The Carolinas Center for Medical Excellence

Medicaid Personal Care Services: Regional Training and Provider Forum April 2013

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Module I Learning Objectives

The module is designed to provide an overview an updates on:

- **Current Clinical Coverage Policy 3L, Personal Care Services (PCS) forms and**
- **Technical Denials**
- **Plan of Care Development and Aide Documentation**

Types of Processing Requests

- New Referral
- Change of Status (COS)
- Change of Provider (COP)

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Required Forms to Submit Requests

New Referrals*
- Licensed Residential Facilities (DMA 3068)
- Home Care Agencies (DMA 3041)

Change of Status (COS)*
- Licensed Residential Facilities (DMA 3069)
- Home Care Agencies (DMA 3042)

Change of Provider (COP)
- Licensed Residential Facilities (DMA 3070)
- Home Care Agencies (DMA 3043)

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Types of Processing Requests

New Referral

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Required Forms to Submit Requests

New Referrals
(Revised 3/8/2013)

- Licensed Residential Facilities (DMA 3068)
- Home Care Agencies (DMA 3041)

Who Can Submit a New Referrals?

- Primary Care Physician (PCP)
- Attending Physicians
- Nurse Practitioners
- Physician Assistants

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New Referrals
Revised 3/8/2013)

Licensed Residential Facility (DMA 3068)

N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
LICENSED RESIDENTIAL FACILITY: NEW REFERRAL
Completed form serves as authorization to conduct eligibility assessment to receive PCS in licensed care home.

Complete this form and send to The Carolinas Center Medical Excellence (CCME) via fax at 877-272-1942 or mail: *CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.* For questions, contact CCME at 800-228-3365. E-mail questions to PCSAssessment@thecarolinascenter.org.

Referral Date: _____(mm/dd/yyyy) Referral Entity: ☐ PCP ☐ Attending MD ☐ PA ☐ Nurse Practitioner

Section A. Patient Demographics
Medicaid ID#: _____
Patient 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: _____ State: _____ Zip: _____ Phone: (_____) _____-_____
Alternate Contact/Parent/Guardian (required if patient under 18): First: _____ Last: _____
Relationship to Patient: _____ Phone: (_____) _____-_____
Facility Name (Current Residence): _____ Provider Number: _____

Section B. Patient Medical History- 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)

Conditions listed are (check all that apply): ☐ Chronic Medical ☐ Physical Disability ☐ Mental Illness ☐ MR/Developmental ☐ Dementia
Medically Stable: ☐ Yes ☐ No Check if Active Adult Protective Services: ☐ Yes ☐ No
Date Of Last Visit With Referring Practitioner: _____ (mm/dd/yyyy)
Patient Currently Hospitalized Or In Medical Facility: ☐ Yes ☐ No If yes, Planned Discharge Date: _____ (mm/dd/yyyy)
Other Federal/State Programs Recipient Is Currently Receiving: ☐ CAP ☐ Medicare HH ☐ PDN ☐ Hospice
In the absence of caregivers, is resident at risk of any of the following? (check all that apply):
☐ Falls ☐ Malnutrition ☐ Skin Breakdown ☐ Adverse Consequences of Medication Non-Compliance
Is 24-hour caregiver availability required to ensure resident 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?)

Section C. Attesting Practitioner Information
Practitioner Last Name: _____ First Name: _____ NPI#: _____
Date of Patient's Last Visit with Attesting Practitioner: _____ (mm/dd/yyyy)
Practice Name (if applicable): _____
Office Contact Last Name: _____ First: _____ Position: _____
Phone: (_____) _____-_____ Fax: (_____) _____-_____ E-mail: _____
Practitioner Signature: _____ Date: _____ (mm/dd/yyyy)
Dated signature is verification that information in Section B is accurate for this patient and authorization to conduct PCS eligibility assessment.

DMA-3068
Revised 3/8/13

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New Referrals
(Revised 3/8/2013)

Licensed Residential Facility (DMA 3068)

N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
LICENSED RESIDENTIAL FACILITY: NEW REFERRAL
Completed form serves as authorization to conduct eligibility assessment to receive PCS in licensed care home.

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Referral Date: _____(mm/dd/yyyy) Referral Entity: ___PCP ___Attending MD ___PA ___Nurse Practitioner

Section A. Patient Demographics
Medicaid ID#: _____
Patient 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: _____ State: _____ Zip: _____ Phone: (_____) _____-_____
Alternate Contact/Parent/Guardian (required if patient under 18): First: _____ Last: _____
Relationship to Patient: _____ Phone: (_____) _____-_____
Facility Name (Current Residence) _____ Provider Number: _____

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New Referrals
(Revised 3/8/2013)

Licensed Residential Facility (DMA 3068)

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

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

Conditions listed are (check all that apply): ____ Chronic Medical ____Physical Disability____ Mental Illness ____ MR/Developmental Dementia

Medically Stable: ___Yes ___No **Check if Active Adult Protective Services:** ___Yes ___No

Date Of Last Visit With Referring Practitioner:_____(mm/dd/yyyy)

Patient Currently Hospitalized Or In Medical Facility: ____Yes ___No **If yes, Planned Discharge Date:** _____(mm/dd/yyyy)

Other Federal/State Programs Recipient Is Currently Receiving: ____CAP ___Medicare HH ___PDN ___Hospice

In the absence of caregivers, is resident at risk of any of the following? (check all that apply):

_____Falls _____Malnutrition _____Skin Breakdown ____Adverse Consequences of Medication Non-Compliance

Is 24-hour caregiver availability required to ensure resident safety? ___Yes ___No

(e.g., Does resident have unscheduled ADL needs or require safety supervision or structured living, or is resident unsafe if alone for extended periods?)

All **New Referrals** will require the referring entity to provide both the Medical Diagnosis and the ICD-9 Code.

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New Referrals
(Revised 3/8/2013)

Licensed Residential Facility (DMA 3068)

Section C. Attesting Practitioner Information

Practitioner Last Name: _____ **First Name:** _____ **NPI#:** _____

Date of Resident's Last Visit with Attesting Practitioner: _____ (mm/dd/yyyy)

Practice Name: _____
(if applicable)

Office Contact Last Name: _____ **First:** _____ **Position:** _____

Phone: (_____) _____-_____ **Fax:** (_____) ____-_____ **E-mail:** _____

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

Dated signature is verification that information in Section B is accurate for this patient and authorization to conduct PCS eligibility assessment.

