

MassHealth PCA Prior Authorization

Pediatric PCA Evaluation Time-for-Task Tool

[Clear](#)

Section 1: General Information

Evaluation Information:

Evaluation Type:	☐ Initial Evaluation ☐ Reevaluation
Split PA	☐ Yes ☐ No If split PA, please indicate type: ☐ Vacation assessment ☐ School assessment
Site of Evaluation:	☐ Home ☐ Nursing Facility (specify): _____ ☐ Hospital (specify): _____ ☐ Other (specify): _____
Site of Evaluation Address:	
Date of Evaluation:	

Requesting Provider Information:

Requesting Provider ID/SL:	
Requesting Provider Name:	

Consumer Information:

Consumer Name:		Consumer DOB:	
Consumer MassHealth ID Number:		Consumer Telephone:	
Consumer Address:			
Has the Consumer had a change in their demographic information? ☐ Yes ☐ No			
If Yes, please instruct the consumer to update their information through the Massachusetts Health Connector Online Portal or by calling 1-800-841-2900 (TTY: 1-800-497-4648)			

Consumer Details:

List any Consumer Communication Difficulties:	
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[Print](#)[Clear](#)

Consumer Name: _____	Date Of Evaluation: _____
List of Medications (a list can also be attached and uploaded to the provider portal):	

Diagnosis (Primary diagnosis affecting functional status and warranting PCA services):

Primary Diagnosis:	Date of Onset:
Weight (lbs.):	Height (inches):

Medical History

List consumer's medical history relevant to the chronic condition that prevents the consumer from performing his/her/their ADLs/IADLs, such as changes in the consumer's medical condition from previous year's evaluation, diagnosis, hospitalizations, and surgical procedures and further describes the consumer's functional abilities and limitations. Attach a separate sheet if necessary.

Medical History: _____

IMPORTANT DISCLAIMER – MUST READ:

Evaluators should consult [130 CMR 422.422\(A\)](#) for a definition of the ADLs and IADLs described below, the Time-for-Tasks Guidelines for the MassHealth PCA Program and/or Appendix 2 Schematic of Age Ranges at Which Non-Disabled Children Master Functional Items Tool of the PCA Operating Standards, as appropriate.

Consumer Name: _____

Date Of Evaluation: _____

Section 2: ADLs

If the consumer requires a different level of assist during the day/evening and night hours, please select the highest Level of Assist you need to request time for, and provide explanatory comments.

A. Mobility

☐ ADL requires a flexible schedule?

Mobility Activities	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A							
	☐ Independent, no device								
	☐ Independent, with device: ☐ Cane ☐ Walker ☐ Wheel Chair ☐ Other								
		Day/Evening				Night			
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt	
	☐ 1 person physical assist with mobility								
	☐ 1 person physical assist with stairs								
☐ Nonambulatory / Bedbound									

Mobility Transfers *excludes bathing and toileting transfers	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A							
	☐ Independent, no device								
	☐ Independent, with device: ☐ Slideboard ☐ Trapeze ☐ Grab bar ☐ Other _____								
		Day/Evening				Night			
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt	
	☐ 1 person physical assist with transfers								
	☐ 2 person physical assist with transfer								
☐ Mechanical / manual lift									

☐ Mobility Repositioning	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A							
		Day/Evening				Night			
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt	
	☐ Physical assist with repositioning								

MOBILITY TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

B. Passive Range of Motion (PROM) ☐ ADL requires a flexible schedule?

PROM		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Upper Extremities Left							
	☐ Upper Extremities Right							
	☐ Lower Extremities Left							
	☐ Lower Extremities Right							

PROM TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

C. Bathing☐ ADL requires a flexible schedule?

Bathing Activities *excludes washing hair/shampooing	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Physical assist required (select tasks below)							
	☐ Physical assist with showering activity; <i>including routine transfers</i>							
	☐ Physical assist w/sponge/bed bath and drying, <i>including routine transfers</i>							
	☐ Physical assist w/tub bathing & drying, <i>including routine transfers</i>							

Washing Hair	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Physical assist with washing hair							

Bathing Special Transfer		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Special bathing transfer required (select special transfers below)							
	☐ Requires 2 person assist with transfer							
	☐ Mechanical / manual lift							

BATHING TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

D. Grooming☐ ADL requires a flexible schedule?

		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
Grooming Activities	Nail Care ☐ N/A							
	☐ Independent							
	☐ Minimum							
	☐ Moderate							
	☐ Maximum							
	☐ Total dependence							
	Oral Care ☐ N/A							
	☐ Independent							
	☐ Minimum							
	☐ Moderate							
	☐ Maximum							
	☐ Total dependence							
	Hair ☐ N/A							
	☐ Independent							
	☐ Minimum							
	☐ Moderate							
	☐ Maximum							
	☐ Total dependence							
	Shaving ☐ N/A							
	☐ Independent							
☐ Minimum								
☐ Moderate								
☐ Maximum								
☐ Total dependence								
Other ☐ N/A								
☐ Independent								
☐ Minimum								
☐ Moderate								
☐ Maximum								
☐ Total dependence								

