Clear Form Data
FILLABLE FORM

DHS-3244P-ENG 10-08

Minnesota Department of Human Services

Referral for PCA Services

DATE OF REFERRAL	☐ INITIAL ASSESSMENT OR ☐ REASSESSMENT	DATE CURRENT SERVICE AGREEMENT ENDS	DATE OF ASSESSMENT (County assessor completes)

Recipient information

NAME			GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH
ADDRESS				PMI NUMBER
CITY	COUNTY	STATE	ZIP	PHONE NUMBER
PRIMARY CONTACT/RESPONSIBLE PARTY				PHONE NUMBER

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

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

PREPAID HEALTH PLAN ☐ Y ☐ N	MEDICARE NUMBER ☐ Y ☐ N	THIRD PARTY LIABILITY (INSURANCE) NAME ☐ Y ☐ N	WAIVER/AC ☐ Y ☐ N

Physician information

PHYSICIAN NAME	PHYSICIAN CLINIC		
ADDRESS			
CITY	STATE	ZIP	PHONE NUMBER

PCA provider(s) information

NAME	PROVIDER NPI/UMPI	NAME	PROVIDER NPI/UMPI
☐ PCPO ☐ PCA CHOICE AGENCY ☐ OTHER	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

PERSON APPEARS TO BE 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

Recipient specific information

Diagnosis	Date of Onset (if known)	ICD-9-CM

IDENTIFY LIVING ARRANGEMENT:

OTHER COMMENTS ABOUT THIS REFERRAL:

Instructions for Referral for PCA Services:

This form is designed to be used as a referral form for Personal Care Assistance (PCA) services. A referral for a PCA assessment can be completed in several ways. PCA providers or other referral sources must complete the form and fax or mail it to the recipient's county. If you do not provide the information required on the form or it is impossible to read, the form will be returned to you and/or will result in a delay of the PCA assessment. The county can also complete the form during a telephone intake by assessor.

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

Initial assessment or reassessment: Enter an "x" for whether this is a referral for an initial assessment or a reassessment.

Date current service agreement ends: If an "x" is entered for reassessment, enter the date in mm/dd/yy format that the recipient's current PCA Service Agreement ends.

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

Recipient information: Complete this section in its entirety regarding the person who is in need of PCA services.

> **PMI:** Enter the recipient's PMI. Also know as Medical Assistance number (MA number) or also known as, MHCPID.
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> **EVS verification:** Confirm the person's major medical program and Prepaid Health Plan through the Eligibility Verification System (EVS) the telephone or online. PCA providers must verify Medical Assistance eligibility every month. Persons 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 section in its entirety regarding the person's physician and clinic.

PCA provider(s) information: Complete this section in its entirety. Indicate if you are a PCA provider, a PCPO and/or PCA choice provider agency, by entering an "x" identifying which type of provider. Must enter NPI/UMPI code(s). If applicable location or taxonomy code in code box. Identify any second PCA provider information.

Language: Complete this section in its entirety.

Direct own care/responsible party: This section allows the referral source to provide information about the person's ability to direct their own care. This information is verified by the assessor 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 section in its entirety. The ICD-9-CM codes must be the most updated version. Indicate type of living arrangement, ex. own home, apartment, assisted living, foster care, with family, etc. Indicate if there is a current qualified professional (QP) and describe services performed and amount of time used in the comment section.