DMA-3068
Revised 3/8/2013

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New Referrals
(Revised 3/8/2013)

Home Care Agency (DMA 3041)

N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
Home Care Agency: NEW REFERRAL

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail:
CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Referral Entity: ___PCP ___ Attending MD ___PA ___Nurse Practitioner **Referral Date:** _____ (mm/dd/yyyy)

Section A. Patient Demographics
Medicaid ID#: _____
Patient 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: _____ **State:** _____ **Zip:** _____ **Phone:** (____) _____
Alternate Contact/Parent/Guardian (required if patient is under 18): **First:** _____ **Last:** _____
Relationship to Patient: _____ **Phone:** (____) _____

Section B. Patient's Medical History – List *both* the current **medical diagnoses** and **ICD-9 codes** that currently limit the 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)

Medically Stable: ___Yes ___No **Check if Active Adult Protective Services** ___
Date Of Last Visit With Referring Practitioner: _____ (mm/dd/yyyy)
Patient Currently Hospitalized Or In Medical Facility: ___Yes ___No If yes, Planned Discharge Date: _____ (mm/dd/yyyy)
Other Federal/State Programs Patient Is Currently Receiving: ___CAP ___Medicare HH ___PDN ___Hospice

Section C. Referring Practitioner
NPI#: _____ **Practitioner First Name:** _____ **Last Name:** _____
Facility Contact Name: _____ **Contact Position:** _____
Phone: (____)_____ **Fax:** (____)_____ **Email:** _____

Section D. Primary Demographics
Same As Referring Practitioner ___ **Yes** ___ **No If yes, go to Section E.**
NPI#: _____ **Practitioner First Name:** _____ **Last:** _____
Facility Contact Name: _____ **Contact Person:** _____
Phone: (____)_____ **Fax:** (____)_____ **Email:** _____

Section E. Authorization For PERSONAL CARE SERVICES (PCS) Assessment
Referring Practitioner Signature: _____ **Date:** _____(mm/dd/yyyy)
If hospital or medical facility discharge, signed order from referring practitioner available in medical records? ___**Yes** ___**No**
Signature of facility representative: _____ **Date:** _____(mm/dd/yyyy)

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Rev 3/8/13

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New Referrals
(Revised 3/8/2013)

Home Care Agency (DMA 3041)

N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
Home Care Agency: NEW REFERRAL

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail:
CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Referral Entity: ___PCP ___ Attending MD ___PA ___Nurse Practitioner **Referral Date:** _____ (mm/dd/yyyy)

Section A. Patient Demographics
Medicaid ID#: _____
Patient 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: _____ **State:** _____ **Zip:** _____ **Phone:** (____) _____
Alternate Contact/Parent/Guardian (required if patient is under 18): **First:** _____ **Last:** _____
Relationship to Patient: _____ **Phone:** (____) _____

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New Referrals
(Revised 3/8/2013)

Home Care Agency (DMA 3041)

Section B. Patient's Medical History – List *both* the current **medical diagnoses** and **ICD-9 codes** that currently limit the 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)

Medically Stable: ☐ Yes ☐ No **Check if Active Adult Protective Services** ☐

Date Of Last Visit With Referring Practitioner: _____ (mm/dd/yyyy)

Patient Currently Hospitalized Or In Medical Facility: ☐ Yes ☐ No If yes, Planned Discharge Date: _____ (mm/dd/yyyy)

Other Federal/State Programs Patient Is Currently Receiving: ☐ CAP ☐ Medicare HH ☐ PDN ☐ Hospice

All **New Referrals** will require the referring entity to provide both the Medical Diagnosis and the ICD-9 Code.

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New Referrals
(Revised 3/8/2013)

Home Care Agency (DMA 3041)

Section C. Referring Practitioner

NPI#: _____ **Practitioner First Name:** _____ **Last Name:** _____

Facility Contact Name: _____ **Contact Position:** _____

Phone: (____) _____ **Fax:** (____) _____ **Email:** _____

Section D. Primary Demographics

Same As Referring Practitioner ___ **Yes** ___ **No If yes, go to Section E.**

NPI#: _____ **Practitioner First Name:** _____ **Last:** _____

Facility Contact Name: _____ **Contact Person:** _____

Phone: (____) _____ **Fax:** (____) _____ **Email:** _____

Section E. Authorization For PERSONAL CARE SERVICES (PCS) Assessment

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

If hospital or medical facility discharge, signed order from referring practitioner available in medical records? ☐ **Yes** ☐ **No**

Signature of facility representative: _____ **Date:** _____ (mm/dd/yyyy)

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How to Submit New Referrals

Completed referrals should be typed or printed legibly.

Forms may be faxed to CCME at 877-272-1942

Forms may be mailed to:

CCME
ATTN: PCS Independent Assessment
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598

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How Are New Referrals Processed?

UNABLE TO PROCESS: Due to missing information

INCOMPLETE: Due to missing information

COMPLETE: Non-qualifying

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How Are New Referrals Processed?

UNABLE TO PROCESS : Due to missing information

- Beneficiary Name
- Beneficiary Address
- Medicaid Number
- Date of Birth
- Date of Request
- Referring Entity
- Required Signatures
- Referral Source Name and NPI

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How Are New Referrals Processed?

INCOMPLETE : Due to missing information

- Date of last MD visit is not answered
- Medical stability question is not answered
- Medical diagnoses are not listed
- ICD-9 diagnoses codes are not listed

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How Are New Referrals Processed?

COMPLETE: Non-qualifying

- Date of last visit with referring MD is greater than 90 days
- Medical stability question is marked no

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How Are New Referrals Processed?

UNABLE TO PROCESS : Due to missing information

INCOMPLETE : Due to missing information

COMPLETE: Non-qualifying

Will result in a Technical Denial of the Request

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Complete and Qualifying New Referrals

If the **New Referral** is complete and adheres to the requirements as outlined in *Clinical Coverage Policy 3L, Section 5.4.5*, the referral will be processed.

- Resident will be contacted by a CCME Scheduler
- A Medicaid PCS eligibility assessment will be conducted on the resident
- Provider will receive the referral on the QiRePort Provider Interface or via fax
- Provider will accept or decline the referral
- Upon acceptance of the referral an authorization notice will be issued to beneficiary. The provider will receive a copy.

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How to Obtain Copies of the Independent Assessment?

QiRePort

CCME Call Center

LRF Fax Request

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS) FOR LICENSED ADULT CARE HOME RESIDENTS
LICENSED FACILITY REQUEST FOR PCS INDEPENDENT ASSESSMENT COPY

Licensed Adult Care Home Provider: Use this form to request a copy of the completed PCS Assessment for Medicaid beneficiaries that reside in your facility.
Send completed form to CCME via fax at 877-272-1942, or mail to:
CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
Receipt may be confirmed with CCME at 800-228-3365. E-mail questions to PCSAssessment@thecarolinascenter.org

PLEASE COMPLETE ALL FIELDS.

