

**PCA ASSESSMENT REQUEST FORM**

Incomplete or illegible forms will be returned to sender. Please complete the entire form. All information is required in order for UCare to initiate the process for either an initial PCA Assessment or PCA Reassessment.

Today's Date:

CURRENT MEMBER INFORMATION			
First Name:		Member's UCare ID #:	
Last Name:		PMI:	
Address:		Phone #:	
City:		Zip Code:	
Diagnosis:		ICD-9:	
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	DOB:
<i>*If a Responsible Party (RP) is required the DHS-5856 form must be completed and on file. The RP must be present during Face to Face PCA Assessment. The PCA Caregiver cannot be appointed as the Responsible Party.*</i>			
Responsible Party:		Relationship:	
Responsible Party Phone #:			

CURRENT AUTHORIZATION INFORMATION			
<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Annual Reassessment	<input type="checkbox"/> Early Assessment due to Change in Condition *Supporting Medical Documentation Required*	
*Is member enrolled in a HCBS Wavier Program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current UCare Auth No:		Start Date:	End Date:
Current PCA Hours Approved:			
PCA Provider Name:		Provider UCare ID #:	
Request Sent By:		Title:	
Phone #:		Fax #:	

PHYSICIAN INFORMATION			
Ordering Physician Name:		Last MD Exam:	
Primary Care Clinic:		Phone #:	
Address:		Fax #:	

ASSESSMENT SCHEDULING AND CONTACT INFORMATION			
Appointment Contact:		Phone #:	
Relation to Member:		Best Time To Contact:	
Interpreter Needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language:	
Additional Information:			

PLEASE FAX OR MAIL COMPLETED FORM TO:	
PCA Fax Line: 612-884-2094	UCare Clinical Services P.O. Box 52 Minneapolis, MN 55440-0052 Phone: 612-676-6705 Toll Free: 1-877-523-1515

Instructions

1. Fill in all sections of the request form. Incomplete or illegible forms will be returned to sender.
2. For annual reassessments, complete and send this form at least 60 days prior to the end of the PCA authorization. *(MN Statute 256B.0659 Subd. 24. (14) - request reassessment at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner.)*
3. Provide updated member and physician information.
4. Fax completed form to:

PCA Fax Line 612-884-2094

OR

Mail completed form to:

UCare, Clinical Services

P.O. Box 52

Minneapolis, MN 55440-0052

Phone: 612-676-6705 or 1-877-447-4384

5. Please allow 30 days for assessment to be completed by the Public Health Nurse.