



Personal Care Assistance (PCA) Assessment and Service Plan

Attention. If you want free help translating this information, ask your worker.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker).

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງຖາມນຳພັນກຽມຊ່ວຍວຽກຂອງທ່ານ.

Hubaddhu. Yo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị.

LB1-0001 (10-09)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2400 or (800) 747-5484. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

PCA Assessment and Service Plan Recipient Information Page

Instructions

| |
|-------------------------|
| ASSESSMENT DATE |
| MMIS ENTRY DATE |
| ASSESSMENT MAILING DATE |
| 30-DAY NOTICE SPAN |

| | |
|----------------|-------|
| RECIPIENT NAME | PMI # |
|----------------|-------|

This is your copy of the PCA Assessment and Service Plan. You will find the details of your assessment including information about Complex Health Related Needs, Behavior Descriptions and Dependencies in Activities of Daily Living (ADLs).

The assessor completed and reviewed the assessment findings with you. The amount of daily time for your PCA services is determined according to Minnesota Statute 256B.0652, subdivision 6. A summary of your PCA assessment results is written on this page and on page 9 of this form. Please review all of the pages of this form to learn more details about the assessment.

| Home Care Rating | | Total time/day | | Consumer Support Grant Budget | |
|------------------|-------|----------------|-------|-------------------------------|--------|
| | UNITS | MINUTES | HOURS | \$ | /month |

| Overall assessment results since last assessment (Check all that apply) | What is different from your last assessment (Check all that apply) |
|---|--|
| <input type="checkbox"/> Initial Assessment <input type="checkbox"/> Same <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Termination <input type="checkbox"/> Denial | <input type="checkbox"/> You do not meet access criteria <input type="checkbox"/> You have a different Home Care Rating <input type="checkbox"/> You have less dependencies <input type="checkbox"/> You meet criteria for additional time <input type="checkbox"/> You do not meet criteria for additional time |

You will receive another letter in the mail from the Minnesota Department of Human Services. The letter is named MA Home Care Service Agreement. Here is how to read the information on the letter.

| Service Agreement # | Recipient ID | Recipient Name | Effective Date | Through Date |
|-----------------------------|---|----------------|---------------------------------|------------------------------------|
| 000000000000 | 12345678 | Doe, John | 02/1/10 | 01/31/11 |
| Unique authorization Number | Your Medical Assistance identity number | Your name | Begin date of service agreement | End date of this service agreement |

| Line NBR | Status | Procedure Code | Mod 1-4 | Procedure Description | |
|-----------------------------------|---|--|---------|--|--------------------------|
| 01 | Approved | T1019 | | Personal Care Services, 15 min | |
| | Quantity: 1,456 units | | | State Date: 2/1/10 | End Date: 7/31/10 |
| Line number on service agreement. | Service is approved or denied. Quantity is the total number of units approved. To calculate the PCA hours per day: 1. For each Line NBR, divide (÷) the Quantity units by the number of days between the Start Date and End Date = the number of units/day. 2. Divide (÷) number of units/day by 4 = number of hours/day. | Providers use the Procedure Code to bill for PCA services. Number of service units available for the time period. | | Name of Home Care Service. Start Date of the service. | End Date of the service. |

#000 Reason Code is a 3-digit number that gives a reason of action on a line number. There may be more than one reason code on a line number.



