



Minnesota Department of Human Services

# Personal Care Assistance (PCA) Assessment and Service Plan

**651-431-4300 or 866-267-7655**

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntauv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໄປຮອດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-4300 toll-free 866-267-7655, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

# PCA Assessment and Service Plan Recipient Information Page

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

## Instructions

RECIPIENT NAME	PMI #
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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 on this page and on page 11 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)	
<b>Assessment</b> <input type="checkbox"/> Initial <input type="checkbox"/> Approve <input type="checkbox"/> Deny	<b>Reassessment</b> <input type="checkbox"/> Same <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Termination	<b>Service Update</b> <input type="checkbox"/> Same	<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	

If you are enrolled with a managed care plan, you will receive a letter in the mail from your managed care plan. Please contact your managed care plan if you have questions about that letter. If you are not enrolled in a managed care plan you will receive a letter in the mail from the Minnesota Department of Human Services. The letter from DHS is named MA Home Care Service Agreement. Here is an example of how to read the information on that letter.

Service Agreement #	Recipient ID	Recipient Name	Effective Date	Through Date
(Sample) 0000000000	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

<b>Assessment/Service Plan</b>		<input type="checkbox"/> INITIAL	<input type="checkbox"/> REASSESSMENT	DATE OF ASSESSMENT/SERVICE PLAN	
REFERRAL SOURCE		PHONE NUMBER		DATE OF REFERRAL	
<b>Recipient (R) Information</b>					
NAME			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH
ADDRESS				PMI NUMBER	
CITY	STATE	COUNTY		ZIP	PHONE NUMBER
<b>ELIGIBILITY VERIFICATION</b> 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 <input type="checkbox"/> BB01		
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	
<b>Physician Information</b>					
PHYSICIAN NAME			CLINIC NAME		
ADDRESS				PHYSICIAN PHONE NUMBER	
CITY			STATE	ZIP	
<b>PCA Provider(s) Information</b>					
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	
EXPLAIN:				TAXONOMY CODE	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		PHONE NUMBER	
				FAX NUMBER	
<b>Language</b>					
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	
<b>Direct Own Care/Responsible Party (RP)</b>					
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
<b>Recipient Specific Information (Must be completed)</b>					
<b>Diagnosis: list primary diagnosis first</b>		<b>Comments</b>		<b>ICD Code</b>	
OTHER COMMENTS ABOUT THIS REFERRAL					

ASSESSMENT DATE	RECIPIENT NAME	PMI #
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**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.
- Y  N Is this a new responsible party since the last assessment?

**2. 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, new diagnosis, date of onset or exacerbation, and severity. Ask for demonstration and document thorough description of observation.



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**5. 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. NOTE: When typing text in the box, watch to keep the text within the size of the box. When additional text is needed, continue the text in the comment space at the end of this section. Be sure to identify the text with the complex health-related need.

O=Observed R=Reported

Complex Health-Related Need	Y	N	Description of Need	O	R*
<b>*Tube Feeding</b>	<input type="checkbox"/>	<input type="checkbox"/>			
Gastrojejunostomy Tube (G-J Tube)					
Continuous tube feeding lasting longer than 12 hours/day					
<b>*Parenteral/IV Therapy</b>	<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					
<b>*Wounds</b>	<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					
<b>*Respiratory Interventions</b>	<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					

**PCA Assessment  
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Complex Health-Related Need	Y	N	Description of need	O	R
<b>*Catheter Insertion and Maintenance</b> <input type="checkbox"/> <input type="checkbox"/>					
Sterile catheter changes more than 1 time/month					
Clean self-catheterization more than 6 times/day					
Bladder irrigations					
<b>*Bowel Program</b> <input type="checkbox"/> <input type="checkbox"/>					
Program completed more than 2 times/week requiring more than 30 minutes to complete					
<b>*Neurological Intervention</b> <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					
<b>*Other Congenital or Acquired Diseases</b> <input type="checkbox"/> <input type="checkbox"/>					
Creates need for <b>significantly increased direct hands-on assistance and interventions</b> in 6 to 8 ADLs					

Recipient has 2 or more ADLs <input type="checkbox"/> Y <input type="checkbox"/> N				
<b>Total number of Yes answers</b>		Multiply by 30 minutes = Total Time for Complex Health-Related Needs <b>(Only applies if recipient has 2 or more ADLs)</b>	<b>Total Time</b>	

**Comments on complex health-related needs**

ASSESSMENT DATE	RECIPIENT NAME	PMI #
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**6. Behaviors** — Describe any behaviors of the recipient including the description, frequency, intervention needed and how the behavior affects the person’s day.