Section A. Facility Information *Complete all fields.*
Today's Date: ___/___/_____ (mm/dd/yyyy)
Facility Name: _____ Medicaid Provider Number: _____
Facility Contact Person: _____ Contact Position: _____
Facility Fax Number: (___) ___ - _____ Facility Phone: (___) ___ - _____ County: _____

Section B. List of Assessments needed *List each request on a separate line, and complete all fields.*

	Medicaid ID#	First Name	Last Name	Date of Birth (mm/dd/yyyy)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

Attach additional sheet to request more than 25 PCS Assessments.

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Types of Processing Requests

Change of Status (COS)

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Required Forms to Submit Requests

Change of Status (COS)
(Revised 3/8/2013)

- Licensed Residential Facilities (DMA 3069)
- Home Care Agencies (DMA 3042)

Who Can Submit a Change of Status (COS)?

- Provider
- Beneficiary
- Beneficiary's family, guardian, or person with Power of Attorney
- Beneficiary's Primary Care Physician

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Change of Status (COS)

- Providers may report status changes for beneficiaries approved for PCS services. A Change of Status reassessment should be requested for a beneficiary who, since the previous assessment, **has experienced a change** in condition that **affects the needs** for hands-on assistance with Activities of Daily Living (ADLs) or other services covered under **Clinical Coverage Policy 3L**.

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Change of Status (COS) Licensed Residential Facility

Revised (3/8/2013)

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR LICENSED FACILITY RESIDENT: CHANGE OF STATUS

Complete this form and send to The Carolinas Center for Medical Excellence [CCME] via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ___PCP ___Attending MD ___Licensed Facility PCS Provider ___Beneficiary/Responsible Party ___Other If Other, Relationship to Beneficiary_____

Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID#: _____

Beneficiary 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: _____ State: ____ Zip: _____ Phone: (____) _____ - _____

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

Relationship to Beneficiary: _____ Phone: (____) _____ - _____

Section B. Beneficiary Medical History

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

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

Medically Stable: ___Yes ___No Check if Active Adult Protective Services ☐

Reason for Change in Condition Requiring Reassessment for Services:
☐ Change in medical condition ☐ Change in caregiver status ☐ Change in beneficiary location affecting ability to perform ADLs
☐ Hospitalization Discharge Date: ___/___/___ (mm/dd/yyyy) ☐ Other _____

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

Section C. Facility/ PCS Provider Information: (Complete if request submitted by Licensed Facility PCS Provider)

Facility/ PCS Provider Name: _____ NPI#: _____

Medicaid Provider Number: _____ Facility License Number: _____ License Date: _____

Location: _____

Facility Type: ___Family Care Home ___Adult Care Home ___SLF-5600a ___SLF-5600c ___Adult Care bed in Nursing Facility

Special Care Unit? ___Yes ___No (Select Yes if stand-alone Special Care Unit OR SCU bed)

Facility Contact Name: _____ Contact Position: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ E-mail: _____

Section D. Referring Practitioner Demographics (Complete if request submitted by PCP or Attending MD.)

NPI#: _____ Practitioner First Name: _____ Last Name: _____

Practice Contact Name: _____ Contact Position: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ E-mail: _____

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Change of Status (COS) Licensed Residential Facility (DMA 3069)

Revised (3/8/2013)

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR LICENSED FACILITY RESIDENT: CHANGE OF STATUS

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail:
CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ___PCP ___Attending MD ___Licensed Facility PCS Provider ___Beneficiary/Responsible Party
___Other If Other, Relationship to Beneficiary_____

Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID#: _____

Beneficiary 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: _____ **State:** ___ **Zip:** _____ **Phone:** (_____) _____ - _____

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

Relationship to Beneficiary: _____ **Phone:** (_____) _____ - _____

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Change of Status (COS) Licensed Residential Facility (DMA 3069)

Revised (3/8/2013)

Section B. Beneficiary Medical History

Beneficiary Medical History – List *both* the current medical diagnoses and ICD-9 codes that currently limit the beneficiary'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 Enter "E" for Exacerbation	Date (mm/yyyy)

Medically Stable: ___Yes ___No **Check if Active Adult Protective Services**

Reason for Change in Condition Requiring Reassessment for Services:

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

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

All **Change of Status** requests will require the referring entity to provide both the Medical Diagnosis and the ICD-9 Codes.

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Change of Status (COS) Licensed Residential Facility (DMA 3069)

Revised (3/8/2013)

Section C. Facility/ PCS Provider Information: (Complete if request submitted by Licensed Facility PCS Provider)

Facility/ PCS Provider Name: _____ **NPI#:** _____

Medicaid Provider Number: _____ **Facility License Number** _____ **License Date** _____

Location: _____

Facility Type: ☐ Family Care Home ☐ Adult Care Home ☐ SLF-5600a ☐ SLF-5600c ☐ Adult Care bed in Nursing Facility

Special Care Unit? __Yes __No (Select Yes if stand-alone Special Care Unit OR SCU bed)

Facility Contact Name: _____ **Contact Position:** _____

Phone: (____) ____ - _____ **Fax:** (____) ____ - _____ **E-mail:** _____

Section D. Referring Practitioner Demographics (Complete if request submitted by PCP or Attending MD.)

NPI#: _____ **Practitioner First Name:** _____ **Last Name:** _____

Practice Contact Name: _____ **Contact Position:** _____

Phone: (____) ____ - _____ **Fax:** (____) ____ - _____ **E-mail:** _____

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Revised 3/8/2013

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Change of Status (COS) Home Care Agency (DMA 3042)

Revised (3/8/2013)

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR HOME CARE AGENCIES: CHANGE OF STATUS

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ◯PCP ◯Attending MD ◯ PCS Agency ◯Beneficiary/Responsible Party

Date of Referral: _____ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID#: _____

Beneficiary 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: _____ **State:** ____ **Zip:** _____ **Phone:** (____) ____ - _____

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

Relationship to Beneficiary: _____ **Phone:** (____) ____ - _____

Section B. Beneficiary Medical History

Beneficiary Medical History- List both the current medical diagnoses and ICD-9 codes that currently limit the beneficiary'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)

Medically Stable: ☐ Yes ☐ No **Check if Active Adult Protective Services** ☐

Reason for Change in Condition Requiring Reassessment for Services:

