

**North Carolina Department of Health and Human Services - Division of Medical Assistance  
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)  
ATTESTATION OF MEDICAL NEED**

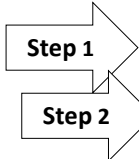
**PCS is a Medicaid benefit based on an unmet need for assistance with Activities of Daily Living (ADLs), which means bathing, dressing, toileting, eating, and mobility in the setting of care.**

Completed form should be faxed to Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).

**For the Expedited Assessment Process contact Liberty Healthcare Corporation at 1-855-740-1400.**

For questions, call 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@libertyhealth.com.

**Please select one:**     New Request                       Change of Status: Medical    **Date of Request:** \_\_\_/\_\_\_/\_\_\_



**SECTION A. BENEFICIARY DEMOGRAPHICS**

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

**Medicaid ID#:** \_\_\_\_\_ **PASRR#(For ACHs Only):** \_\_\_\_\_ **PASRR Date:** \_\_\_/\_\_\_/\_\_\_

**Gender:**  M  F    **Language:**  English  Spanish  Other \_\_\_\_\_

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

**County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_ Phone: \_\_\_\_\_

Active Adult Protective Services Case?  Yes  No

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**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 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 ICD-10 code for each.

Medical Diagnosis	ICD-10 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
	____.____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	____.____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	____.____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	____.____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	____.____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**In your clinical judgment, the ADL limitations are:**     Short Term (3 Months)     Intermediate (6 Months)  
 Expected to resolve or improve (with or without treatment)     Chronic and stable     Age Appropriate

**Is Beneficiary Medically Stable?**  Yes  No

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



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

The **beneficiary requires an increased level of supervision.**    Initial if Yes: \_\_\_\_\_

The **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 if Yes: \_\_\_\_\_

Regardless of setting, the **beneficiary requires a physical environment 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 if Yes: \_\_\_\_\_

The **beneficiary has a history of safety concerns** related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.    Initial if Yes: \_\_\_\_\_

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

Practice Stamp:

Practice NPI#: \_\_\_\_\_

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

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

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

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

Sign Here

**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."*

Change of Status - Medical

**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 for all reasons):

**- PRACTITIONER FORM ENDS HERE -**

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