

Authorization Request for Personal Care Services (PCS)

Upload this request through the Provider Web Portal.

Questions? Call: (800) 525-2395

For information on completing this form, see the instructions online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu, then click on Form Number FA-24-I).

DATE OF REQUEST: ____/____/____

SECTION 1: FOR NEVADA MEDICAID USE ONLY

SECTION 2: PURPOSE OF REQUEST		
<input type="checkbox"/> Update Visit (annual) <input type="checkbox"/> Significant Change in Condition <input type="checkbox"/> Temporary Service Authorization <input type="checkbox"/> One-Time Service	<input type="checkbox"/> Information Only 	<input type="checkbox"/> Cancel Authorization Agency's last date of service: ____/____/____ Reason: <input type="checkbox"/> Recipient Ineligible <input type="checkbox"/> Recipient Expired <input type="checkbox"/> Other: _____

SECTION 3: CONTACT INFORMATION			
RECIPIENT INFORMATION			
Last Name:		First Name:	
Recipient Medicaid ID:		Date of Birth:	
Translator Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Language:	
Address:			
City:	State:	Zip Code:	Phone:

PCS AGENCY INFORMATION		
PCS Agency Name:		City:
NPI/API:	Phone:	Fax:

LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION (if applicable*)		
<i>*Complete this section if the definition of LRI is met. Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents. Attach a completed copy of form FA-24B (LRI Availability Determination for the Personal Care Services Program) with any submitted request when the recipient resides with an LRI. It is the responsibility of the provider to attach a current work note (availability) or a copy of the permanent disability form or an updated disability form if the disability was/is temporary (capability). If this section is not addressed and appropriate paperwork not attached, this request will be denied and the form will be returned to the provider. See the FA-24 Instructions on the Forms webpage at www.medicaid.nv.gov for additional instructions regarding this section.</i>		
Does recipient have an LRI? (see definition above) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
LRI Name:		Phone:
Relationship to Recipient:	Does LRI reside with recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the LRI also on the PCS Program: <input type="checkbox"/> Yes <input type="checkbox"/> No	Receives _____ hrs/wk	
LRI Employment Status: <input type="checkbox"/> Employed # Hrs/wk: _____ Days Off: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Other		

Nevada Medicaid and Check Up
Authorization Request for Personal Care Services (PCS)

Recipient Name:		Recipient Medicaid ID:	
ALTERNATE CONTACT INFORMATION <i>(An alternate contact is needed for scheduling purposes in the event the recipient and/or LRI are unavailable.)</i>			
Alternate Contact Name:			
Phone:		Relationship to Recipient:	
Can this person be contacted in case we are unable to contact recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION 4: DIAGNOSES AND INCIDENTS			
DIAGNOSIS/DIAGNOSES AFFECTING THE INDIVIDUAL'S ABILITY TO COMPLETE TASKS:			
Is anyone else in the home receiving PCS at this time?			
<input type="checkbox"/> Yes - Who: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			
INCIDENTS, INCLUDING A SUMMARY OF ALL REPORTED SERIOUS OCCURRENCES, WITHIN PAST 90 DAYS <i>(Check all that apply. The Summary of Reported Serious Occurrences section is mandatory.)</i>			
<input type="checkbox"/> Hospitalization Discharged date or anticipated discharge date: _____			
<input type="checkbox"/> Recent Fall	<input type="checkbox"/> Surgery Type: _____		<input type="checkbox"/> Loss of non-paid caregiver
<input type="checkbox"/> New Medical Condition/Diagnosis <i>(specify)</i> :			
<input type="checkbox"/> Addition or loss of other services <i>(specify)</i> :			
<input type="checkbox"/> Summary of Reported Serious Occurrences: _____ _____ _____ _____			
<input type="checkbox"/> No Serious Occurrences			
SECTION 5: COMMENTS <i>(General comments that would assist an assessor in completing an accurate assessment; include reason for request):</i>			
SECTION 6: PERSON COMPLETING/SUBMITTING THIS REQUEST <i>(This person will be contacted with questions or if additional information is needed to process this request.)</i>			
Name:		Phone:	

Nevada Medicaid and Check Up
Authorization Request for Personal Care Services (PCS)

SECTION 7: PERSONAL CARE ATTENDANT (PCA) INFORMATION *(An LRI cannot be a PCA) (Mandatory fields)*

PCA Name:

PCA Phone Number: (cannot be the agency's phone number)

PCA is a relative: ☐ Yes ☐ No If Yes, what is the relationship:

PCA resides: ☐ In home ☐ Out of home PCA is not related but lives in home: ☐ Yes ☐ No

PCA is not related and is not living with recipient: ☐ Yes ☐ No

SECTION 8: ADDITIONAL COMMENTS

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/authorization is not a guarantee of payment.