☐ Change in medical condition ☐ Change in caregiver status

☐ Change in beneficiary's location affecting ability to perform ADLs

☐ Hospitalization Discharge Date: ___/___/___ (mm/dd/yyyy) ☐ Other

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

_____

Section C. Referral Source if not Beneficiary or Beneficiary's Responsible Party:

NPI#: _____ **First Name:** _____ **Last Name:** _____

Facility Contact Name: _____ **Contact Position:** _____

Phone: (____) ____ - _____ **Fax:** (____) ____ - _____ **E-mail:** _____

Section D. Primary Care Physician Demographics

Same As Referring Practitioner: ☐ Y ☐ N. If yes, request is complete, submit to CCME

NPI#: _____ **Practitioner First Name:** _____ **Last Name:** _____

Facility Contact Name: _____ **Contact Position:** _____

Phone: (____) ____ - _____ **Fax:** (____) ____ - _____ **E-mail:** _____

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Change of Status (COS)
Home Care Agency - DMA 3042

Revised (3/8/2013)

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR HOME CARE AGENCIES: CHANGE OF STATUS

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail:
CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ○PCP ○Attending MD ○ PCS Agency ○Beneficiary/Responsible Party

Date of Referral: _____ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID#: _____
Beneficiary 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: _____ **State:** ___ **Zip:** _____ **Phone:** (_____) _____-_____

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

Relationship to Beneficiary: _____ **Phone:** (_____) _____-_____

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Change of Status (COS)
Home Care Agency - DMA 3042

Revised (3/8/2013)

Section B. Beneficiary Medical History

Beneficiary Medical History- List *both* the current **medical diagnoses** and **ICD-9** codes that currently limit the beneficiary'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)

Medically Stable: Yes No **Check if Active Adult Protective Services** ☐

Reason for Change in Condition Requiring Reassessment for Services:

☐ Change in medical condition ☐ Change in caregiver status

☐ Change in beneficary's location affecting ability to perform ADLs

☐ Hospitalization Discharge Date: ___/___/___ (mm/dd/yyyy) ☐ Other

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

All **Change of Status** requests will require the referring entity to provide both the Medical Diagnosis and the ICD-9 Codes.

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Change of Status (COS) Home Care Agency - DMA 3042

Revised (3/8/2013)

Section C. Referral Source if not Beneficiary or Beneficiary's Responsible Party:

NP#: _____ First Name: _____ Last Name: _____

Facility Contact Name: _____ Contact Position: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____ E-mail: _____

Section D. Primary Care Physician Demographics

Same As Referring Practitioner: Y N; If yes, request is complete; submit to CCME

NP#: _____ Practitioner First Name: _____ Last Name: _____

Facility Contact Name: _____ Contact Position: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____ E-mail: _____

DMA-3042
06/01/11 Rev 3/8/13

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When Should a Change of Status (COS) be Submitted?

Change of Status Request should be submitted if there has been a change in:

- The beneficiary's health that affects their ability to perform ADLs
- Caregiver status
- The location or environment that affects ability to perform ADLs

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Types of Processing Requests

Change of Provider (COP)

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Required Forms to Submit Requests

Change of Provider (COP)

- Licensed Residential Facilities (DMA 3070)
- Home Care Agencies (DMA 3043)

Who Can Submit a Change of Provider (COP)?

- Primary Care Physician (PCP)
- Physician Assistant
- Nurse Practitioner
- Attending Physician
- Beneficiary
- Beneficiary's responsible party

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Change of Provider (COP) or Transfer Licensed Residential Facility (DMA 3070)

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS)
REQUEST FOR CHANGE OF PROVIDER/ FACILITY TRANSFER FOR LICENSED FACILITY RESIDENT

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ___ PCP ___ Attending MD ___ Beneficiary ___ Beneficiary's Responsible Party
___ Licensed facility provider (*check only if beneficiary transfer to a licensed facility is planned or occurred*)

Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID#: _____

Beneficiary Name (as shown on Medicaid Card) First: _____ MI: ___ Last: _____

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

Current Address: _____ **City:** _____

County: _____ **State:** ___ **Zip:** _____ **Phone:** (_____) _____ - _____

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

Relationship to Beneficiary: _____ **Phone:** (_____) _____ - _____

Section B. Provider/Facility Information

Reason for Provider/Facility Change (select one):

☐ Beneficiary choice ☐ Current agency/facility 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 established with a new provider agency; no discharge/transfer planned at this time

Beneficiary's Preferred Provider/Facility (if known):

Agency/Facility Name: _____ **Phone:** (_____) _____ - _____

Medicaid Provider Number: _____ **Facility License Number** _____ **License Date** _____

Location: _____

Facility Type: ___ Family Care Home ___ Adult Care Home ___ SLF-5600a ___ SLF-5600c ___ Adult Care bed in Nursing Facility

Special Care Unit? ___ Yes ___ No (Select Yes if stand-alone Special Care Unit OR SCU bed)

Beneficiary's Alternate Preferred Provider/Facility (if known):

Agency/Facility Name: _____ **Phone:** (_____) _____ - _____

Medicaid Provider Number: _____ **Facility License Number** _____ **License Date** _____

Location: _____

Facility Type: ___ Family Care Home ___ Adult Care Home ___ SLF-5600a ___ SLF-5600c ___ Adult Care bed in Nursing Facility

Special Care Unit? ___ Yes ___ No (Select Yes if stand-alone Special Care Unit OR SCU bed)

Section C. Contact Information for Questions about Change of Provider Request (if not Beneficiary or Alternate Contact listed in Section A):

Contact Name: _____ **Relationship to Beneficiary:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____ **E-mail:** _____

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12/19/2012

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Change of Provider (COP) Licensed Residential Facilities DMA 3070

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS)
REQUEST FOR CHANGE OF PROVIDER/ FACILITY TRANSFER FOR LICENSED FACILITY RESIDENT

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ___ PCP ___ Attending MD ___ Beneficiary ___ Beneficiary's Responsible Party
___ Licensed facility provider (*check only if beneficiary transfer to a licensed facility is planned or occurred*)

Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID#: _____

Beneficiary Name (as shown on Medicaid Card) First: _____ MI: ___ Last: _____

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

Current Address: _____ **City:** _____

County: _____ **State:** ___ **Zip:** _____ **Phone:** (_____) _____ - _____

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

Relationship to Beneficiary: _____ **Phone:** (_____) _____ - _____

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Change of Provider (COP) Licensed Residential Facilities DMA 3070

Section B. Provider/Facility Information

Reason for Provider/Facility Change (select one):

☐ Beneficiary choice ☐ Current agency/facility 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 established with a new provider agency; no discharge/transfer planned at this time

