Annual Certification Due:_____

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

Referral Date:_____ Date Initial Assessment Completed:_____ Date Last Reassessment Completed:_____

Provider Name:_____ PCS Provider #:_____ Provider Phone #:_____

Provider Address:_____

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME:_____
2. MEDICAID ID # (MID):_____ 3. SOCIAL SECURITY# _____
4. PATIENT ADDRESS:_____
5. PATIENT PHONE:_____ 6. SEX: ☐Male ☐Female 7. DATE OF BIRTH (mm/dd/yy):_____
8. PATIENT LIVES: *Check all that apply* ☐Alone ☐w/Spouse ☐w/Adult Child(ren) ☐w/Parent(s) ☐w/others
9. CONTACT PERSON'S NAME:_____ RELATIONSHIP TO PATIENT:_____
   ADDRESS:_____ PHONE: (H)_____ (W)_____
10. ATTENDING PHYSICIAN'S NAME:_____ PHONE:_____
    ADDRESS:_____
11. DATE OF MOST RECENT EXAM (mm/dd/yy):_____ 12. Vital Signs @ Assessment: B/P____ T____ P____ R____ Wt____ Ht____
13. REASON FOR REFERRAL:_____ Referral Source:_____
14. DIAGNOSIS (Specify date of onset and ICD-9 code):_____

_____

_____

_____

15. CURRENT CARE (Type and Source):_____

_____

ASSESSMENT

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

17. Self-Administered? ☐Yes ☐No If no, who assists? (Name/Relationship)_____ Reminders needed? ☐Yes ☐ No

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

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

Limitations in Activities of Daily Living (ADLs)

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

A. ADL Self-Performance Scores

0. INDEPENDENT: No help needed or oversight needed.
1. SUPERVISION: Oversight, encouragement, or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives hands-on help in *guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene self monitoring of meds and / or* other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, substantial or consistent hands-on assistance *with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and /* or weight bearing assistance is needed.
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores

0. No set-up or physical help needed 1.Set-up help only 2.One person physical assist 3.Two+ persons assist and/or one person assist w/assistive equipment

			A. ADL Self-Performance	B. ADL Support Provided	Place a check in the box if assistance is needed
19.	**Ambulation:**	Note assistive equipment patient is to use while ambulating: ☐Cane ☐ Quad cane ☐Walker ☐ Bed/chair bound ☐other _____			
20.	**Non-ambulatory/ Transfer:**	Moving to and between surfaces: bed, chair, wheelchair, standing position. Note assistive equipment patient is to use during transfer: ☐ Manual wheelchair ☐ Electric wheelchair ☐Hoyer lift ☐Transfer Board ☐Trapeze Bar ☐ other _____ Note self sufficiency once transferred _____			
21.	**Nutrition:**	*Check assistance needed with taking in food by any method.* ☐Oral ☐Parenteral ☐ Tube_____ ☐Feed patient ☐Set-up only Dietary Restrictions_____ Supplements_____ Diet Ordered_____ Meal Prep: ☐ 1 meal_____ ☐ 2meals_____ Kitchen cleanup (cleaning table, stove, washing dishes, putting away items used, sweeping)_____			
22.	**Respiration:**	☐Normal ☐Dyspneic with minimal exertion ☐Tracheostomy ☐Mechanical Oxygen: ☐Continuous ☐Intermittent ☐Nebulizer Treatments _____ A. Dust_____ B. Vacuum_____ C. Mop_____ D. Sweep_____			
23.	**Endurance:**	☐Pt. is never short of breath (SOB) ☐Pt. is SOB when walking more than 20 feet or climbing stairs ☐Patient is SOB when walking less than 20 feet and or dressing self or using commode ☐Pt is SOB w/minimal exertion (i.e. eating, talking, performing ADLs, agitation) ☐Pt is SOB at rest ☐Pt has generalized weakness A. Change bed linens_____ B. Make bed_____ C. Grocery shop_____ D. Pick-up medicine_____ E. Pay utility bills _____ F. Take out garbage_____ ☐Check smoke alarm: _____			
24.	**Skin:**	☐Normal ☐Dry, cracked or bleeding areas ☐Pressure areas ☐Decubiti A. Diabetic foot care required?: ☐Yes ☐No Freq:_____ B. Nail Care?: ☐Yes ☐No Freq:_____			
25.	**Bathing:**	A. Taking full body bath_____ B. Shower_____ C. Sponge bath_____ D. Shampooing hair_____ E. Clean bathroom after bathing_____ ☐ Transferring in and out of tub and shower *Devices needed:* ☐ Shower bench ☐ Bath Safety Bars ☐Detachable shower head			
26.	**Personal hygiene:**	☐Combing hair ☐Brushing teeth ☐Cleaning dentures ☐Washing/drying face and hands and perineum A. Braiding or setting hair_____ B. Shaving_____			
27.	**Dressing:**	☐Laying out clothes ☐Retrieving clothes from closet ☐Putting clothes on and taking clothes off ☐Donning/removing TED Hose ☐ Donning/removing prosthesis A. ROM_____ B. Launder pt's clothes, bed linens, towels, and washcloths_____			
28.	**Bladder :**	*Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self.* ☐Normal ☐Ileostomy ☐Indwelling catheter ☐Condom Catheter ☐Occasional incontinence (less than daily) ☐Daily incontinence ☐Incontinence during the day and night *Devices/supplies needed:* ☐ Bed/chair bound ☐ Bedside commode ☐ Elevated Toilet Seat ☐ Bedpan ☐Urinal ☐Pads ☐Diapers ☐Cath Care			
29.	**Bowel:**	*Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self.* ☐Normal ☐Occasional Incontinence (less than daily) ☐Daily incontinence ☐Constipation ☐Ostomy *Devices/supplies needed:* ☐Bedside Commode ☐ Elevated Toilet Seat ☐Bedpan ☐ Pads ☐ Diapers ☐Enemas_____ ☐Bowel Program_____			
30.	**Self-monitoring:**	Self-monitoring of: ☐ Pre-poured medications ☐ Blood Sugars: Notify MD if BS is above_____ or below_____ BP: Notify MD if BP is > _____ or < _____ ☐ Weight: Notify MD if pt. loses or gains ____lbs. within ____days.			

