



Minnesota Department of **Human Services**

PCA Provider Request Form for MA Health Status Assessment

PCA providers may complete this form and submit it to the county PHN to request a PCA assessment.

Please check: Initial Reassessment Service Update Flexible Shared Care

Client Name _____ Address _____ City _____ State _____ Zip _____ DOB ____/____/____ Client Telephone _____ County of Residence _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Referral _____ Current PA Exp. Date _____ PMI # _____ Medicare # / SS # _____ Private Insurance (TPL) _____ _____
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Legal Guardian/Primary Contact _____ Relationship _____ Phone (Home) _____ (Work) _____	Primary Language Spoken _____ Interpreter Needed <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter Name _____ Phone _____
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Physician _____ Phone _____
 Physician Address _____

PCA Agency _____ Phone _____
 PCA Agency Contact _____ Provider ID # _____

Diagnosis	Date of Onset of Exacerbation	ICD-9-CM	Severity Rating			
			0	1	2	3
a.			0	1	2	3
b.			0	1	2	3
c.			0	1	2	3
d.			0	1	2	3

Referred by (if not PCA agency) _____ Phone _____
 Comments _____

Space below is to be completed by county public health nurse only

Personal Care Attendant	X5645	RN Supervision	X4037
Start/End Date		Start/End Date	
Total Units/Year		Total Units/Year	
Last _____ First _____		Phone _____ Assessment Date _____	