Reset Form

MassHealth Evaluation for Personal Care Attendant (PCA) Services

Consumer Name: _____ **Communication Difficulties** _____

Site of Evaluation: _____ **Date of Evaluation**: _____ **Type of Evaluation**: ☐ Initial ☐ Re-eval

List of Medications†: _____

Evaluators should consult 130 CMR 422.410 for a definition of the ADLs and IADLs described below.

Day/Evening PCA Activity-ADLs (6:00 A.M. – Midnight)	**Status***	**PCA Time (in Mins.)**	**Frequency**		**Total Mins. per Week**	**Equipment Used**	**Comments (attach additional sheet if needed)**
			Day	**Week**			
Mobility – Transfers (specify type and level)							
Assistance with Medications							
Bathing (includes transfers) Tub							
Bed Bath							
Shower							
Washing Hair							
General Grooming							
Dressing							
Undressing							
Weekly Day/Evening PCA Minutes Subtotal (Page 1):							

† **Attach additional sheet if necessary**

* I = Independent; A = Physical Assistance Required; D = Dependent

MassHealth Evaluation for Personal Care Attendant (PCA) Services (cont.)

Consumer Name: _____ **Date of Evaluation**: _____

Day/Evening PCA Activity-ADLs (6:00 A.M. – Midnight)	**Status***	**PCA Time (in Mins.)**	**Frequency**		**Total Mins. per Week**	**Equipment Used**	**Comments** (attach additional sheet if needed)
			Day	**Week**			
Passive Range of Motion (ROM) UEs							
LEs							
Eating							
Bladder Care (specify type)							
Bowel Care (specify type)							
Weekly Day/Evening PCA Minutes Subtotal (Page 2):							

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MassHealth Evaluation for Personal Care Attendant (PCA) Services (cont.)

Consumer Name: _____ **Date of Evaluation**: _____

Day/Evening PCA Activity-IADLs (6:00 A.M. – Midnight)	Status*	PCA Time (in Mins.)	Frequency		Total Mins. per Week	Equipment Used	Comments (attach additional sheet if needed)
			Day	Week			
Laundry							
Shopping							
Housekeeping							
Meal Preparation and Clean-up							
Other (specify)							

Weekly Day/Evening IADL Minutes Subtotal (Page 3):	
Weekly Day/Evening ADL minutes (page 1+2)	
Total Weekly Day/Evening PCA minutes:	
Total Weekly Day/Evening PCA Hours (Round up to nearest 15-minute unit. For example, 23.3=23.5; 42.7=42.75.):	

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MassHealth Evaluation for Personal Care Attendant (PCA) Services (cont.)

Consumer Name: _____ **Date of Evaluation**: _____

Night PCA Activity (repositioning, toileting, etc. — specify below)

Night PCA Activity (Midnight - 6:00 A.M) (describe the ADL for which physical assistance is needed)	**Status***	**PCA Time (in Mins.)**	**Frequency per Night**	**Total Mins. per Night**	**Equipment Used**	**Comments (attach additional sheet if needed)**

Total PCA Minutes per Night:	
Total Billable Hours per Night (round up to nearest hour — enter "2" if less than two hours):	
Total Weekly Billable Night PCA Hours	

Case Summary/Additional Comments:

Day/evening PCA hours requested per week: _____ Night PCA hours requested per night _____

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MassHealth Evaluation for Personal Care Attendant (PCA) Services (cont.)

Consumer Name: _____ **Date of Evaluation**: _____

Evaluator Signoffs

Requested PCA Activity Time

We confirm that the consumer meets the criteria of the MassHealth PCA Program and requires physical assistance for the following number of hours of PCA activity time:

Day/evening PCA hours requested per week: _____ Night PCA hours (if any) requested per night: _____

Surrogate (check only one of the two boxes below) I/we have conducted an assessment of the consumer's ability to independently manage the PCA program in accordance with 130 CMR 422.422(A) and have determined that:

☐ Based on our assessment, the consumer appears to have the necessary cognitive and emotional ability and skills to perform all of the tasks of managing PCA services and ***does not require a surrogate***.

☐ Based on our assessment, the consumer does not have the necessary cognitive or emotional ability and skills to perform some or all of the tasks of managing PCA services and ***requires a surrogate***.

Surrogate name, address, and phone number: _____

_____

_____

Surrogate's relationship to consumer: _____

Print Name and title of assessor: _____

Signatures

Occupational Therapist Evaluator: _____ Date: _____

Registered Nurse Evaluator: _____ Date: _____

I was evaluated in person and I have reviewed this evaluation:

Consumer or legal guardian signature (include surrogate signature as appropriate):

_____ Date: _____

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MassHealth Evaluation for Personal Care Attendant (PCA) Services (cont.)

Consumer Name: _____ **Date of Evaluation**: _____

Physician or Nurse Practitioner Signoff

Enclosed is (Check One):

- ☐ **documentation of verbal authorization from physician or nurse practitioner in accordance with 130 CMR 422.416(A)(4)(b). The PCA agency must obtain physician or nurse practitioner signoff within 60 days after the request for prior authorization is sent to MassHealth; or**
- ☐ **physician or nurse practitioner sign-off (see below).**

I understand that a MassHealth PCA consumer must have a long-term, chronic disability that results in a need for physical assistance with two or more of the following activities of daily living: mobility; assistance with medications; bathing or grooming; dressing/undressing; range of motion; eating and toileting. In my opinion the consumer meets these criteria. I find the consumer is medically appropriate for nonskilled PCA services and is sufficiently medically and emotionally stable to benefit from PCA services. The consumer is able to direct his or her own care or has a surrogate who accepts formal responsibility to direct the care.

☐ **The consumer requires _____hours per week of day/evening PCA services.**

☐ **The consumer requires _____ hours per week of night PCA services (from midnight to 6:00 A.M.)**

Physician or nurse practitioner signature: _____ **Date:** _____

Name of physician ☐ or nurse practitioner ☐ (print): _____ **Date:** _____

Physician/nurse practitioner address:_____

_____

Telephone number: _____

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MassHealth Evaluation for Personal Care Attendant (PCA) Services (cont.)

Consumer Name: _____ **Date of Evaluation**: _____

Occupational Therapy Functional Status Report

An occupational therapist (OT) must complete this form for all initial evaluations for PCA services and for reevaluations for PCA services when the consumer's medical condition or functional status has changed.

1. How does the consumer's diagnosis manifest as a disabling condition?

2. How does the consumer's disability affect his or her ability to perform ADLs and IADLs?

3. What is the level of assistance required to complete ADLs?

4. Describe the consumer's functional status, including specific level of assistance required for transfers, if applicable.

5. Has the consumer been evaluated for adaptive equipment or assistive devices? ☐ Yes ☐ No If yes, describe results of evaluation.

OT Signature: _____ Date: _____

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