Beneficiary's Preferred Provider/Facility (if known):

Agency/Facility Name: _____ **Phone:** (_____) _____ - _____

Medicaid Provider Number: _____ **Facility License Number** _____ **License Date** _____

Location: _____

Facility Type: ☐ Family Care Home ☐ Adult Care Home ☐ SLF-5600a ☐ SLF-5600c ☐ Adult Care bed in Nursing Facility

Special Care Unit? ☐ Yes ☐ No (Select Yes if stand-alone Special Care Unit OR SCU bed)

Beneficiary's Alternate Preferred Provider/Facility (if known):

Agency/Facility Name: _____ **Phone:** (_____) _____ - _____

Medicaid Provider Number: _____ **Facility License Number** _____ **License Date** _____

Location: _____

Facility Type: ☐ Family Care Home ☐ Adult Care Home ☐ SLF-5600a ☐ SLF-5600c ☐ Adult Care bed in Nursing Facility

Special Care Unit? ☐ Yes ☐ No (Select Yes if stand-alone Special Care Unit OR SCU bed)

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Change of Provider (COP) Licensed Residential Facilities DMA 3070

Section C. Contact Information for Questions about Change of Provider Request (if not Beneficiary or Alternate Contact listed in Section A):

Contact Name: _____ **Relationship to Beneficiary:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____ **E-mail:** _____

DMA-3070
12/19/2012

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Change of Provider (COP)
Home Care Agency
(DMA 3043)

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS)
REQUEST FOR CHANGE OF PROVIDER FOR HOME CARE AGENCY BENEFICIARIES

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ___ PCP ___ Attending MD ___ Beneficiary ___ Beneficiary's Responsible Party
Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Beneficiary Demographics
Medicaid ID#: _____
Beneficiary 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: _____ State: ___ Zip: _____ Phone: (___) ___-___
Alternate Contact/Parent/Guardian (required if Beneficiary under 18): First: _____ Last: _____
Relationship to Beneficiary: _____ Phone: (___) ___-___

Section B. Provider Information
Reason for Provider Change:
- ☐ Beneficiary choice
- ☐ Current agency unable to continuing providing services
- ☐ Other: _____

Status of PCS Services:
- ☐ Discharged on ___/___/___ (mm/dd/yyyy)
- ☐ Scheduled for discharge on ___/___/___ (mm/dd/yyyy)
- ☐ Continue receiving services until established with a new provider agency; no discharge planned at this time

Beneficiary's Preferred Provider (if known):
Agency Name: _____
Location: _____
Phone: (___) ___-___

Agency Name (Alternate): _____
Location: _____
Phone: (___) ___-___

Section C. Contact Information for Questions about Change of Provider Request (if not Beneficiary or Alternate Contact listed in Section A):
Contact Name: _____ Relationship to Beneficiary: _____
Phone: (___) ___-___ Fax: (___) ___-___ E-mail: _____

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Change of Provider (COP) Home Care Agency DMA 3043

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS)
REQUEST FOR CHANGE OF PROVIDER FOR HOME CARE AGENCY BENEFICIARIES

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Requested By: ___ PCP ___ Attending MD ___ Beneficiary ___ Beneficiary's Responsible Party
Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Beneficiary Demographics
Medicaid ID#: _____
Beneficiary 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: _____ State: ___ Zip: _____ Phone: (___) ___-___
Alternate Contact/Parent/Guardian (required if Beneficiary under 18): First: _____ Last: _____
Relationship to Beneficiary: _____ Phone: (___) ___-___

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Change of Provider (COP) Home Care Agency DMA 3043

Section B. Provider Information

Reason for Provider Change:
- ☐ Beneficiary choice
- ☐ Current agency unable to continuing providing services
- ☐ Other: _____

Status of PCS Services:
- ☐ Discharged on ___/___/___ (mm/dd/yyyy)
- ☐ Scheduled for discharge on ___/___/___ (mm/dd/yyyy)
- ☐ Continue receiving services until established with a new provider agency; no discharge planned at this time

Beneficiary's Preferred Provider (if known):

Agency Name: _____

Location: _____

Phone: (_____) _____ - _____

Agency Name (Alternate): _____

Location: _____

Phone: (_____) _____ - _____

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Change of Provider (COP) Home Care Agency (DMA 3043)

Section C. Contact Information for Questions about Change of Provider Request (if not Beneficiary or Alternate Contact listed in Section A):

Contact Name: _____ **Relationship to Beneficiary:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____ **E-mail:** _____

DMA-3043
06/01/11

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Required Forms to Submit Requests

New Referrals
Revised (3/8/2013)

- Licensed Residential Facilities (DMA 3068)
- Home Care Agencies (DMA 3041)

Change of Status (COS)
Revised (3/8/2013)

- Licensed Residential Facilities (DMA 3069)
- Home Care Agencies (DMA 3042)

Change of Provider (COP)

- Licensed Residential Facilities (DMA 3070)
- Home Care Agencies (DMA 3043)

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Locating Forms to Submit Requests

New Referrals
Revised 3/8/2013

- Division of Medical Assistance Personal Care Services (PCS) Webpage
- Carolina Center *for* Medical Excellence (CCME) Personal Care Services (PCS) Webpage

Change of Status (COS)
Revised 3/8/2013

- Division of Medical Assistance Personal Care Services (PCS) Webpage
- Carolina Center *for* Medical Excellence (CCME) Personal Care Services (PCS) Webpage
- QiRePort Provider Interface*

Change of Provider (COP)

- Division of Medical Assistance Personal Care Services (PCS) Webpage
- Carolina Center *for* Medical Excellence Personal Care Services (PCS) Webpage
- QiRePort Provider Interface*
- CCME Call Center

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Locating Forms to Submit Requests

Division of Medical Assistance (DMA) Personal Care Services Webpage - www.ncdhhs.gov/dma/pcs/pas.html

Carolina Center for Medical Excellence (CCME)Personal Care Services webpage - www.thecarolinascenter.org/pcs

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Locating Forms to Submit Requests: DMA Website

DHHS Home | A-Z Site Map | Divisions | About Us | Contacts | En Español Search DHHS Search DMA GO

NC Department of Health and Human Services

NC Division of Medical Assistance

For Beneficiaries | For County Staff | For Providers | Statistics and Reports

DMA HOME
- Medicaid Providers
  - A-Z Provider Topics
  - Calendars
  - Claims and Billing
  - Community Care (CCNC/CA)
  - Contacts for Providers
  - Enrollment
  - EPSDT and Health Check
  - Fee Schedules/Cost Reports
  - Forms
  - Fraud and Abuse
  - HIPAA
  - Library (bulletins, policies)
  - National Provider Identifier
  - Programs and Services
  - Seminars
- ABOUT DMA
- CONTACT DMA

Quick Links
- Archived 1915 b/c Waiver Content

DHHS > DMA >

Consolidated Personal Care Services (PCS)

EFFECTIVE DATE: January 1, 2013

The Consolidated Personal Care Services (PCS) program is a Medicaid State Plan benefit designed to provide personal care services to individuals residing in a private living arrangement, or a residential facility licensed by the State of North Carolina as an adult care home, or a combination home as defined in G.S. 131E-101(1a).G.S. 131E-101(1a); or resides in a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency.

