ___________ ☐ b. Pick up medicine/medical supplies _______________ ☐ c. Pay utility bill ___________ ☐ d. Reading/Writing/Reporting __________

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

Other Client Information

Check the appropriate box that applies to the patient.

32.	**Respiration**	☐ Normal ☐ Dyspneic with minimal exertion ☐ Tracheostomy ☐ Mechanical Oxygen: ☐ Continuous __________(O_2 rate) ☐ Intermittent ☐ Nebulizer Treatments ______________________ ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance **and** requires continuous use of oxygen
33.	**Endurance**	☐ Pt. is never short of breath (SOB) ☐ Pt. is SOB when walking > 20 feet or climbing stairs ☐ Patient is SOB when walking < 20 feet and/or dressing self or using commode ☐ Pt is SOB w/minimal exertion (i.e. eating, talking, performing ADLs, agitation) ☐ Pt is SOB at rest ☐ Pt has generalized weakness ☐ Pt has hx/high risk for falls
34.	**Pain:** *7-day look-back*	Location of pain________________________________ Severity of Pain: *Rate 0 – 10: O=no pain and 10=worst pain* ______ Pain frequency: ☐ No pain ☐ Pain < daily ☐ Pain daily ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement Pain control: ☐ No pain ☐ Pain improved w/medication ☐ No pain relief or improvement w/medication ☐ Other pain mgmt. _______
35.	**Cognitive Skills for Daily Decision Mkg:**	☐ Independent (decisions consistent/reasonable) ☐ Modified independence (some difficulty in new situations only) ☐ Moderately impaired (decisions poor, cues/supervision required) ☐ Severely impaired (never/rarely makes decision) ☐ Patient requires step-by-step verbal prompting ☐ MR/DD _________________ (level) ☐ Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
36.	**Behavior:**	☐ Cooperative ☐ Passive ☐ Physically abusive ☐ Verbally abusive ☐ Wanders ☐ Injures self/others/property ☐ Non-responsive
37.	**Vision:**	☐ Adequate for daily activities ☐ Limited (sees large objects) ☐ Very limited (blind) *Client uses:* ☐ Glasses ☐ Contacts
38.	**Hearing:**	☐ Adequate for daily activities ☐ Hears loud sounds/voices ☐ Very limited (deaf) *Client uses:* ☐ Hearing aids
39.	**Speech:**	☐ Normal ☐ Slurred ☐ Weak ☐ Other impediment: specify_______________ Primary language(s) spoken_________________
40.	**Communication Method:**	☐ Speech ☐ Gestures ☐ Writing ☐ Assistive Device: specify type ____ ☐ Client unable to write; have client make mark here: ____________________________ Nurse's initials: ____________________

41. Patient's perception of what he/she thinks their needs are: **(in patients own words)**

42. Has the patient executed an advance directive (living will or durable power of attorney)? ☐ No ☐ Yes If yes, specify location of original doc.: _______________

43. Is there a DNR order? ☐ Yes ☐ No If yes, was DNR order discussed with pt.? ☐ Yes ☐ No
Has a copy of the DNR been obtained? ☐ Yes ☐ No If no, has the MD been contacted to obtain copy? ☐ Yes ☐ No

44. SAFETY ASSESSMENT: Is the patient's home adequate or suitable to carry out the Plan of Care according to your agency's policies? ☐ Yes ☐ No
Water? ☐ Yes ☐ No Telephone? ☐ Yes ☐ No Heating? ☐ Yes ☐ No Cooling? ☐ Yes ☐ No Electric capability sufficient? ☐ Yes ☐ No
Smoke alarm? ☐ Yes ☐ No Fire extinguisher? ☐ Yes ☐ No If O_2 is in use, have safety precautions been included on Plan of Care? ☐ Yes ☐ No ☐ N/A
Safety devices in bathroom? ☐ Yes ☐ No Patient emergency #s in clear view? ☐ Yes ☐ No
Has patient been instructed on the use of DME? ☐ Yes ☐ No List the DME company used : ________________________________
Specify what DME is already used in the home:____
Specify what DME has been ordered: ____

45. Are there sources (family, friends, programs, or other agencies) available to meet the ADL and IADL needs?
☐ Yes, please explain:
☐ No, please explain reason(s) for inability to assist:

NURSE ASSESSOR CERTIFICATION

I certify that I, and no one else, have completed the above in-home assessment of the patient's condition. I understand falsification as: "an individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the NC Board of Nursing for investigation."

☐ Based on the assessment, I have determined that the patient needs hands on assistance with Personal Care due to the patient's medical condition. I have developed the plan of care to meet those needs.

☐ I have determined that the patient does not meet the criteria for personal care services.

____ ___________________/________

PRINT RN NAME RN SIGNATURE Date Signed: Time in /out of home

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

PLAN OF CARE

If the assessment indicates that the patient has medically-related personal care needs requiring PCS, show the plan for providing care beside the day(s) services are needed. Write in the category # of the assigned task(s) that is designated on the assessment. The key below lists the category numbers. Write in the time (in 15 minute increments or in hours) required for each day. **Do not include tasks that are performed by the family or others; include only the tasks that the PCS provider performs (unmet needs).**

46. ☐ Additional time needed; check numbered block for the category (from page 3) extra time is needed and document information specific to client needs in the space below for exceptions to time and task guidance. ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38 ☐39 ☐40

ADL #	ADL Name	Monitoring		IADL #	IADL Name
19	Mobility	25	Personal Hygiene	27	Meal preparation
20	Eating			28	Home Mgt. Bathroom
21	Bathing			29	Home Mgt. Bedroom/Living areas
22	Dressing	26	Delegated Medical Monitoring		
23	Toileting			30	Home Mgt. General
24	Continence			31	Home Mgt. Errands

Day of the Week	Task(s) To Be Accomplished Specify the category # and the amount of time required for each task (i.e. # 19: 15 minutes)		Total Time per Day *(in 15 min increments or in hours)*
	ADL	IADL	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

47. **Goals/Objectives:** The need for PCS is expected to ☐change OR ☐end on _____/______/_____. If no change is expected, state why:

____

48. Order obtained to **assess the patient** for hands on assistance needs with:
___mobility ___eating ___bathing ___dressing ___toileting ___ continence.
Who conveyed/obtained this verbal order? ___________________________/___________________________ Order date: ___/___/___

49. Order was obtained to **start/continue PCS**: _____ days a week for hands on assistance needs with:
___mobility ___eating ___bathing ___dressing ___toileting ___ continence.
Who conveyed/obtained this verbal order? _________________________________/_________________________________ Order date: ___/___/___

PHYSICIAN CERTIFICATION

☐ I certify that I am the patient's primary physician and the patient is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the Personal Care Services in the above plan of care. I understand falsification as: "an individual who certifies a false statement in this plan may be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Medicine."

☐ I have determined that the patient does **NOT** meet the criteria for Personal Care Services.

ATTENDING PHYSICIAN'S SIGNATURE ____ DATE__________________________

Carolina Access #: ______________