DHS-3244-ENG 11-09

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).

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານ.

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 nầy 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.

Minnesota Department of **Human Services**

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PCA Assessment and Service Plan

Instructions

Assessment/Service Plan

☐ INITIAL ☐ REASSESSMENT	DATE OF ASSESSMENT/SERVICE PLAN

REFERRAL SOURCE	PHONE NUMBER ( )	DATE OF REFERRAL

Recipient (R) Information

NAME	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH
ADDRESS		PMI NUMBER

CITY	STATE	COUNTY	ZIP	PHONE NUMBER ( )

ELIGIBILITY VERIFICATION DATE: ____/____/________

YOU CAN VERIFY RECIPIENT ELIGIBILITY ONLINE VIA MN–ITS (HTTP://MN-ITS.DHS.STATE.MN.US) FOR UP TO 50 RECIPIENTS AT ONE TIME.

PROGRAM ☐ EH ☐ IM ☐ KK ☐ LL ☐ MA ☐ NM ☐ RM

PREPAID HEALTH PLAN ☐ Y ☐ N	MEDICARE ☐ Y ☐ N	THIRD PARTY LIABILITY (INSURANCE) ☐ Y ☐ N	WAIVER/AC ☐ Y ☐ 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
☐ PCPO ☐ PCA CHOICE AGENCY ☐ OTHER EXPLAIN:	TAXONOMY CODE	☐ PCPO ☐ OTHER	TAXONOMY CODE

ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP

PHONE NUMBER ( )	FAX NUMBER ( )	PHONE NUMBER ( )	FAX NUMBER ( )

Language

LANGUAGE INTERPRETER NEEDED ☐ Y ☐ N	LANGUAGE SPOKEN	SIGN LANGUAGE INTERPRETER NEEDED ☐ Y ☐ N

Direct Own Care/Responsible Party (RP)

PERSON ABLE TO DIRECT OWN CARE ☐ Y ☐ N ☐ UNKNOWN IF "NO" A RESPONSIBLE PARTY MUST BE PRESENT AT THE ASSESSMENT.	RESPONSIBLE PARTY NAME LIVES WITH RECIPIENT ☐ Y ☐ N	PHONE NUMBER ( )	
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

PCA Assessment and Service Plan

RECIPIENT NAME	PMI #

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

- ☐ 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 ☐ YES ☐ NO:	FREQUENCY CODE ☐ DAILY (1) ☐ 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

RECIPIENT NAME	PMI #

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**	☐	☐			
G/J Tube					
Continuous tube feeding lasting longer than 12 hours/day					
***Parenteral/IV Therapy**	☐	☐			
IV therapy more than two times per week lasting longer than 4 hours for each treatment					
Total parenteral nutrition (TPN) Daily					
***Wounds**	☐	☐			
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**	☐	☐			
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**	☐	☐			
Sterile catheter changes more than 1 time/month					
Clean self-catheterization more than 6 times/day					
Bladder irrigations					
***Bowel Program**	☐	☐			
Program completed more than 2 times/week requiring more than 30 minutes to complete					
***Neurological Intervention**	☐	☐			
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					

PCA Assessment and Service Plan

RECIPIENT NAME	PMI #

Complex health-related need	Y	N	Description of need	O	R
***Other Congenital or Acquired Diseases**	☐	☐			
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**	

RECIPIENT NAME	PMI #

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

O=Observed R=Reported	O	R

Determination of additional time — If any of the behaviors documented above require assistance at least 4 times/week and meet any of the following descriptions, add an additional 30 minutes of time per description to the base time for the recipient. 90 minutes is the maximum time allowed.	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		

Total number of Yes answers		Multiply by 30 minutes = Total Time for Behaviors	**Total Time**	

PCA Assessment and Service Plan

RECIPIENT NAME	PMI #

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 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 ☐ Y ☐ N		units/day	minutes/day	CSG/month
Home care rating ________	Base =			$
	Additional =			$
Base + additional = total	Total =			$

4. Overall Results Since Last Assessment

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

☐ PCA Choice ☐ Shared Service | Time at assessment In________ Out________

	Consumer Yes	Consumer No	Resp. Party Yes	Resp. Party No	Assessor Yes	Assessor 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)

	Yes	No
I was present and provided interpretation for the PCA assessment.		
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 ☐ Medicare ☐ Private Health Insurance ☐ Private Long-term Care Insurance ☐ Veterans Benefits ☐ Workers' Compensation ☐ 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**
☐	☐	Home health aide (Medicare-certified home health agency)	
☐	☐	Private duty nurse (PDN class A licensed or Medicare-certified agency)	
☐	☐	Skilled nurse visit (Medicare-certified home health agency)	
☐	☐	Therapies: physical, occupational, speech, respiratory (Medicare-certified home health agency)	

		Other services	**Contact**
☐	☐	Home and community based ☐ AC ☐ CAC ☐ CADI ☐ DD ☐ EW ☐ TBI	
☐	☐	Medical – primary doctor	
☐	☐	Medical - specialist	

		Mental health services	**Contact**
☐	☐	Adult Rehabilitative Mental Health Services (ARMHS)	
☐	☐	Children's Therapeutic Services and Supports (CTSS), therapy, skills training, crisis assistance, behavioral aide	
☐	☐	County mental health services	
☐	☐	Mental health crisis response services	
☐	☐	Mental health diagnostic and functional assessment	
☐	☐	Outpatient mental health services, individual, family and group therapy	
☐	☐	Other	

		County/Community services	**Contact**
☐	☐	Case management/service coordination	
☐	☐	Community integration	
☐	☐	Equipment/supplies/technology	
☐	☐	Financial assistance	
☐	☐	Hospice	
☐	☐	Long-term care consultation	
☐	☐	Transportation	
☐	☐	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**