

HSCSN Personal Care Aide (PCA) Referral Form
Please complete the information and fax to HSCSN at 202-721-7190

I. MEMBER INFORMATION			
Member Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Ht	Wt
Member ID:	Date of Birth:		
Primary Diagnosis :			
Treating Diagnosis/ICD 9 Code for Home Care:			
II. OTHER PERTINENT CLINICAL INFORMATION			
III. REQUESTING PROVIDER INFORMATION (MD or NP): Please Print			
Provider Name		Phone	
Address			
City	State	ZIP	
Provider Signature		Date	
IV. REASON FOR REFERRAL			
<p>HSCSN requires an initial and periodic assessment of the enrollee by a Home Health RN to determine personal care aide needs in the home. Based on Medicaid regulations and medical necessity requirements, the enrollee must have a documented need for home care; services cannot be authorized for convenience or babysitting.</p> <p>Upon receipt and review of the completed Home Health RN assessment, the HSCSN Home Health nursing staff will send the RN assessment to the treating provider with an order indicating the level of care, number of hours and schedule, as determined by the assessment. The treating provider will review, sign and date the order with modifications as needed.</p> <p>Indicate the service(s) being requested:</p> <p><input type="checkbox"/> Personal Care Aide (PCA)- services not related to a behavioral health condition provided by non-licensed staff to assist with basic personal care services, including bathing, grooming, toileting, feeding, and mobility. If enrollee requires assistance related to his/her behavioral health needs please complete the BH Home Services Form.</p> <p>Comments: _____</p> <p><input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Social Work</p> <p>Comments: _____</p>			
<p>This referral form does not guarantee approval for PCA services. The Physician will be sent the outcome of the RN assessment and recommendations by fax, within 72 hours of completion of the assessment. Please contact the HSCSN UM Department 202-467-2737 if you have any questions about the referral or form.</p>			

HSCSN Home Care Order

Instructions: Please complete the information and fax to HSCSN at 202-721-7190

I. PATIENT INFORMATION			
Enrollee Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Enrollee ID:	Date of Birth:	Height:	Weight:
Primary Diagnosis :			
Treating Diagnosis/ICD 9 Code for Home Care:			
Date of RN Assessment: _____ <input type="checkbox"/> Initial <input type="checkbox"/> 6 Month Reassessment			
II. RECOMMENDATIONS (RN Assessment Attached)			
<input type="checkbox"/> PCA Hours/day _____ # Days/Wk _____ Dates of Service: _____ to _____			
<input type="checkbox"/> Additional evaluation(s)/service(s) recommended based on RN assessment of enrollee:			
<input type="checkbox"/> PT _____ <input type="checkbox"/> OT _____ <input type="checkbox"/> ST _____			
<input type="checkbox"/> SW _____			
<input type="checkbox"/> Behavioral Health Home Services _____			
If you wish to discuss the Personal Care Aide or other recommendations, please call 202-467-2737 to speak with a Physician Reviewer.			
PROVIDER NAME (MD or NP): Print		Signature/ Date:	
Phone Number:			