



Physician Statement of Need For Personal Care Assistant Services

Purpose: This form is required by law to establish that Personal Care Assistance (PCA) services for an individual are medically necessary. The form is required annually for ongoing services and any time an individual has a change in medical condition affecting service needs. The amount of PCA services needed (identifying the number of hours of service) is determined by a county PHN or Case Manager through an assessment conducted in the person's home. Failure to return this form to the PCA provider could result in the delay of services to the individual (Minnesota Statutes 256B.0625, Subd. 19c and 256B.0655, Subd. 1b).

PCA is a home care service benefit under Medicaid available to people of all ages. Eligible people include individuals with physical disabilities, chronic diseases, behavioral diagnoses and mental illness. Services are delivered by a personal care assistant and may be provided in the person's own home or in the community. PCA services can provide a range of assistance and support services. Services and supports can include:

- Assistance with activities of daily living (ADL's) such as bathing, dressing, and grooming
- Instrumental activities of daily living (IADL's) such as meal preparation and housekeeping
- Health related tasks that can be delegated, under state law, by a licensed health care professional
- Redirection and intervention for behavior including observation and monitoring.

For more information on PCA program:
http://www.dhs.state.mn.us/id_000847.hcsp

PCA Provider complete this section

PATIENT NAME (Last, First, Middle Initial)		DOB	MA ID# (PMI#)		MEDICARE ID#
ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE #
PATIENT'S PHYSICIAN NAME		CLINIC TELEPHONE #		CLINIC FAX #	
PATIENT'S CLINIC NAME		PATIENT'S CLINIC ADDRESS			

Physician return completed form to PCA provider at:

PCA PROVIDER NAME, MAILING ADDRESS AND/OR FAX #:

Physician complete this section (*Nurse Practitioner or Physicians Assistant may also complete form)

LENGTH OF TIME PATIENT IN YOUR CARE		DATE OF LAST OFFICE VISIT			
Does the patient listed above have a diagnosis or condition that results in need for PCA?					
<input type="checkbox"/> YES If yes, complete form and return to PCA provider in above box.			<input type="checkbox"/> NO If no, complete form and Fax to DHS at (651) 431-7473		
Diagnosis List ICD – 9 Codes:					
1ST	2ND	3RD	OTHER		
Please write a description of this patient's need for PCA service (DO NOT PRESCRIBE an hourly amount) OR reason(s) PCA services are not appropriate for this patient:					
PRINT PHYSICIAN NAME*		PHYSICIAN SIGNATURE*			DATE

To report suspected fraud or abuse of Medicaid services call SIRS Hotline: (651) 431-2650
For help with locating services call Disability Linkage Line: (866) 333-2466