N.C. Department of Health and Human Services – Division of Medical Assistance

PERSONAL CARE SERVICES (PCS) REQUEST FOR SERVICES FORM

Completed form should be sent to Liberty Healthcare Corporation-NC via fax at 484-434-1571 or 855-740-1600 (toll free) or mail: ATTN: Liberty Healthcare Corporation, PCS Program 5540 Centerview Dr. Suite 114, Raleigh, NC 27606-3386. For questions, contact 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@libertyhealth.com. **DISCLAIMER: Adherence to the INSTRUCTIONS for the Request for Services Form is REQUIRED. If a request for services form is submitted incomplete, an unable to process notification will be issued and a new request for services form will be required. For the Expedited Assessment Process contact Liberty Healthcare Corporation at 1-855-740-1400**

PROVIDER TYPE (select one) **DATE OF REQUEST:** _____(mm/dd/yyyy)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a
☐ SLF-5600c ☐ Special Care Unit (stand-alone Special Care Unit or SCU bed)

SECTION A. RECIPIENT DEMOGRAPHICS

Medicaid ID#: _____

Recipient's 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: _____ **Zip:** _____ (zip code + 4 digit extension) **Phone:** _____

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

Relationship to Patient: _____ **Phone:** _____

Provider Name (if applicable) _____ **Provider Phone:**_____

SECTION B. RECIPIENT'S MEDICAL HISTORY – complete this section only if submitting a NEW REFERRAL or CHANGE OF STATUS request.

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)

SECTION C. NEW REFERRAL REQUEST complete this section if submitting a New Referral.

☐ **Check the box to the left and complete sections A, B, and C if submitting a New referral.**

Referral Entity (select one)**:** ☐ Primary Care Physician ☐ Attending MD ☐ Physician Assistant (PA) ☐ Nurse Practitioner (NP)

Is Recipient Medically Stable: ☐ Yes ☐ No **Is there an active Adult Protective Services (APS) case:** ☐ Yes ☐ No

Date of last visit to Referring Entity: _____(mm/dd/yyyy)

Other state/federal programs recipient is currently receiving (select all that apply)**:** ☐ Medicare Home Health ☐ Private Duty Nurse ☐ CAP ☐ Hospice ☐ Unknown

Is 24-hour caregiver availability required to ensure recipient's 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?)

Is recipient currently hospitalized or in a medical facility: ☐ Yes ☐ No If yes, planned discharge date: _____(mm/dd/yyyy)
Is recipient currently in a Skilled Nursing Facility (SNF): ☐ Yes ☐ No if yes, planned discharge date: _____(mm/dd/yyyy)

Referring Entity's Name: _____ **NPI#:**_____

Practice Name: _____(if applicable)

Name of Practice Point of Contact:_____ Position: _____

Phone (including area code): _____ Fax (including area code): _____

Point of Contact's Email Address:_____

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

NOTE: Dated signature is verification that the information in sections A, B, and C is accurate for this recipient and authorization to conduct a PCS eligibility assessment. If requesting an assessment for greater than 80 hours of PCS completion of **sections A, B, C, and E with a second signature is REQUIRED on page 2. If not stop here and submit to Liberty.**

SECTION D. CHANGE OF STATUS REQUEST – complete this section if submitting a Change of Status (COS).

☐ **Check the box to the left and complete sections A, B, and D if submitting a Change of Status. If the Change of Status is requesting an assessment for greater than 80 hours of PCS completion of Sections A, B, D, and E are REQUIRED.**

Requested By (select one): ☐ Primary Care Physician ☐ Attending MD ☐ PA ☐ NP ☐ PCS Provider ☐ Recipient ☐ Responsible Party ☐ Other (Relationship to Recipient): _____

Is Recipient Medically Stable: ☐ Yes ☐ No **Is there an active Adult Protective Services (APS) case:** ☐ Yes ☐ No

Reason for Change in Condition Requiring Reassessment:

☐ Change in medical condition ☐ Change in recipient's location affecting ability to perform ADLs

☐ Change in caregiver status ☐ Hospitalization Discharge Date: _____(mm/dd/yyyy)

☐ Other: _____

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

Provider Name: _____

PCS Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Provider Contact Name: _____ Contact's Position: _____

Practice Phone_____ Practice Fax: _____

Email: _____

Referring Entity/Practitioner Information (Complete if change of status is submitted by the recipient's PCP, Attending MD, PA, or NP).

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

Practice Name: _____(if applicable)

Practice Contact's Name: _____ Contact's Position: _____

Practice Phone_____ Practice Fax: _____

Email: _____

SECTION E. PHYSICIAN ATTESTATION: Session Law 2013-306 requires that a physician attest that the recipient meets each of the criteria below to be eligible for up to 50 additional hours of PCS as determined through the independent assessment.

- The **recipient** requires an increased level of supervision.
- The **recipien**t requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- Regardless of setting, the **recipient** requires a physical environment that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- The **recipient** has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

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

NOTE: If submitting a **New Referral or Change of Status (COS) is requesting an assessment for greater than 80 hours** the dated signature is verification that information in sections A, B, C, D (if COS) & E are accurate for this recipient and authorization to conduct the PCS eligibility assessment. If submitting a **Physician Attestation only** the dated signature is verification that information in

sections A, B and E are accurate for this recipient and authorization to conduct the PCS eligibility assessment.

SECTION F. CHANGE OF PROVIDER REQUEST – complete this section if submitting a Change of Provider (COP).

☐ **Check the box to the left and complete sections A and F only.**

Requested By (select one): ☐ Primary Care Physician ☐ Attending MD ☐ Physician Assistant ☐ Nurse Practitioner ☐ Recipient ☐ Responsible Party

NOTE: Home Care Agencies and Licensed Residential Facilities should have beneficiaries or the recipient's legal representatives to call the Liberty Healthcare Corporation-NC Call Center for Change of Provider (COP) requests at 855-740-1400 or 919-322-5944. Home Care Agencies and Licensed Residential Facilities may assist the recipient or legal representative in placing the call.

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

☐ Recipient or legal representative's choice

☐ Current provider unable to continuing providing services

☐ Other:_____

Status of PCS Services (select one)**:**

☐ Discharged/Transferred on _____(mm/dd/yyyy)

☐ Scheduled for discharge/transfer on _____(mm/dd/yyyy)

☐ Continue receiving services until recipient is established with a new provider agency; no discharge/transfer is planned

Recipient's Preferred Provider (select one):

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a

☐ SLF-5600c ☐ Special Care Unit (stand-alone Special Care Unit or SCU bed)

Agency Name:_____ Phone: _____

Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Physical Address:

_____

Recipient's Alternate Preferred Provider (select one)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a

☐ SLF-5600c ☐ Special Care Unit (stand-alone Special Care Unit or SCU bed)

Agency Name:_____ Phone: _____

Provider NPI#: _____ PCS Provider Locator Code#: _____(three digit code)

Facility License # (if applicable): _____ License Date (if applicable): _____(mm/dd/yyyy)

Physical Address:

_____

Contact Information for Questions about Change of Provider Request (if not recipient or alternate contact listed in section A).

Contact's Name: _____ **Relationship to Recipient:** _____

Phone: _____ **Fax:** _____ **Email:** _____