PCA Assessment and Service Plan

Instructions

| | | | | | | |
|---|--|--|--------|---|--|---|
| Assessment/Service Plan | | | | <input type="checkbox"/> INITIAL <input type="checkbox"/> REASSESSMENT | DATE OF ASSESSMENT/SERVICE PLAN | |
| REFERRAL SOURCE | | | | PHONE NUMBER | | DATE OF REFERRAL |
| Recipient (R) Information | | | | | | |
| NAME | | | | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | DATE OF BIRTH |
| ADDRESS | | | | | PMI NUMBER | |
| CITY | | STATE | COUNTY | ZIP | PHONE NUMBER | |
| ELIGIBILITY VERIFICATION DATE: ____/____/____ | | | | PROGRAM | | |
| YOU CAN VERIFY RECIPIENT ELIGIBILITY ONLINE VIA MN-ITS (HTTP://MN-ITS.DHS.STATE.MN.US) FOR UP TO 50 RECIPIENTS AT ONE TIME. | | | | <input type="checkbox"/> EH <input type="checkbox"/> IM <input type="checkbox"/> KK <input type="checkbox"/> LL <input type="checkbox"/> MA <input type="checkbox"/> NM <input type="checkbox"/> RM | | |
| PREPAID HEALTH PLAN <input type="checkbox"/> Y <input type="checkbox"/> N | | MEDICARE <input type="checkbox"/> Y <input type="checkbox"/> N | | THIRD PARTY LIABILITY (INSURANCE) <input type="checkbox"/> Y <input type="checkbox"/> N | | WAIVER/AC <input type="checkbox"/> Y <input type="checkbox"/> N |
| Physician Information | | | | | | |
| PHYSICIAN NAME | | | | CLINIC NAME | | |
| ADDRESS | | | | | PHYSICIAN PHONE NUMBER | |
| CITY | | | | | STATE | ZIP |
| PCA Provider(s) Information | | | | | | |
| AGENCY NAME | | NPI/UMPI | | AGENCY NAME | | NPI/UMPI |
| <input type="checkbox"/> PCPO <input type="checkbox"/> PCA CHOICE AGENCY <input type="checkbox"/> OTHER | | TAXONOMY CODE | | <input type="checkbox"/> PCPO <input type="checkbox"/> OTHER | | TAXONOMY CODE |
| EXPLAIN: | | | | | | |
| ADDRESS | | | | ADDRESS | | |
| CITY | | STATE | ZIP | CITY | | STATE ZIP |
| PHONE NUMBER | | FAX NUMBER | | PHONE NUMBER | | FAX NUMBER |
| Language | | | | | | |
| LANGUAGE INTERPRETER NEEDED <input type="checkbox"/> Y <input type="checkbox"/> N | | LANGUAGE SPOKEN | | | SIGN LANGUAGE INTERPRETER NEEDED <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Direct Own Care/Responsible Party (RP) | | | | | | |
| PERSON ABLE TO DIRECT OWN CARE <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNKNOWN | | | | RESPONSIBLE PARTY NAME | | PHONE NUMBER |
| IF "NO" A RESPONSIBLE PARTY MUST BE PRESENT AT THE ASSESSMENT. | | | | LIVES WITH RECIPIENT <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| RP ADDRESS | | | | CITY | | STATE ZIP |
| Recipient Specific Information | | | | | | |
| Diagnosis | | | | ICD-9-CM Code | | Date of onset if known |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| IDENTIFY LIVING ARRANGEMENT | | | | | | |
| OTHER COMMENTS ABOUT THIS REFERRAL | | | | | | |

1. Directing Own Care Determination — People must be able to direct their own care or have a Responsible Party that provides the support needed to direct the PCA care.

- ☐ Y ☐ N Can this person identify their own needs?
- ☐ Y ☐ N Can this person direct and evaluate caregiver/PCA task accomplishments?
- ☐ Y ☐ N Can this person provide and/or arrange for their health and safety?
- ☐ Y ☐ N Responsible Party is required and present for assessment.

Name of Responsible Party:

2. Diagnosis and ICD-9-CM Codes — List each medical diagnosis and ICD-9-CM code. Comments could include a new diagnosis, date of onset or exacerbation and severity.

| Diagnosis | ICD-9-CM code | Comments |
|-----------|---------------|----------|
| | | |
| | | |
| | | |

3. Health Description – Describe the person’s overall health condition and ability to function in the community including information about their living environment, sensory deficits, hospitalizations and informal support available. Indicate any changes in health status.

PCA Assessment and Service Plan

RECIPIENT NAME

PMI #

4. Medications — List all medications including nebulizer medications, oxygen and PRN medications with the route, dosage and frequency. Add additional pages if more space is needed.

| Medication | Route | Dosage | Frequency |
|------------|-------|--------|-----------|
| | | | |
| | | | |
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| | | | |

☐ Y ☐ N Needs assistance or help of another

☐ Y ☐ N Uses pill caddy

☐ Y ☐ N Needs help obtaining prescriptions

5. PCA Recommendations to DHS

RESTRICTED MA ☐ YES ☐ NO **NOTE:** If restricted, a recipient is limited to monthly use of PCA hours and must select a PCPO provider.

| | | | | |
|--|--|----------------------------|-------------------------|--------------------|
| PERSON MEETS ACCESS CRITERIA <input type="checkbox"/> YES <input type="checkbox"/> NO: | FREQUENCY CODE <input type="checkbox"/> DAILY (1) <input type="checkbox"/> FLEXIBLE (5) | | TOTAL # OF DAILY UNITS | TOTAL DAILY HOURS |
| | | | TOTAL # OF ANNUAL UNITS | TOTAL ANNUAL HOURS |
| SERVICE AGREEMENT START DATE | | SERVICE AGREEMENT END DATE | | |
| 1ST DATE SPAN T1019 | START DATE: | END DATE | PERCENT | # OF UNITS |
| 2ND DATE SPAN T1019 | START DATE: | END DATE | PERCENT | # OF UNITS |
| SUPERVISION T1019 UA | AVERAGE MONTHLY UNITS | | TOTAL ANNUAL UNITS | |

REASON CODES/COMMENTS

6. Complex Health-Related Needs — A complex health-related need is an intervention that is ordered by a physician and specified in a care plan. A PCA may or may not be able to assist with the health-related need.

