

# Medicaid Personal Care Services (PCS) Webinar: Overview of Personal Care Services (PCS) Forms and Technical Denials

March 27, 2013

Kimberlee Hyman

Carolinas Center *for* Medical Excellence

# Webinar Objectives

The webinar is designed to provide an overview and updates on:

- **Current Clinical Coverage Policy 3L, Personal Care Services (PCS) forms and**
- **Technical Denials**

# Types of Processing Requests

---

New Referral

Change of  
Status (COS)

Change of  
Provider (COP)

# 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)

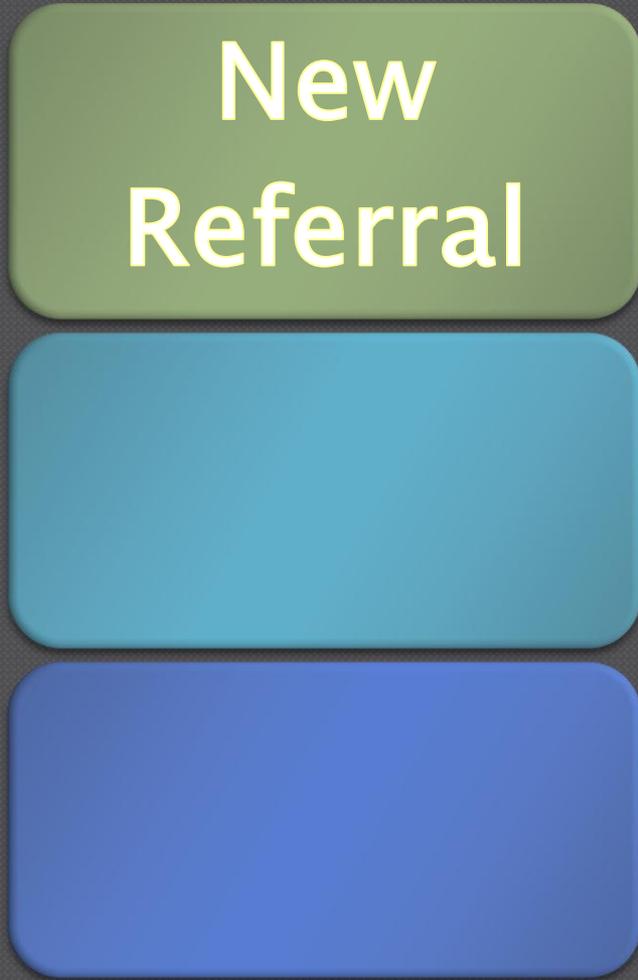
## Change of Provider (COP)

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

# Types of Processing Requests

---

**New  
Referral**



# 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

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@thecarolinascenior.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.

New Referrals  
 Revised 3/8/2013

Licensed  
 Residential  
 Facility  
 (DMA 3068)

# New Referrals

# 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

Medical ID#: \_\_\_\_\_

Patient Name (as shown on Medical 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: \_\_\_\_\_

# 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.**

## New Referrals

# 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

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](mailto: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)

New Referrals  
 (Revised 3/8/2013)

Home Care  
 Agency  
 (DMA 3041)

# New Referrals

# 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](mailto: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: (\_\_\_\_) \_\_\_\_\_

# 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.

# New Referrals

## 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)

# 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



# How Are New Referrals Processed?

---

**UNABLE TO PROCESS: Due to missing information**

**INCOMPLETE: Due to missing information**

**COMPLETE: Non-qualifying**

# 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

# 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

# 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

# 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**

# 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.

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@thecarolinacenter.org](mailto:PCSAssessment@thecarolinacenter.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.

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

Attach additional sheet to request more than 25 PCS Assessments.

