

**DMA-3051  
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)  
ATTESTATION OF MEDICAL NEED**

**MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRACTITIONERS COMPLETE PAGES 1 & 2 ONLY**

Step 1

<b>REQUEST TYPE:</b> (select one)	<b>DATE OF REQUEST:</b>
<input type="checkbox"/> Change of Status: Medical <input type="checkbox"/> New Request	____ / ____ / ____

Step 2

**Form Submission:** Fax Carolina Complete Health at 1-833-238-7689  
**Expedited Assessment Process Info:** Contact Carolina Complete Health at 1-833-552-3876  
**Questions:** Call Carolina Complete Health at 1-833-552-3876

**SECTION A. BENEFICIARY DEMOGRAPHICS**

**Beneficiary's Name:** First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Medicaid ID#:** \_\_\_\_\_ **RSID#(ACH Only):** \_\_\_\_\_ **RSID Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Gender:**  Male  Female    **Language:**  English  Spanish  Other \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

Alternate Contact (Select One):  Parent     Legal Guardian (required if beneficiary < 18)     Other

Relationship to Beneficiary (NON-PCS Provider): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Active Adult Protective Services Case?  Yes  No

**Beneficiary currently resides:**  At home     Adult Care Home     Hospitalized/medical facility     Skilled Nursing Facility

Group Home     Special Care Unit (SCU)     Other \_\_\_\_\_ D/C Date (Hospital/SNF): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Step 3

**SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS**

Identify the current **medical diagnoses related to the beneficiary's need for assistance with** qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List both the diagnosis and the COMPLETE ICD-10 Code.

Medical Diagnosis	ICD-10 Code	Impacts ADLs	Date of Onset (mm/yyyy)
1.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**In your clinical judgment, ADL limitations are:**  Short Term (3 Months)     Intermediate (6 Months)     Age Appropriate

Expected to resolve or improve (with or without treatment)     Chronic and stable

**Is Beneficiary Medically Stable?**  Yes  No

**Is 24-hour caregiver availability required to ensure beneficiary's safety?**  Yes  No

Step 4

**OPTIONAL ATTESTATION: Practitioner should review the following and initial only if applicable:**

**Beneficiary requires an increased level of supervision.**

Initial: \_\_\_\_\_

**Beneficiary 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.

Initial: \_\_\_\_\_

**Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures** to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.

Initial: \_\_\_\_\_

**Beneficiary has a history of safety concerns** related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Initial: \_\_\_\_\_

Step 5

**SECTION C. PRACTITIONER INFORMATION**

**Attesting Practitioner's Name:** \_\_\_\_\_ **Practitioner NPI#:** \_\_\_\_\_

**Select one:**  Beneficiary's Primary Care Practitioner  Outpatient Specialty Practitioner  Inpatient Practitioner

**Practice Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_

**Practice Contact Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

*Practice Stamp*

**Date of last visit to Practitioner:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **\*\*Note:** Must be < 90 days from Received Date

**Practitioner Signature AND Credentials:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*\*Signature stamp not allowed\**

*"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."*

Step 6

**SECTION D. CHANGE OF STATUS: MEDICAL Complete for medical change of status request only.**

Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (Required):

**--- PRACTITIONER FORM ENDS HERE ---**

**NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE PAGE 3 ONLY**

Step 1

<b>REQUEST TYPE:</b> (select one)	<b>DATE OF REQUEST:</b>
<input type="checkbox"/> Change of Status: Non-Medical <input type="checkbox"/> Change of Provider	____ / ____ / ____

**Form Submission:** Fax Carolina Complete Health at 1-833-238-7689  
**Questions:** Call Carolina Complete Health at 1-833-552-3876

Step 2

**BENEFICIARY DEMOGRAPHICS**

**Beneficiary's Name:** First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Medicaid ID#:** \_\_\_\_\_ **Gender:**  Male  Female **Language:**  English  Spanish

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  Other \_\_\_\_\_

**County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

Alternate Contact (Select One):     Parent     Legal Guardian (required if beneficiary < 18)     Other

Relationship to Beneficiary (NON-PCS Provider): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Step 3

**Beneficiary currently resides:**  At home     Adult Care Home     Hospitalized/medical facility     Skilled Nursing Facility  
 Group Home     Special Care Unit (SCU)     Other \_\_\_\_\_ D/C Date (Hospital/SNF): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION E: CHANGE OF STATUS: NON-MEDICAL**

<b>Requested by (Select One):</b>	<input type="checkbox"/> PCS Provider	<input type="checkbox"/> Beneficiary	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Power of Attorney (POA)	<input type="checkbox"/> Responsible Party	<input type="checkbox"/> Family (Relationship): _____
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**Requestor Name:** \_\_\_\_\_

PCS Provider NPI#: \_\_\_\_\_ PCS Provider Locator Code#: \_\_\_\_\_

Facility License # (if applicable): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Contact's Name: \_\_\_\_\_ Contact's Position: \_\_\_\_\_

Provider Phone: (\_\_\_\_) \_\_\_\_\_ Provider Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Reason for Change in Condition Requiring Reassessment**  
(Select One):     Change in Days of Need     Change in Caregiver Status     Change in Beneficiary location affects ability to perform ADLs  
 Other: \_\_\_\_\_

Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (Required):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Step 4

**SECTION F: CHANGE OF PCS PROVIDER**

**Requested by (Select One):**  Care Facility     Beneficiary     Other (Relationship): \_\_\_\_\_

Requestor's Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

<b>Reason for Provider Change (Select One):</b>	<input type="checkbox"/> Beneficiary or legal representative's choice	<input type="checkbox"/> Current provider unable to continue providing services	<input type="checkbox"/> Other: _____
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**Status of PCS Services (Select One):**  
 Discharged/Transferred     Scheduled Discharge/Transfer     No Discharge/Transfer Planned.  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Continue receiving services until established with a new provider.

Step 5

**BENEFICIARY'S PREFERRED PROVIDER (Select One):**

<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Family Care Home	<input type="checkbox"/> Adult Care Home	<input type="checkbox"/> Adult Care Bed in Nursing Facility	<input type="checkbox"/> SLF-5600a	<input type="checkbox"/> SLF-5600c	<input type="checkbox"/> Special Care Unit
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Agency Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Provider NPI#: \_\_\_\_\_ Provider Locator Code#: \_\_\_\_\_

Facility License # (if applicable): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Physical Address: \_\_\_\_\_