Behaviors and Descriptions	O	R*
Presence of Level I Behavior: physical aggression toward self, others or destruction of property that requires the immediate response of another person. <span style="float: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</span>		
Describe Level I Behavior		
Describe increased vulnerability due to cognitive deficits or social inappropriate behavior		
Describe resistive to care, verbal aggression		

Determination of additional time	Y	N
— Do any of the behaviors documented above require assistance at least 4 times/week? If so, add an additional 30 minutes of time per description to the base time for the recipient. 90 minutes is the maximum time allowed.		
*Increased vulnerability due to <b>cognitive</b> deficits or socially inappropriate behavior		
* <b>Resistive</b> to care, verbal aggression		
*Physical <b>aggression</b> towards self, others or destruction of property that requires the immediate response of another person		

Recipient has 2 or more ADLs <input type="checkbox"/> Y <input type="checkbox"/> N			
<b>Total number of Yes answers</b>		Multiply by 30 minutes = Total Time for Behaviors (Only applies if recipient has 2 or more ADLs)	<b>Total Time</b>

**PCA Assessment  
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**7. Activities of Daily Living** – Dependency in an ADL means a person requires assistance to begin and complete the activity and has a need on a daily basis or needs on the days during the week the activity is completed for:

1. Cuing **and** constant supervision to complete the task **or**
2. Hands-on assistance to complete the task.

NOTE: When typing text in the box, watch to keep the text within the size of the box. When additional text is needed, continue the text in the comment space at the end of this section. Be sure to identify the text with the ADLs.

O=Observed R=Reported

Activity	Y	N	Description of assistance needed	O	R
Dressing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Grooming/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
*Eating	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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Activity	Y	N	Description of assistance needed	O	R
*Transfers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
*Mobility	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Positioning	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
*Toileting	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Total Number of Dependencies					

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

Recipient has 2 or more ADLs  Y  N

<b>Total number of Yes answers for critical ADLs</b>		Multiply by 30 minutes = Total Time for Critical ADLs (Only applies if recipient has 2 or more ADLs)	<b>Total Time</b>	
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**General Comments**

Please provide additional details, observations and explanations regarding any change since the previous assessment. Focus on health status, dependencies, denial, reduction or termination of services.

	Y	N	U
Does the recipient live in PCA provider agency-owned or controlled housing?			
Shared services			
Referrals to other services completed	<input type="checkbox"/> Yes <input type="checkbox"/> N/A		

# PCA Assessment and Service Plan

ASSESSMENT DATE	RECIPIENT NAME	PMI #
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## Summary based on your assessment. This is a summary of the results.

### 1. Access to PCA Service

This person meets access criteria through:  1 ADL dependency and/or Level 1 Behavior  
 2 or more ADL dependencies

This person does not meet access criteria:

### 2. Covered PCA Service Areas

ADLs  Behaviors  Health-related needs  IADLs (\*For children under age 18, see instructions.)

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)

Select only <b>one</b> home care rating below:	units/day	minutes/day	CSG/month
LT – Home care rating <input type="checkbox"/> Y <input type="checkbox"/> N (2 units/30 minutes maximum)			\$
Home care rating _____ <input type="checkbox"/> Y <input type="checkbox"/> N Base =			\$
<b>Complex Health + Behavior + Critical ADLs = Additional</b> Additional =			\$
EN – Ventilator dependent <input type="checkbox"/> Y <input type="checkbox"/> N (112 units/1680 minutes maximum)			\$
<b>Total =</b>			\$

### 4. Overall Results Since Last Assessment

**Units/hours**  Initial  Same  Increase  Decrease  Termination  Denial  
 PCA Choice  Shared Service Time at assessment In \_\_\_\_\_ Out \_\_\_\_\_  Phone Service Update

	Consumer		Resp. Party		Assessor	
	Yes	No	Yes	No	Yes	No
Accurate information provided for this PCA assessment						
Assessor provided 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 and you were given information about other services that might meet your needs.

CONSUMER NAME	SIGNATURE	DATE	
RESP. PARTY NAME	SIGNATURE	DATE	
RESP. PARTY NAME	SIGNATURE	DATE	
ASSESSOR NAME	SIGNATURE	DATE	
NAME	RELATIONSHIP	SIGNATURE	DATE

	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 <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 and initiate referrals to other payers, programs or services that may meet assessed needs more appropriately than PCA. Recipients are responsible to follow-up on the recommendations.

Currently Receiving	Recommended	<b>MA Home care services</b> (Physician's orders required)	<b>Contact</b>
<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

		<b>Other services</b>	<b>Contact</b>
<input type="checkbox"/>	<input type="checkbox"/>	Home and community-based <input type="checkbox"/> AC <input type="checkbox"/> BI <input type="checkbox"/> CAC <input type="checkbox"/> CADI <input type="checkbox"/> DD <input type="checkbox"/> EW	
<input type="checkbox"/>	<input type="checkbox"/>	Medical – primary doctor	
<input type="checkbox"/>	<input type="checkbox"/>	Medical - specialist	
<input type="checkbox"/>	<input type="checkbox"/>	Occupational therapy evaluation	

		<b>Mental health services</b>	<b>Contact</b>
<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	

		<b>County/Community services</b>	<b>Contact</b>
<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](http://www.minnesotahelp.info)

Health Plan Contacts [http://www.dhs.state.mn.us/dhs\\_id\\_056879.pdf](http://www.dhs.state.mn.us/dhs_id_056879.pdf)