Consolidated Personal Care Services (PCS) is available to individuals who has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance; two ADLs, one of which requires extensive assistance; or two ADLs, one of which requires assistance at the full dependence level. The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility.

PCS program eligibility is determined by an independent assessment conducted by the Division of Medical Assistance or its designee; and shall be provided in accordance with an individualized plan of care.

DMA Clinical Policy & Programs
Home and Community Care-Personal Care Services
Phone 919-855-4340
E-Mail: PCS_Program_Questions@dhhs.nc.gov

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Locating Forms to Submit Requests: DMA Website

Quick Links
- Archived 1915 b/c Waiver Content
- Basic Medicaid Billing Guide
- Clinical Coverage Policies and Provider Manuals
- DMA Contract Standardized Training
- Medicaid Bulletin
- Proposed Medicaid Clinical Coverage Policies

Related Sites
- MH/DD/SAS Home Page

Phone 919-855-4340
E-Mail: PCS_Program_Questions@dhhs.nc.gov

Important Links
- PCS Clinical Policy 3L
- House Bill 950 Session Law 2012-142
- N.C. Medicaid State Plan and Amendments
- North Carolina Medicaid State Plan Amendment (SPA) NC 12-013 - Personal Care Services
- House Bill 5
- Carolina Center for Medical Excellence (CCME)
- 1915 State Plan Archives
- Subscribe to received HPES Medicaid Alerts
- Send PCS questions by email to CCME
- QI Report Welcome Page

Additional Information

Expand All Items Below | Collapse Items Below

- Frequently Asked Questions
- Announcements
- Training
- Bulletins
- Forms
- Archives

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Locating Forms to Submit Requests: CCME Website

News Room | Events | Careers | Login/Registration

The Carolinas Center for Medical Excellence

Search: CCME Medicare | Enter Keyword(s)

Who We Are | Who We Serve | What We Do | My CCME

Home > What We Do > State Programs Management > Personal Care Services

Font Size A A A

- Home Care Agencies
- Licensed Residential Facilities
- PCS FAQs
- PCS Trainings
- PCS Forms
- PCS Important Links

Quick Links
- HCA Announcements
- LRF Announcements

Personal Care Services (PCS)

The North Carolina Division of Medical Assistance (DMA) has contracted with The Carolinas Center for Medical Excellence (CCME) to conduct Independent Assessments for Personal Care Services (PCS) for Medicaid recipients in North Carolina. Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes (ACH), family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated Clinical Coverage Policy 3L, PCS benefit.

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Locating Forms to Submit Requests: CCME Website

The Carolinas Center *for* Medical Excellence

News Room | Events | Careers | Login/Registration

Search CCME Medicare Enter Keyword(s)

Who We Are | Who We Serve | What We Do | My CCME

Home > What We Do > State Programs Management > Personal Care Services > PCS Forms

Font Size A A A

- Home Care Agencies
- Licensed Residential Facilities
- PCS FAQs
- PCS Trainings
- PCS Forms
- PCS Important Links

Quick Links

- Home Care Agencies
- Licensed Residential Facilities

PCS Forms

This section contains forms pertaining to the PCS program only. Please visit our Home Care Agencies Forms page or Licensed Resident Facilities Forms page for specific forms pertaining to each.

Note: You may need to download and install plug-ins on your computer in order to access and open certain files from this page. Free copies may be downloaded by visiting our Plug-In Downloads webpage. Documents on this page are in PDF format unless noted.

- Change of Provider
- Change of Status Request Form
- Clinical Coverage Policy 3L
- Electronic Plan of Care
- New Referral
- Provider Billing Number Update Form
- QiRePort

Change of Provider

Licensed Residential Facility Change of Provider (103 KB)
Form (DMA 3070) to request a change of provider or a facility transfer for a licensed residential facility resident.

Home Care Agency Change of Provider Form (82 KB)
Fillable form (DMA 3043) for current PCS beneficiaries to change their home care agency provider

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Provider Resources For Processing Requests

Division of Medical Assistance (DMA)

- **DMA Personal Care Services Webpage**: http://www.ncdhhs.gov/dma/pcs/pas.html
- **Home and Community Care Section:** 919-855-4340
- **Email:** PCS_program_questions@dhhs.nc.gov

Carolina Center for Medical Excellence (CCME)

- **Personal Care Services webpage** www.thecarolinascenter.org/pcs
- **CCME Call Center:** 1-800-228-3365 (Mon-Fri from 8- 5pm)
  - Option 2 - Independent Assessment of PCS
  - Option 3 - Personal Care Services Claims
- **Email:** PCSAssessment@thecarolinascenter.org

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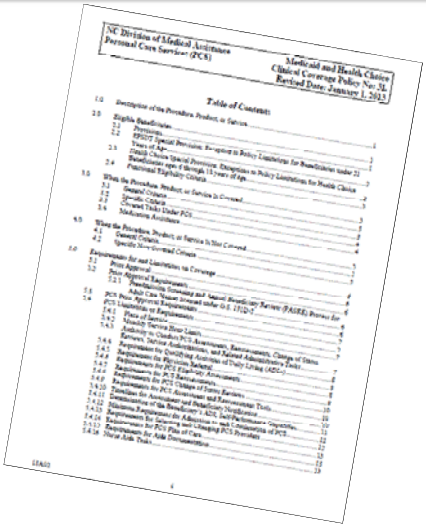
What Are the Requirements for Aide Documentation?



NC Division of Medical Assistance
Personal Care Services (PCS)

Medicaid and Health Choice
Clinical Coverage Policy No: 3L
Revised Date: January 1, 2013

Table of Contents

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What Are the Requirements for Aide Documentation?

