DMA-3051 REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS) ATTESTATION OF MEDICAL NEED

Change of Status: Medical New Request		MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRA		ETE PAGES 10					
Form Submission: Fax Carolina Complete Health at 1-83-706-0238 Expedited Assessment Process Info: Contact Carolina Complete Health at 1-833-552-3870 Questions: Lal Carolina Complete Health at 1-833-708 Settion A. ERNEFICIARY DEMOGRAPHICS Beneficiary's Name: First: MI: Mit: Last: DOB; / / Gender: Male Address: City: Council City: Council City: Council City: Address: Phone: [_] Altamate Contact (Select One): Parent Legal Guardian (required if beneficiary < 18) Other Name: Phone: [_] Name: Phone: [_] Active Adult Protective Services Case? Yes Vame: Dispetialized/medical facility Section B, BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS Identify the current work and diagnoses related to the beneficiary section of assistance with qualifying Activities of Daily Luing (bething, dispeties of Daily Luing	ep 1	REQUEST TYPE: (select one)	DATE OF REQUEST:						
Expedited Assessment Process Infe: Contact Caroling Complete Health at 1-833-552-3876 22 Section A. BENEFICIARY DEMOGRAPHICS 9 Section A. BENEFICIARY DEMOGRAPHICS 9 9		Change of Status: Medical New Request	I						
Beneficiary's Name: First: M: Last: DOB: / Medicald ID#: RSID#AcH Only): RSID Total / Gender: Mail Female Language: English Spanish Other Address:		Expedited Assessment Process Info: Contact Carolina Complete H							
Medical ID#: RSID#(ACH Only): RSID Date: / Gender: Male Female Language: English Spanish Other Address:	ep 2								
Gender: Male Female Language: English Spanish Other	\neg								
Address: Zip: Phone: (
Alternate Contact (Select One): Parent Legal Guardian (required if beneficiary < 18)		Gender: Alle Female Language: Englis	h 🗌 Spanish 🔲 Ot	her					
Alternate Contact (Select One): Parent Legal Guardian (required if beneficiary < 18)		Address:	City:						
Relationship to Beneficiary (NON-PCS Provider):		County:Zip:	Phone: ()						
Name:		Alternate Contact (Select One):	ardian (required if benefi	ciary<18) □	Other				
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) OtherO/C Date (Hospital/SNF):/ // 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 bath the diagnosis and the COMPLETE ICD-10 Code. Identify the current medical Diagnosis ICD-10 Impacts Date of Onset Code Medical Diagnosis ICD-10 Impacts No Impacts 1		Relationship to Beneficiary (NON-PCS Provider):							
Beneficiary currently resides: At home Adult Care Home Hospitalized/medical facility Skilled Nursing Facility Group Home Special Care Unit (SCU) OtherD/C Date (Hospital/SNF):/ /		Name: Pho	ne: <u>()</u>						
Group Home Special Care Unit (SCU) OtherD/C Date (Hospital/SNF):/ 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 Impacts Date of Onset (mm/yyyy) 1.		Active Adult Protective Services Case? Yes No							
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 <u>both</u> the diagnosis and the COMPLETE ICD-10 Code. Medical Diagnosis ICD-10 IDD Impacts Date of Onset (mm/yyyy) I. ICD-10 Impacts Date of Onset (mm/yyyy) I. Interview of Yes 3. Impacts Pate of Onset (mm/yyyy) 4. Impacts Interview of Yes 5. Impact Yes 6. Impact Yes 7. Impact Yes 8. Impact Yes 9. Impact Yes 9.		Beneficiary currently resides: 🗌 At home 🗌 Adult Care Home 🗌] Hospitalized/medical fa	cility 🗌 Skilled	Nursing Facility				
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 <u>both</u> the diagnosis and the COMPLETE ICD-10 Code. Medical Diagnosis ICD-10 Impacts Date of Onset 1.	Ν	Group Home Special Care Unit (SCU) Other	D/C Date (Hospital/SNF):	/ /				
(bathing, dressing, mobility, tolieting, and eating). List <u>both</u> the diagnosis and the COMPLETE ICD-10 Code. Medical Diagnosis ICD-10 Code Impacts ADLs Date of Onset (mm/yyyy) 1.	p 3								
Medical Diagnosis Code AbLs (mm/yyyy) 1.			sis and the COMPLETE I	CD-10 Code.					
1. Yes 2. Yes 3. Yes 4. Yes 5. Yes 6. Yes 7. Yes 8. Yes 9. Yes 10. Yes In your clinical judgment, ADL limitations are: Short Term (3 Months) In your clinical judgment, ADL limitations are: Short Term (3 Months) Is Beneficiary Medically Stable? Yes No No		Medical Diagnosis	-						
3. Yes 4. Yes 5. Yes No Yes No No 6. Yes No No 7. Yes No No 8. Yes 9. Yes 10. Yes 10. Yes No No 10. Yes No Age Appropriate Expected to resolve or improve (with or without treatment) Chronic and stable Is Beneficiary Medically Stable? Yes		1.			(1111// 9999)				
3.		2.							
4.									
4.		3.							
Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable Image: second stable		4.							
Image: Second stable in the second stable is Beneficiary Medically Stable? Image: Second stable is the second									
6. Yes 7. Yes 8. Yes 9. Yes 10. Yes 10. Yes In your clinical judgment, ADL limitations are: Short Term (3 Months) Intermediate (6 Months) Age Appropriate Is Beneficiary Medically Stable? Yes No		5.							
7. Image: Second stable 8. Image: Second stable 9. Image: Second stable 10. Image: Second stable Image: Second stable Image: Second stable									
8. Yes 9. Yes 10. Yes No Yes No Yes No Yes 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		0.							
8. Yes 9. Yes 10. 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		7.		□ Yes					
9. Yes 10. Yes In your clinical judgment, ADL limitations are: Short Term (3 Months) In termediate (6 Months) Age Appropriate Expected to resolve or improve (with or without treatment) Chronic and stable Is Beneficiary Medically Stable? Yes				□ No					
9. Image: Second stable 10. Image: Second stable In your clinical judgment, ADL limitations are: Short Term (3 Months) In the second stable Intermediate (6 Months) Is Beneficiary Medically Stable? Yes No No		8.							
10. Image: State of the		9							
10. Image: Second stable In your clinical judgment, ADL limitations are: Short Term (3 Months) In termediate (6 Months) Age Appropriate Expected to resolve or improve (with or without treatment) Chronic and stable Is Beneficiary Medically Stable? 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		10.							
Expected to resolve or improve (with or without treatment) Chronic and stable Is Beneficiary Medically Stable? Yes No	·	In your clinical judgment, ADL limitations are: Short Term (3 Months) Intermediate (6 Months) Age Appropriate							
Is Beneficiary Medically Stable? Yes No			,						
		Expected to resolve or improve (with or without treatment)	Chronic and stable						
			Chronic and stable						

