Clear Form

Minnesota Department of **Human Services**

DHS-3244P-ENG 7-16

Referral for Reassessment for PCA Services

DATE OF REFERRAL	DATE CURRENT SERVICE AGREEMENT ENDS	DATE OF ASSESSMENT (County assessor completes)

Recipient information

NAME	GENDER	DATE OF BIRTH	PMI NUMBER	PHONE NUMBER
	◯ Male ◯ Female			

ADDRESS	CITY	COUNTY	STATE	ZIP CODE

PRIMARY CONTACT OR RESPONSIBLE PARTY	PRIMARY CONTACT'S PHONE NUMBER	WHICH PCA SERVICE MODEL DOES THE RECIPIENT CURRENTLY USE?
		◯ Traditional PCA ◯ PCA Choice

EVS VERIFICATION DATE:
651-431-4399 OR 800-657-3613
YOU ALSO CAN VERIFY RECIPIENT ELIGIBILITY ONLINE VIA MN–ITS (HTTP://MN-ITS.DHS.STATE.MN.US) FOR UP TO 50 RECIPIENTS AT ONE TIME.

MAJOR PROGRAM (See Pg. 2 for definitions)
☐ IM ☐ KK ☐ LL ☐ MA
☐ NM ☐ RM ☐ EH ☐ BB01

PREPAID HEALTH PLAN	MEDICARE NUMBER	THIRD PARTY LIABILITY (INSURANCE) NAME	WAIVER/AC
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Physician information

PHYSICIAN NAME	PHYSICIAN CLINIC	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

PCA provider(s) information

NAME	NAME

TAXONOMY CODE	PROVIDER NPI/UMPI	TAXONOMY CODE	PROVIDER NPI/UMPI

ADDRESS	ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

PHONE NUMBER	FAX NUMBER	PHONE NUMBER	FAX NUMBER

Language

LANGUAGE INTERPRETER NEEDED	LANGUAGES SPOKEN	SIGN LANGUAGE INTERPRETER NEEDED
◯ Yes ◯ No		◯ Yes ◯ No

Direct own care/responsible party

PERSON APPEARS TO BE ABLE TO DIRECT OWN CARE	RESPONSIBLE PARTY NAME	PHONE NUMBER
◯ Yes ◯ No ◯ Unknown IF "NO" A RESPONSIBLE PARTY MUST BE PRESENT AT THE ASSESSMENT.	LIVES WITH RECIPIENT ◯ Yes ◯ No	

Recipient specific information

Diagnosis	Date of onset (if known)	ICD code

IDENTIFY LIVING ARRANGEMENT

OTHER COMMENTS ABOUT THIS REFERRAL

Instructions for Referral for Reassessment for PCA Services

PCA providers or other referral sources use this form as a referral for personal care assistance (PCA) services. Complete the form and fax or mail it to the recipient's lead agency (county, tribe or MCO). If you do not provide the required information or if the form is impossible to read, lead agency will return it to you and will result in a delay of the PCA assessment. The lead agency also can complete the form during a telephone intake by assessor. For an initial assessment, the person or their representative should contact the lead agency.

Date of referral Enter the date that the referral for PCA services is being sent to the lead agency in mm/dd/yy format. NOTE: Provider agency must request the reassessment 60 days before the current service agreement ends.

Date current service agreement ends Enter the date in mm/dd/yy format that the recipient's current PCA service agreement ends.

Date of assessment (lead agency assessor completes) Assessor must enter the date in mm/dd/yy format that the assessment was conducted.

Recipient information This section should be about the person who needs PCA services. Complete all of it.

PMI Enter the recipient's PMI. This also is known as the Medical Assistance number (MA number) or the MHCPID.

If the written agreement your agency has with the PCA recipient reflects that the person has chosen to perform all of the employer duties for their individual PCA providers, the person has chosen to use PCA Choice.

EVS verification Confirm the person's major medical program and Prepaid Health Plan through the Eligibility Verification System (EVS) via telephone or online. PCA providers must verify Medical Assistance eligibility every month. People with the following major programs are eligible to have the PCA assessment completed by the assessor and be reimbursed by Medical Assistance:

- EH – Emergency MA
- IM – Institute for mental disease
- KK and LL – MinnesotaCare
- MA – Medical Assistance
- NM – Non-citizen medical
- RM – Refugee medical.

Enter the EVS verification date in mm/dd/yy format

Enter an "x" next to the person's major program

Enter the person's Prepaid Health Plan when EVS indicates one.

Physician information Complete this entire section regarding the person's physician and clinic.

PCA provider(s) information Complete this entire section. You must enter NPI/UMPI code(s). If applicable, include location or taxonomy code in code box. Identify any second PCA provider information.

Language Complete this entire section.

Direct own care/responsible party This section allows the referral source to provide information about the person's ability to direct his or her own care. The assessor verifies this information during the assessment. If applicable, enter responsible party name and telephone number. Indicate whether the responsible party lives with the recipient.

Recipient specific information Complete this entire section. The ICD codes must be the most updated version. Indicate type of living arrangement (e.g., own home, apartment, assisted living, foster care, with family, etc.)