- Document performance of ADL tasks
- Frequency of performance
- Date of services and tasks were provided
- Name of the aide

REFERENCES:
5.4.15 Requirements for Aide Documentation & 5.4.16 Nurse Aide Tasks

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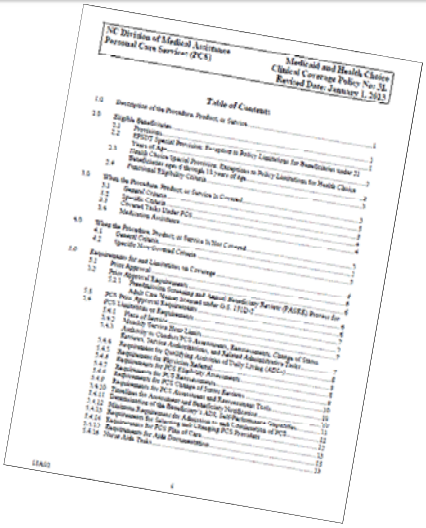
What Are the Requirements for Aide Documentation?



NC Division of Medical Assistance
Personal Care Services (PCS)

Medicaid and Health Choice
Clinical Coverage Policy No: 3L
Revised Date: January 1, 2013

Table of Contents

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What Are the Requirements for Aide Documentation of Task Deviations?

- Care task or tasks not performed
- Reasons tasks were not performed.

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Module II Learning Objectives

Participants will be able to:

- Define person centered planning and person centered thinking;
- Describe three outcomes of person centered planning;
- Discuss methods to improve the quality of questions; and.
- Assess their current level of person centeredness

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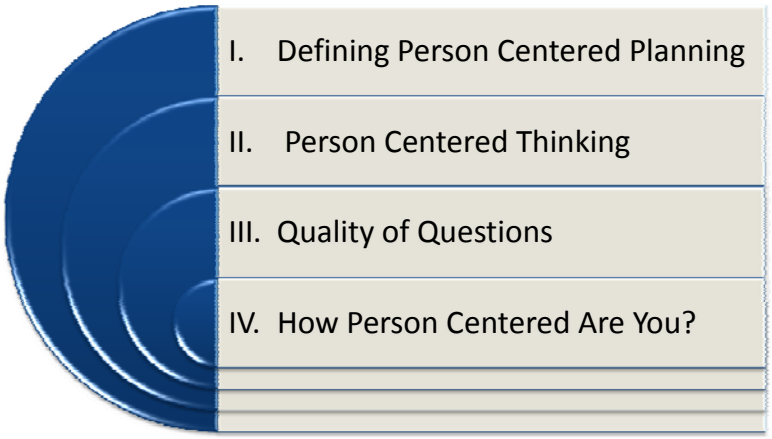
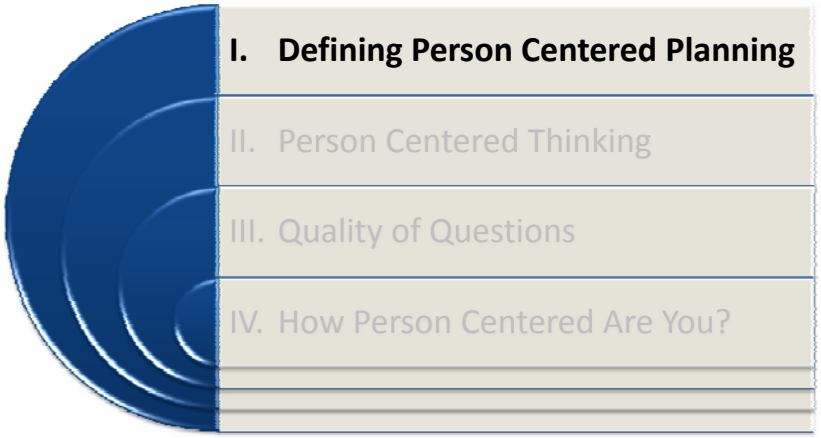
Module II Outline:



Module II Outline:



Q: How do you define person centered planning?

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Person Centered Planning (PCP) Definition

Person-centered planning is a process, directed by the family or individual intended to identify the strengths, capacities, and preferences, needs and desired outcomes of the individual.

INTRODUCTION

- Person-centered planning attempts to identify and highlight the unique talents, gifts and capabilities the beneficiary.
- Explore and discover where in the “real” world these gifts can be shared and appreciated.
- The beneficiary identifies planning goals to achieve personal outcomes.
- Engaging in active listening with the beneficiary, learning what is important to them, and lending time and energy to support them.

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Q: What are the outcomes of person centered planning?

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Person Centered Planning Outcomes

1. The beneficiary feels welcomed and heard.
2. The beneficiary has authority to plan and pursue his or her own vision.
3. PCS Assessment of needs is fair and accurate.
4. PCS Assessment and discovery identify personally defined quality of life.

Getting to the PCP Outcomes

Monitoring questions should be asked repeatedly, not just at the time of assessment:

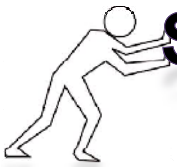
- Did needs change?
- Did assets change?

Getting to the PCP Outcomes

Monitoring questions should be asked repeatedly, not just at the time of assessment:

- Did capabilities change?
- Are existing services meeting beneficiary's needs?

How Do We Think About and Plan For The Future?



SYSTEM CENTERED APPROACH

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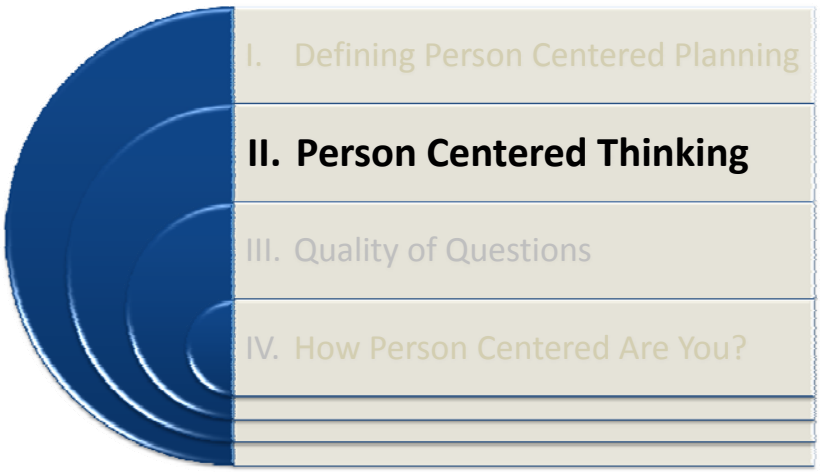
How Do We Think About and Plan For The Future?

Person Centered Approach

- Ensure personal safety of the beneficiary
- Promote informed decision making
- Promote partnerships with all stakeholders
- Organize to respond to the individual
- Accessible providers who are culturally accepting.