Step 4	OPTIONAL ATTESTATION: <i>Practitioner should review the following and initial <u>only</u> if applicable:</i>					
	Beneficiary requires an increased level of supervision.					
	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.					
	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.					
N	Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.					
Step 5	SECTION C. PRACTITIONER INFORMATION					
$\square \checkmark$	Attesting Practitioner's Name:Practition	er NPI#:				
	Select one: Beneficiary's Primary Care Practitioner Outpatient Specialty Practice Name:	actitioner Inpatient Practition NPI#:				
	Practice Contact Name:	Practice Stamp				
	Address:					
	Phone: Fax:					
	Date of last visit to Practitioner: / /**Note: Must be < 90 days from Received Date					
	Practitioner Signature AND Credentials:	Date:	/			
N	*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.					
Step 0	Describe the specific medical change in condition and its impact on the beneficiary's r		quired):			

---- PRACTITIONER FORM ENDS HERE ---

Beneficiary Name: _____

Step 1 REQUEST TYPE: (select one) DATE OF REQUEST:	ONLY							
	REQUEST TYPE: (select one) DATE OF REQUEST:							
Change of Status: Non-Medical Change of Provider								
Form Submission: Fax Carolina Complete Health at 1-833-706-0238 Questions: Call Carolina Complete Health at 1-833-552-3876								
Step 2 BENEFICIARY DEMOGRAPHICS	BENEFICIARY DEMOGRAPHICS							
Beneficiary's Name: First:MI: Last: DOB: /	/							
Medicaid ID#: Gender: 🛛 Male 🗍 Female Language: 🗍 English 🗍 S	Medicaid ID#: Gender: 🛛 Male 🗍 Female Language: 🗍 English 🗍 Spanish							
Address: City: Other	Address: City: Other							
County: Zip: Phone: ()								
Alternate Contact (Select One):								
Relationship to Beneficiary (NON-PCS Provider):								
Name: Phone: ()								
]							
Beneficiary currently resides:	Facility							
□ Group Home □ Special Care Unit (SCU) □ Other D/C Date (Hospital/SNF): /								
Step 3 SECTION E: CHANGE OF STATUS: NON-MEDICAL Requested by PCS Beneficiary Legal Power of Responsible Family (R								
(Select One): Provider Guardian Attorney (POA) Party								
Requestor Name:								
PCS Provider NPI#: PCS Provider Locator Code#:								
Facility License # (if applicable): Date: / /								
Contact's Name: Contact's Position:								
Provider Phone: Provider Phone:								
Reason for Change in Condition Requiring Reassessment								
(Select One): Change in Days of Need Change in Caregiver Status Change in Beneficiary loca	ation affects							
Other: ability to perform ADLs								
Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (Required):								
Step 4 <u>SECTION F:</u> CHANGE OF PCS PROVIDER								
Requested by (Select One): Care Facility Beneficiary Other (Relationship):								
Requestor's Contact Name: Phone: Phone:	Requestor's Contact Name: Phone: (
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):								
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned.								
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned. Date: / Date: / Continue receiving services until established with the services until established witheservices until established witheservices until	ith a new provider.							
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned. Date: / Date: / Step 5 BENEFICIARY'S PREFERRED PROVIDER (Select One):								
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned. Date: / Date: / Step 5 BENEFICIARY'S PREFERRED PROVIDER (Select One): Home Care Family Care	vith a new provider.							
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned. Date: / Date: / BENEFICIARY'S PREFERRED PROVIDER (Select One): Home Care Family Care Home Home Home Facility	Special Care							
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned. Date: / Date: / BENEFICIARY'S PREFERRED PROVIDER (Select One): Home Care Family Care Home Adult Care Agency Home Agency Name: Phone: (☐ Special Care Unit							
Status of PCS Services (Select One): Discharged/Transferred Scheduled Discharge/Transfer No Discharge/Transfer Planned. Date: / Date: / BENEFICIARY'S PREFERRED PROVIDER (Select One): Home Care Family Care Home Adult Care Agency Home Agency Name: Phone: (☐ Special Care Unit							