GROOMING TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

E. Dressing / Undressing☐ ADL requires a flexible schedule?

Dressing Activities <i>*excludes incontinence management, which is under Toileting</i>	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A							
	☐ Independent, no device								
	☐ Independent, with device								
		Day/Evening				Night			
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt	
	Physical assist required (select tasks below)								
	☐ Physical assist upper extremity dressing								
	☐ Physical assist lower extremity dressing								
	☐ Physical assist with donning footwear								
☐ Physical assist with prosthetics and orthotics/braces									

Undressing Activities <i>*excludes incontinence management, which is under Toileting</i>	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A							
	☐ Independent, no device								
	☐ Independent, with device								
		Day/Evening				Night			
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt	
	Physical assist required (select tasks below)								
	☐ Physical assist upper extremity dressing								
	☐ Physical assist lower extremity dressing								
	☐ Physical assist with removing footwear								
☐ Physical assist with prosthetics and orthotics/braces									

DRESSING / UNDRESSING TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Date Of Evaluation:_____

☐ ADL requires a flexible schedule?

EATING ACTIVITIES TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

G. Toileting☐ ADL requires a flexible schedule?*(MassHealth does not pay PCA time for toilet training)*

Toileting (Bowel / Bladder Care) Activities	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A						
	☐ Independent, no device							
	☐ Independent, with device							
		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Physical assist required: Bladder							
	☐ Physical assist required: Bowel							
	☐ Physical assist with toilet hygiene ☐ Physical assist clothing with management ☐ Physical assist with changing absorbent product ☐ Physical assist with the use of urinal ☐ Physical assist with emptying foley / urostomy bag ☐ Physical assist with emptying colostomy pouch ☐ Physical assist with changing colostomy / urostomy ☐ Bowel regime (digital stimulation)							

Toileting Special Transfer		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Special toileting transfer required (select special transfers below)							
	☐ Requires 2 person assist with transfer ☐ Mechanical / manual lift							

TOILETING TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

H. Assistance with Medications☐ ADL requires a flexible schedule?

Parents/legal guardians are responsible for administering medications to pediatric consumers. If there is a physical limitation that prevents the parent/legal guardian from administering medications, the parent/legal guardian must be available to direct the assistance.

Is a parent/ legal guardian physically able to administer medications?

☐ Yes☐ No☐ N/A

If no, is a parent/ legal guardian available to direct assistance with medication?

☐ Yes☐ No☐ N/A

Assistance with Medications	Level of Assist, avg. min/episode (select one)	☐ Independent ☐ Independent, with prefilled / pre-packaged medications ☐ Physical assist required ☐ N/A						
		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Physical assist with prefilling med box							
	☐ Physical assist with medications (PO, PR, GTTS, Inhalers, topical)							
	☐ Physical assist with Nebulizer treatment							
	☐ Physical assist to administer meds via G-tube							
	☐ Physical assist to administer subcutaneous injections							
	☐ Glucometer check							

MEDICATION TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Consumer Name: _____

Date Of Evaluation: _____

I. Other Healthcare Needs☐ ADL requires a flexible schedule?

Menses Care	Level of Assist	☐ Assist required ☐ Not applicable	
		Day/Evening	
		Mins/Month	Total Mins/Wk (Divide Mins/Month by 4)
	☐ Menses care		

Other Healthcare Needs		Day/Evening				Night		
		Mins/Ep	Eps/Day	Days/Wk	Total Mins/Wk	Mins/Ep	Eps/Ngt	Total Mins/Ngt
	☐ Suctioning Oral Secretions							
	☐ Ostomy Care (different from bowel/bladder category)							
	☐ Oxygen							
	☐ BiPap/Cpap							
	☐ Vent							
	☐ Cough Assist							
	☐ Other (specify)							
	☐ Other (specify)							
	☐ Other (specify)							
	☐ Other (specify)							

OTHER HEALTHCARE NEEDS TOTAL CALCULATIONS		Day/Evening Total Mins/Wk (6AM-Midnight)		Night Total Mins (Midnight - 6AM)	
	Comments:				

