



Minnesota Department of Human Services

# 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, ຈົ່ງຖາມນຳພັນກາງານຊ່ວຍວຽກຂອງທ່ານ.

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 này miễn phí, xin gọi nhân-viên xã-hội của quý vị.

LBI-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.



# 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	

### Recipient (R) Information

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

### 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
<input type="checkbox"/> PCPO <input type="checkbox"/> PCA CHOICE AGENCY <input type="checkbox"/> OTHER	TAXONOMY CODE	<input type="checkbox"/> PCPO <input type="checkbox"/> OTHER	TAXONOMY CODE
EXPLAIN:		ADDRESS	
ADDRESS		ADDRESS	
CITY	STATE   ZIP	CITY	STATE   ZIP
PHONE NUMBER (   )	FAX NUMBER (   )	PHONE NUMBER (   )	FAX NUMBER (   )

### Language

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
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### Direct Own Care/Responsible Party (RP)

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

### Recipient Specific Information

Diagnosis	ICD-9-CM Code	Date of onset if known

IDENTIFY LIVING ARRANGEMENT
OTHER COMMENTS ABOUT THIS REFERRAL

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.

<input type="checkbox"/> Y <input type="checkbox"/> N	Can this person identify their own needs?
<input type="checkbox"/> Y <input type="checkbox"/> N	Can this person direct and evaluate caregiver/PCA task accomplishments?
<input type="checkbox"/> Y <input type="checkbox"/> N	Can this person provide and/or arrange for their health and safety?
<input type="checkbox"/> Y <input type="checkbox"/> 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.



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RECIPIENT NAME	PMI #
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**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*
<b>*Tube Feeding</b>	<input type="checkbox"/>	<input type="checkbox"/>			
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					
<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					

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Complex health-related need	Y	N	Description of need	O	R
<b>*Other Congenital or Acquired Diseases</b>	<input type="checkbox"/>	<input type="checkbox"/>			
Creates need for significantly increased direct hands-on assistance and interventions in 6 to 8 ADLs					
<b>Total number of Yes answers</b>			Multiply by 30 minutes = Total Time for Complex Health-Related Needs	<b>Total Time</b>	

RECIPIENT NAME	PMI #
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**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

<b>Determination of additional time</b> — 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 <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		

<b>Total number of Yes answers</b>		Multiply by 30 minutes = Total Time for Behaviors	<b>Total Time</b>
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**PCA Assessment and Service Plan**

RECIPIENT NAME	PMI #
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**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		

<b>Total number of Yes answers for critical ADLs</b>		Multiply by 30 minutes = Total Time for Critical ADLs	<b>Total Time</b>	
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	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 #
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## 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 <input type="checkbox"/> Y <input type="checkbox"/> N		<b>units/day</b>	<b>minutes/day</b>	<b>CSG/month</b>
Home care rating _____	Base =			\$
	Additional =			\$
<b>Base + additional = total</b>	<b>Total =</b>			\$

### 4. Overall Results Since Last Assessment

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

PCA Choice  Shared Service | Time at assessment In \_\_\_\_\_ Out \_\_\_\_\_

	Consumer		Resp. Party		Assessor	
	Yes	No	Yes	No	Yes	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)

I was present and provided interpretation for the PCA assessment.	Yes	No
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 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
<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"/> CAC <input type="checkbox"/> CADI <input type="checkbox"/> DD <input type="checkbox"/> EW <input type="checkbox"/> TBI	
<input type="checkbox"/>	<input type="checkbox"/>	Medical – primary doctor	
<input type="checkbox"/>	<input type="checkbox"/>	Medical - specialist	
		<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)