O=Observed R=Reported

| Complex Health-Related Need | Y | N | Description of Need | O | R* |
|---|--------------------------|--------------------------|---------------------|---|----|
| *Tube Feeding | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| G/J Tube | | | | | |
| Continuous tube feeding lasting longer than 12 hours/day | | | | | |
| *Parenteral/IV Therapy | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| IV therapy more than two times per week lasting longer than 4 hours for each treatment | | | | | |
| Total parenteral nutrition (TPN) Daily | | | | | |
| *Wounds | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sterile or clean dressing changes or wound vac | | | | | |
| Stage III or IV wounds | | | | | |
| Multiple wounds | | | | | |
| Open lesions or sites that require specialized care such as burns, fistulas, tube sites or ostomy sites | | | | | |
| *Respiratory Interventions | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Oxygen required more than 8 hours/day or night | | | | | |
| Respiratory vest more than 1 time/day | | | | | |
| Bronchial drainage treatment more than 2 times/day | | | | | |
| Sterile or clean suctioning more than 6 times/day | | | | | |
| Dependence on another to apply respiratory ventilation augmentation devices | | | | | |
| *Catheter Insertion and Maintenance | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sterile catheter changes more than 1 time/month | | | | | |
| Clean self-catheterization more than 6 times/day | | | | | |
| Bladder irrigations | | | | | |
| *Bowel Program | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Program completed more than 2 times/week requiring more than 30 minutes to complete | | | | | |
| *Neurological Intervention | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Seizures more than 2 times/week and requires significant physical assistance to maintain safety | | | | | |
| Swallowing disorders diagnosed by a physician and requires specialized assistance from another on daily basis | | | | | |

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and Service Plan

| | |
|----------------|-------|
| RECIPIENT NAME | PMI # |
|----------------|-------|

| Complex health-related need | Y | N | Description of need | O | R |
|--|---|---|--|-------------------|---|
| *Other Congenital or Acquired Diseases <input type="checkbox"/> <input type="checkbox"/> | | | | | |
| Creates need for significantly increased direct hands-on assistance and interventions in 6 to 8 ADLs | | | | | |
| Total number of Yes answers | | | Multiply by 30 minutes = Total Time for Complex Health-Related Needs | Total Time | |

GENERAL COMMENTS

7. Behaviors — Describe any behaviors of the recipient including the description, frequency, intervention needed and how the behavior affects the person's day.



R

Y

N

*Increased vulnerability due to **cognitive** deficits or socially inappropriate behavior

***Resistive** to care, verbal aggression

*Physical **aggression** towards self, others or destruction of property

Multiply by 30 minutes = Total Time for Behaviors

Total Time

8. Activities of Daily Living — A dependency in an ADL is defined as person has a need on a daily basis for:
 1. Cuing **and** constant supervision to complete the task **or**
 2. Hands-on assistance to complete the task.

O=Observed R=Reported

| Activity | Y | N | Description of assistance needed | O | R |
|------------------------------|---|---|----------------------------------|---|---|
| Dressing | | | | | |
| Grooming/Hygiene | | | | | |
| Bathing | | | | | |
| Eating | | | | | |
| Transfers | | | | | |
| Mobility | | | | | |
| Positioning | | | | | |
| Toileting | | | | | |
| Total Number of Dependencies | | | | | |

| Determination of additional time for dependencies in the critical ADLs | Y | N |
|--|---|---|
| *Eating | | |
| *Transfers | | |
| *Mobility | | |
| *Toileting | | |

| | | | | |
|---|--|---|------------|--|
| Total number of Yes answers for critical ADLs | | Multiply by 30 minutes = Total Time for Critical ADLs | Total Time | |
|---|--|---|------------|--|

| | Y | N | U |
|---|---|---|---|
| Does the recipient live in PCA provider agency-owned or controlled housing? | | | |
| Shared services | | | |

PCA Assessment and Service Plan

RECIPIENT NAME

PMI #

Summary based on your assessment. This is a summary of the results.

1. Access to PCA Service

This person meets access criteria through: ☐ ADL dependency ☐ Level 1 Behavior

This person does not meet access criteria: ☐

2. Assessed Needs

☐ ADLs ☐ Behavior ☐ Complex health-related needs ☐ IADLs

PCA hours may be used flexibly over two 6-month periods unless a restricted recipient.