Module II Outline:



Q: What is person centered thinking?

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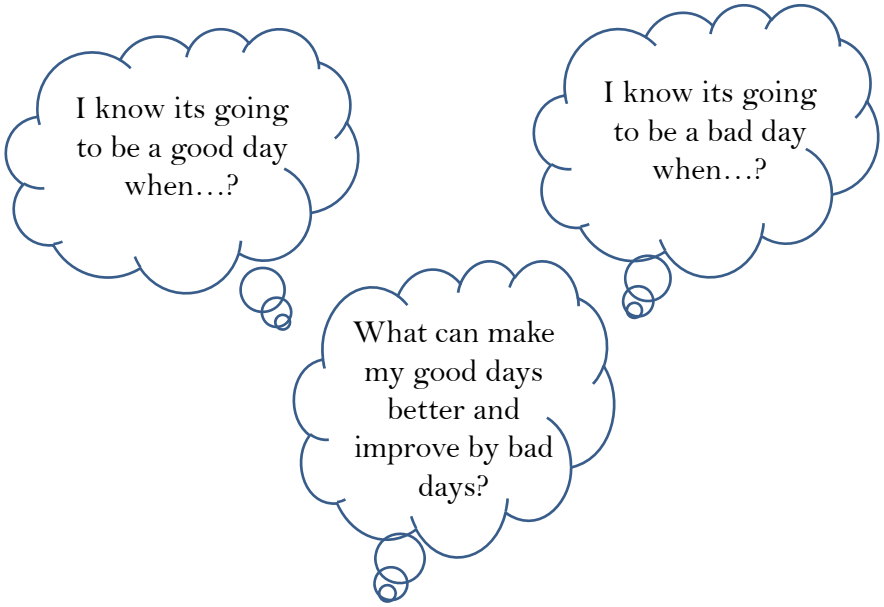
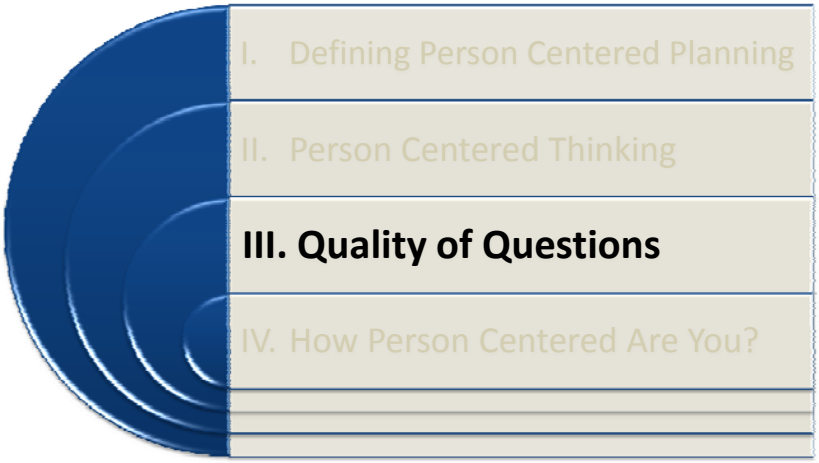
Person Centered Thinking Activity

- I know it's going to be a good day when I arrive to work and……..
- I know it's going to be a bad day when I arrive to work and……..

Person Centered Thinking Activity



Module II Outline:



Q: How do we improve the quality of our questions?

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Improving the Quality of Questions

Closed ended questions

- Give you facts
- Quick answers
- Questioner controls the conversation

Open ended questions

- Respondent thinks and reflects
- Share feelings and opinions
- Hands control to the responder

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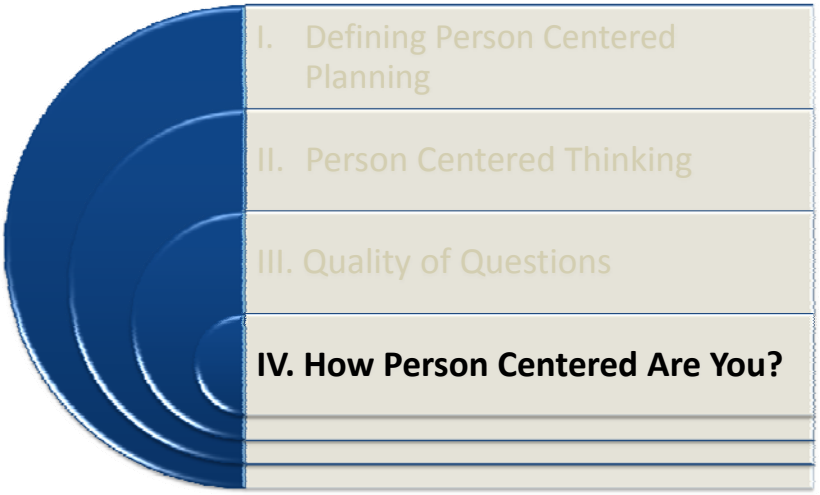
Improving the Quality of Questions

One way to sustain the person-centered approach is by asking ***open-ended questions*** in order to:

- Help understand the beneficiary's thoughts and feelings, which facilitates the process of developing the plan of care.
- Enhance the ability to interact with the beneficiary to share their perspectives.

Module II Outline:



Q: How person centered are you?

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How Person Centered is Your PCP?

- Did you help the beneficiary to use this person-centered process to assist in the planning?
- Did the beneficiary identify anyone else who they wanted to assist in or facilitate the planning?
- Did the desires and goals of the beneficiary form the foundation for the process? Was the process positive and respectful?
- Were the strategies used to gain the beneficiary perspective respectful?
- Does the beneficiary have a formal role in quality assurance?
- Is the beneficiary participating in all phases of the process?

Q: What is person centered planning?

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Personal Care Services Provider Resources

Division of Medical Assistance (DMA)

- **DMA Personal Care Services Webpage**: http://www.ncdhhs.gov/dma/pcs/pas.html
- **Home and Community Care Section:** 919-855-4340
- **Email:** PCS_program_questions@dhhs.nc.gov

Carolina Center for Medical Excellence (CCME)

- **Personal Care Services webpage** www.thecarolinascenter.org/pcs
- **CCME Call Center:** 1-800-228-3365 (Mon-Fri from 8- 5pm)
  - Option 2 - Independent Assessment of PCS
  - Option 3 - Personal Care Services Claims
- **Email:** PCSAssessment@thecarolinascenter.org

HP Enterprise Services (HPES)

- **Toll Free:** 1- 800-688-6696
  - Option 3 - Provider Services
  - Option 7 - PASRR

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