HealthPartners

PCA ASSESSMENT REQUEST / REFERRAL

Utilization Management Department
Phone Number: 952-883-7775
Fax Number: 952-853-8744 Attn: Service Coordinator

☐ Initial ☐ Annual ☐ Early assessment
Supplemental? ☐ Yes ☐ No

NAME: _____

DOB: _____ ☐ M ☐ F

HealthPartners ID #: _____

☐ Lives alone ☐ Lives with PCA
☐ Lives with others ☐ Family foster home

Address: _____
City: _____
State: _____ Zip: _____

Home Phone: _____
Primary Contact: _____
Phone: _____
Primary Doctor: _____
Primary Clinic: _____
Phone: _____
Fax #: _____
Address: _____
City: _____ State: ____ Zip: _____

Diagnosis for PCA Service	ICD-10 code
Primary:	

Language spoken: _____

Interpreter needed: ☐ Yes ☐ No
Sign language interpreter needed: ☐ Yes ☐ No
Hospitalization/Skilled Nursing Facility since last assessment? ☐ Yes ☐ No

Appears to be able to direct own care: ☐ Yes ☐ No
If No, responsible party MUST be present at the assessment.

Responsible Party Name: _____
Relationship: _____
Phone: _____

Is this member currently receiving PCA services?
☐ Yes ☐ No
If *Yes*: Current PCA _____ units/day
Authorization period: _____
Current home care services: ☐ SNV ☐ PT ☐ OT ☐ None
☐ HHA ☐ EW ☐ Homemaking/Chores
How often? ☐ Weekly ☐ Bi-weekly ☐ Monthly
Other _____

PCA VENDOR: _____
Medicare certified: ☐ Yes ☐ No
Address: _____
City: _____ State: ____ Zip: _____
Tax ID#: _____
Phone: _____
Fax: _____
Qualified Prof: _____
Credentials: _____
PCA(s) name: (1) _____
(2) _____
Relationship to member (1) _____
(2) _____
Case Manager's name: _____
Case Manager's phone # _____
Today's date: _____
Completed by _____
Nurse reviewer initials: _____