

**North Carolina Department of Health and Human Services - Division of Medical Assistance  
REQUEST FOR INDEPENDANT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)  
ATTESTATION OF MEDICAL NEED**

**PCS is a Medicaid benefit based on an unmet need for assistance with Activities of Daily Living (ADLs), which means bathing, dressing, toileting, eating, and mobility in the setting of care.**

Completed form should be faxed to Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).  
**For the Expedited Assessment Process contact Liberty Healthcare Corporation at 1-855-740-1400.**  
 For questions, call 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@libertyhealth.com.

**Step 1** Please select one:  New Request  Change of Status: Medical  Change of Status: Non- Medical  Change of PCS Provider Date of Request: \_\_\_/\_\_\_/\_\_\_

**Step 2** **SECTION A. BENEFICIARY DEMOGRAPHICS**

**Beneficiary's Name:** First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

**Medicaid ID#:** \_\_\_\_\_ **PASRR#(For ACHs Only):** \_\_\_\_\_ **PASRR Date:** \_\_\_/\_\_\_/\_\_\_

Gender:  M  F Language:  English  Spanish  Other \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_ Phone: \_\_\_\_\_

Active Adult Protective Services Case?  Yes  No

**Beneficiary currently resides:**  At home  Adult Care Home  Hospitalized/medical facility  Skilled Nursing Facility  
 Group Home  Other \_\_\_\_\_ D/C date (Hospital/SNF) : \_\_\_/\_\_\_/\_\_\_

**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-9 code for each.

Medical Diagnosis	ICD-9 Code (4 or 5 digits required)	Impacts ADLs	Date of Onset (mm/yyyy)
	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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

**OPTIONAL ATTESTATION: Practitioner should review the following and initial only 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: \_\_\_\_\_

Step 4

**SECTION C. PRACTITIONER INFORMATION**

**Attesting Practitioner's Name:** \_\_\_\_\_ **Practitioner NPI#:** \_\_\_\_\_

**Select one:**  Beneficiary's Primary Care Practitioner  Outpatient Specialty Practitioner  Inpatient Practitioner

**Practice Name:** \_\_\_\_\_

Practice Stamp:

Practice NPI#: \_\_\_\_\_

Practice Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**Date of last visit to Practitioner :** \_\_\_\_/\_\_\_\_/\_\_\_\_ **\*\*Note:** Must be < 90 days from request date

**Practitioner Signature AND Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*"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."*

Sign Here

Medical COS Only

**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):

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Beneficiary Name: \_\_\_\_\_

MID#: \_\_\_\_\_

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

**Beneficiary's Name: First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medicaid ID#:** \_\_\_\_\_ Gender:  M  F Language:  English  Spanish  Other

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Alternate Contact/Parent/Guardian (required if beneficiary < 18): First: \_\_\_\_\_ Last: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_ Phone: \_\_\_\_\_

**Beneficiary currently resides:**  At home  Adult Care Home  Hospitalized/medical facility  Skilled Nursing Facility  Group Home  Other \_\_\_\_\_ D/C date (Hospital/SNF) : \_\_\_\_/\_\_\_\_/\_\_\_\_

Non-Medical COS

**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#: \_\_\_\_\_ 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: \_\_\_\_\_

**Reason for Change in Condition Requiring Reassessment:**

Change in beneficiary's location affecting ability to perform ADLs  Change in caregiver status

Change in days of need  Other: \_\_\_\_\_

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

Change of Provider

**SECTION F. CHANGE OF PCS PROVIDER**

**Requested By** (select one):  Care Facility  Beneficiary  Other (Relationship to Beneficiary): \_\_\_\_\_

**Requestor Contact's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Reason for Provider Change** (select one):

Beneficiary 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 beneficiary is established with a new provider agency; no discharge/transfer is planned

**Beneficiary's Preferred Provider (select one):**

<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
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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: \_\_\_\_\_