3. Authorization Summary (Enter PCA in units/minutes; Enter CSG in dollars)

| | | | |
|---|-----------|-------------|-----------|
| EN - Ventilator dependent <input type="checkbox"/> Y <input type="checkbox"/> N | units/day | minutes/day | CSG/month |
| Home care rating _____ Base = | | | \$ |
| Complex Health + Behavior + Critical Adls = Additional Additional = | | | \$ |
| Base + Additional = Total Total = | | | \$ |

4. Overall Results Since Last Assessment

Units/hours ☐ Initial ☐ Same ☐ Increase ☐ Decrease ☐ Termination ☐ Denial

☐ PCA Choice ☐ Shared Service Time at assessment In _____ Out _____

| | Consumer Yes | No | Resp. Party Yes | No | Assessor Yes | No |
|--|-----------------|----|--------------------|----|-----------------|----|
| Accurate information provided for this PCA assessment | | | | | | |
| Assessor provide verbal summary of assessment findings | | | | | | |
| Assessor answered questions | | | | | | |
| Consumer/responsible party given choice of PCA options | | | | | | |

Signature section — To complete the assessment process, your signature is needed to confirm the assessment took place.

| | | | | |
|-------------------|---------------|------------|------|-------|
| CONSUMER NAME: | | SIGNATURE: | | DATE: |
| RESP. PARTY NAME: | | SIGNATURE: | | DATE |
| RESP. PARTY NAME: | | SIGNATURE: | | DATE |
| ASSESSOR NAME: | | SIGNATURE: | | DATE |
| NAME: | RELATIONSHIP: | SIGNATURE: | DATE | |
| NAME | RELATIONSHIP | SIGNATURE: | DATE | |

Interpreter (if required)

| | | |
|---|------------|-------|
| I was present and provided interpretation for the PCA assessment. | Yes | No |
| The assessment information I provided to the assessor is an accurate interpretation of what the recipient/responsible party reported. | | |
| I used _____ language. | | |
| NAME: | SIGNATURE: | DATE: |

Recipient Referrals

| | | |
|---|--------|-------|
| RECIPIENT | | DATE |
| ASSESSOR | AGENCY | PHONE |
| OTHER PAYERS <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Private Long-term Care Insurance <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Other | | |

Assessors must recommend referrals to other payers, programs or services that may meet assessed needs more appropriately than PCA. Recipients must follow up to see if eligible for the programs and services recommended.

| Currently Receiving | Recommended | MA Home care services (Physician's orders required) | Contact |
|--------------------------|--------------------------|---|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Home health aide (Medicare-certified home health agency) | |
| <input type="checkbox"/> | <input type="checkbox"/> | Private duty nurse (PDN class A licensed or Medicare-certified agency) | |
| <input type="checkbox"/> | <input type="checkbox"/> | Skilled nurse visit (Medicare-certified home health agency) | |
| <input type="checkbox"/> | <input type="checkbox"/> | Therapies: physical, occupational, speech, respiratory (Medicare-certified home health agency) | |
| | | Other services | Contact |
| <input type="checkbox"/> | <input type="checkbox"/> | Home and community based <input type="checkbox"/> AC <input type="checkbox"/> CAC <input type="checkbox"/> CADI <input type="checkbox"/> DD <input type="checkbox"/> EW <input type="checkbox"/> TBI | |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical – primary doctor | |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical - specialist | |
| | | Mental health services | Contact |
| <input type="checkbox"/> | <input type="checkbox"/> | Adult Rehabilitative Mental Health Services (ARMHS) | |
| <input type="checkbox"/> | <input type="checkbox"/> | Children's Therapeutic Services and Supports (CTSS), therapy, skills training, crisis assistance, behavioral aide | |
| <input type="checkbox"/> | <input type="checkbox"/> | County mental health services | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental health crisis response services | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental health diagnostic and functional assessment | |
| <input type="checkbox"/> | <input type="checkbox"/> | Outpatient mental health services, individual, family and group therapy | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | |
| | | County/Community services | Contact |
| <input type="checkbox"/> | <input type="checkbox"/> | Case management/service coordination | |
| <input type="checkbox"/> | <input type="checkbox"/> | Community integration | |
| <input type="checkbox"/> | <input type="checkbox"/> | Equipment/supplies/technology | |
| <input type="checkbox"/> | <input type="checkbox"/> | Financial assistance | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospice | |
| <input type="checkbox"/> | <input type="checkbox"/> | Long-term care consultation | |
| <input type="checkbox"/> | <input type="checkbox"/> | Transportation | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | |

If you need help, contact one of the following to obtain a list of agencies in your area:

Disability Linkage Line® **(866) 333-2466** or Senior LinkAge Line® **(800) 333-2433** or

Veterans Linkage Line™ **(888) 546-5838** or visit www.minnesotahelp.info

Health Plan Contacts http://www.dhs.state.mn.us/dhs_id_056879.pdf