**How to Obtain Copies of the Independent Assessment?**

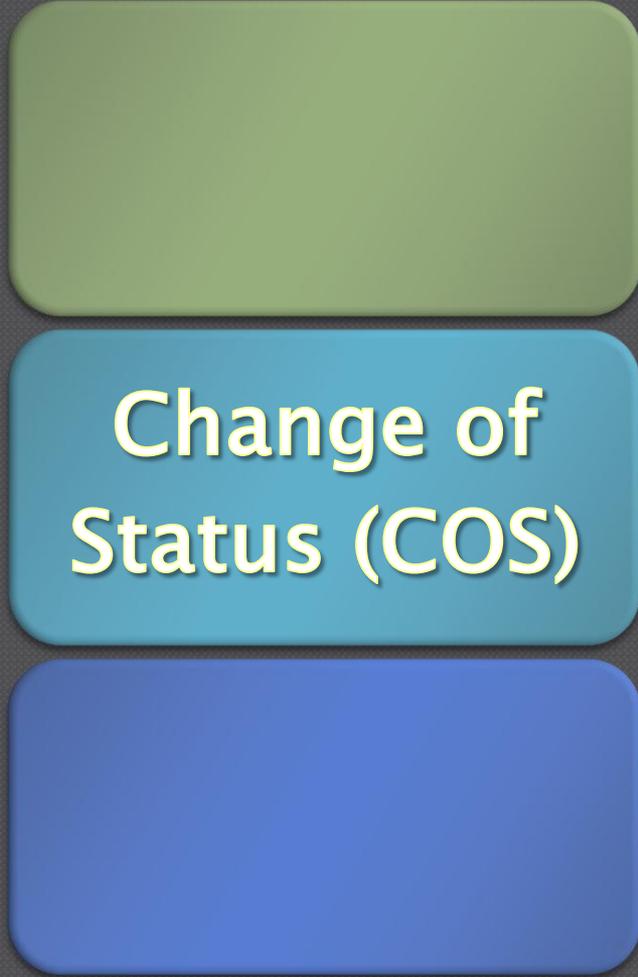
QiRePort

CCME Call Center

LRF Fax Request

# Types of Processing Requests

---



**Change of  
Status (COS)**

# 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 Physician

# 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.

# 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@thecarolinascener.org](mailto:PCSAssessment@thecarolinascener.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: \_\_\_\_\_

# 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](mailto: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: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

# 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.

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

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](mailto: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: \_\_\_\_\_

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

Revised (3/8/2013)

# 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](mailto: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: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

# 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 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):

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

# 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:

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: \_\_\_\_\_

---

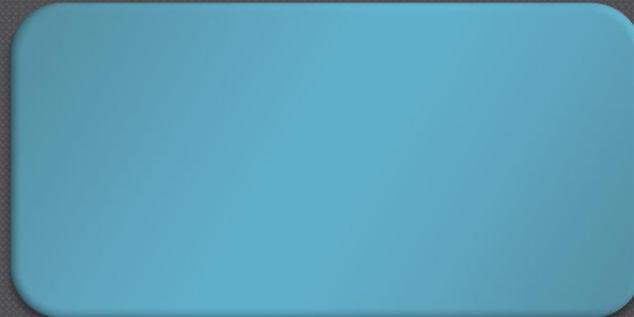
# When Should a Change of Status (COS) be Submitted?

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

# Types of Processing Requests

---



**Change of  
Provider  
(COP)**

# 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

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

**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](mailto: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: \_\_\_\_\_

# 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](mailto: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: (  )  -

# 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)

# 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

# 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 continue 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: \_\_\_\_\_

# 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: (  )  -

# 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: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_

# 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

# 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)

# 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

# Locating Forms to Submit Requests

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

**Carolina Center for Medical Excellence (CCME) Personal Care Services webpage - [www.thecarolinascenter.org/pcs](http://www.thecarolinascenter.org/pcs)**

# Locating Forms to Submit Requests: DMA Website



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](mailto:PCS_Program_Questions@dhhs.nc.gov)

# 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](#)

Home and Community Care Personal Care Services

Phone 919-855-4340

E-Mail: [PCS\\_Program\\_Questions@dhhs.nc.gov](mailto: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](#)



# Locating Forms to Submit Requests: CCME Website

The screenshot displays the CCME website interface. At the top right, there are links for "News Room | Events | Careers | Login/Registration". The main header features the CCME logo and the text "The Carolinas Center for Medical Excellence". A search bar contains the text "CCME Medicare" and a "Search" button. Below the header is a navigation menu with "Who We Are", "Who We Serve", "What We Do", and "My CCME". The breadcrumb trail reads "Home > What We Do > State Programs Management > Personal Care Services". On the right, there are font size controls and a print icon. The left sidebar contains a list of links: "Home Care Agencies", "Licensed Residential Facilities", "PCS FAQs", "PCS Trainings", "PCS Forms" (highlighted with a red arrow), and "PCS Important Links". The main content area is titled "Personal Care Services (PCS)" and contains a paragraph about the North Carolina Division of Medical Assistance (DMA) contracting with CCME for Independent Assessments for Personal Care Services (PCS) for Medicaid recipients in North Carolina. The paragraph lists various settings including private residences, licensed adult care homes (ACH), family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds. At the bottom, there is a "ShareThis" icon.

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

ShareThis

## 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.

# Locating Forms to Submit Requests: CCME Website



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

[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

# Provider Resources

## March 27, 2013 Medicaid PCS Webinar Follow up Question & Answer Conference Call

- Wednesday, April 3, 2013 11:00am–12:00pm – For all PCS providers
- Call in number and access code to participate are:  
Conference Call Number: 1-866-409-2889  
Code: 763-122-0923

# 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](mailto:PCS_program_questions@dhhs.nc.gov)

## Carolina Center for Medical Excellence (CCME)

- Personal Care Services webpage [www.thecarolinascenter.org/pcs](http://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](mailto:PCSAssessment@thecarolinascenter.org)

## HP Enterprise Services (HPES)

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