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

Other Client Information

Check the appropriate box if it applies to the patient.

31.	**Pain:** *7-day look-back*	Location of pain_____ Severity of Pain: *Rate 0 – 10: O=no pain and 10=worst pain* _____ Pain frequency: ☐No pain ☐Pain < daily ☐Pain > daily Pain control: ☐No pain ☐Pain improved with medication ☐No pain relief or improvement w/medication
32.	**Cognitive Skills for Daily Decision Mkg:**	☐Independent (decisions consistent/reasonable) ☐Modified independence (some difficulty in new situations only) ☐Moderately impaired (decisions poor, cues/supervision required) ☐Severely impaired (never/rarely makes decision) ☐Patient requires step-by-step verbal prompting ☐MR/DD _____ (level)
33.	**Behavior:**	☐Cooperative ☐Passive ☐Physically abusive ☐Verbally abusive ☐Wanders ☐Injures self/others/property ☐Non-responsive
34.	**Vision:**	☐Adequate for daily activities ☐Limited (sees large objects) ☐Very limited (blind) *Client uses:* ☐Glasses ☐Contacts
35.	**Hearing:**	☐Adequate for daily activities ☐Hears loud sounds/voices ☐Very limited (deaf) *Client uses:* ☐Hearing aids
36.	**Speech:**	☐Normal ☐Slurred ☐Weak ☐Other impediment: specify_____ Primary Language(s)Spoken_____
37.	**Communication Method:**	☐Speech ☐Gestures ☐Writing ☐Assistive Device: specify type _____ ☐ Client unable to write; have client make mark here: _____ Nurse's initials: _____

38. ☐ Additional time needed. Document here information specific to client needs for other covered home management tasks AND exceptions requiring additional time over identified time guidance:

39. Patient's perception of what he/she thinks their needs are:

40. Please check if any of the following apply to this patient:
- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance **and** requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time. ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night

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

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

43. SAFETY ASSESSMENT: Is the patient's home adequate or suitable to carry out the Plan of Care according to your agency's policies? ☐Yes ☐No
Water: _____ Telephone: _____ Heating: _____ Cooling: _____
Electric Capability Sufficient? ☐Yes ☐No Is there a smoke alarm in the home? ☐Yes ☐No Is there a fire extinguisher in the home? ☐Yes ☐No
If O_2 is in use, have safety precautions been included on Plan of Care? ☐Yes ☐No ☐N/A Are there safety devices located in the bathroom? ☐Yes ☐No
Are patient emergency numbers in clear view? ☐Yes ☐No Is the patient confined to bed or chair? ☐Yes ☐No
Has patient been instructed on the use of Durable Medical Equipment? ☐Yes ☐No List the DME company used : _____
Specify what DME is already available: _____
Specify what DME has been ordered: _____

44. Are there sources (family, friends, programs, or agencies) available to meet the above needs at the time that services have been requested? ☐Yes ☐No

NURSE ASSESSOR CERTIFICATION

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

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

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

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

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

PLAN OF CARE

45. If the assessment indicates that the patient has medically-related personal care needs requiring Personal Care Services, show the plan for providing care beside the day(s) services are needed. Please write in the category # of the assigned task(s) that is designated on the assessment. The key below lists the category numbers. Be sure to write in the time (in 15 minute increments or in hours) required for each day.

Category #	Category Name	Category #	Category Name
19	Ambulation	27	Dressing
20	Non-ambulatory/Transfer	28	Bladder
21	Nutrition	29	Bowel
22, 23	Respiration	30	Self-monitoring
23	Endurance	30	Medication Assistance
24	Skin	31	Pain
25	Bathing	32	Cognitive Skills for Daily Decision-making
26	Personal hygiene	33	Behavior

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

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

_____

47. Has a **verbal order** been obtained to **assess the patient** and determine eligibility for PCS per DMA Guidelines? ☐Yes Date:_____

48. Specify the date that a verbal order was obtained to **start PCS**:_____ Who conveyed/obtained this verbal order?_____

PHYSICIAN CERTIFICATION

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

ATTENDING PHYSICIAN'S SIGNATURE _____ DATE_____