Section 3: IADLs

Background Information

Legally Responsible Person	Parent(s) or legal guardian(s) are responsible for completing the IADLs for a child under age 18 (130 CMR 422.410(C)(1)). 1. <u>Are there any IADLs which the parent/legal guardian is physically unable to conduct?</u> ☐ No (skip to Question #3) ☐ Yes (answer #2 below) ☐ Not Applicable (skip to Question #3) 2. <u>Please select any of the following IADLs which the parent/legal guardian is physically unable to conduct (select all that apply):</u> ☐ Meal Preparation ☐ Laundry ☐ Housekeeping ☐ Shopping ☐ Other Special Needs Note: For any of the IADLs selected, fill out Section 3, A, B, C, D and/or E and provide explanatory comments. 3. <u>Is a second person needed to physically assist for medical transportation?</u> ☐ No ☐ Yes (fill out Section 3, F. Medical Transportation and provide explanatory comments) ☐ Not Applicable
Living Arrangement	4. <u>Does the member live with one or more other people who receive PCA services?</u> ☐ No ☐ Yes <u>If yes, list the names of the other members below:</u>

Consumer Name: _____

Date Of Evaluation: _____

A. Meal Preparation

Meals Provided Outside Home	<u>Does member attend programs or receive services that provide meals outside the home?</u>							
	☐ No ☐ Yes							
	<u>If yes, select all that apply:</u>							
	☐ Breakfast	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thu	☐ Fri	☐ Sat
	☐ Lunch	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thu	☐ Fri	☐ Sat
	☐ Dinner	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thu	☐ Fri	☐ Sat

Meal Preparation		Day/Evening		
		Mins/Day	Days/Wk	Total Mins/Wk
	Breakfast			
	☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			
	Lunch			
	☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			
	Dinner			
	☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			
	Snacks			
	☐ Independent ☐ Min ☐ Mod ☐ Max ☐ Total dependence ☐ N/A			

MEAL PREP TOTAL CALCULATIONS	Day/Evening Total Mins/Wk (6AM-Midnight)
	Comments:

Consumer Name: _____

Date Of Evaluation: _____

B. Laundry

Laundry Assistance	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A			
	Day/Evening Mins/Week				
	☐ Physical assist required (select tasks below)				
	☐ Physical assist with sorting laundry				
	☐ Physical assist with loading/unloading laundry machine				
	☐ Physical assist folding & putting away clothes				
☐ Dependent for all laundry tasks- residential					
☐ Dependent for all laundry tasks- out-of-home laundry					

LAUNDRY TOTAL CALCULATIONS	Day/Evening Total Mins/Wk (6AM-Midnight)
	Comments:

C. Housekeeping

Housekeeping Assistance	Level of Assist (select one)	☐ Independent ☐ Minimum ☐ Moderate ☐ Maximum ☐ Total dependence ☐ N/A			
	Day/Evening Mins/Week				
☐ Physical assist required					

HOUSEKEEPING TOTAL CALCULATIONS	Day/Evening Total Mins/Wk (6AM-Midnight)
	Comments:

Consumer Name: _____

Date Of Evaluation: _____

D. Shopping

Shopping Assistance	Level of Assist (select one)	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ Total dependence	☐ N/A
							Day/Evening Mins/Week
	☐ Physical assist required						

SHOPPING TOTAL CALCULATIONS	Day/Evening Total Mins/Wk (6AM-Midnight)	
	Comments:	

Consumer Name: _____

Date Of Evaluation: _____

E. Other Special Needs

Special Needs		Day/Evening
		Mins/Week
	☐ Other (explain in the comments sections)	

SPECIAL NEEDS TOTAL CALCULATIONS	Day/Evening Total Mins/Wk (6AM-Midnight)
	Comments:

Consumer Name: _____

Date Of Evaluation: _____

F. Medical Transportation

Does member use the PT-1 Form?

☐ Yes ☐ No ☐ N/A

If “No”, explain why & what is being utilized in the comments section.

Medical Provider(s) Appointment(list by name and specialty)	Distance (total miles round trip)	Travel Time (mins)	Transfer Time In / Out of Home (mins)	Transfer Time In / Out of Office (mins)	Mins / Appt (Sum of travel & transfer time)	# Appts / Year	Total Mins/Year	Total Mins/Wk (Divide Mins/Year by 52)

MED TRANSPORTATION TOTAL CALCULATIONS	Day/Evening Total Mins/Wk (6AM-Midnight)
	Comments:

Consumer Name: _____

Date Of Evaluation: _____

Section 4: 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 Requested Mins / Week	
Day/Evening PCA Hours Requested per Week (Divide Mins/Week by 60) (Round up to nearest 15-minute unit. For example, 23.3 = 23.5; 42.7 = 42.75)	
Night PCA Requested Mins / Night	
Night PCA Hours Requested per Night (Divide Mins/Night by 60) (Round up to the nearest hour – enter “2” if less than two hours)	
Nights per week (Specify how many nights per week the consumer will receive PCA services.)	
Total Weekly Billable Night PCA Hours	

Signatures

I evaluated the consumer in person and reviewed this evaluation with the consumer/Legal Guardian:

Evaluator Signature

Date

Evaluator Credentials:

☐ Registered Nurse (RN) ☐ Licensed Practical Nurse (LPN) ☐ Occupational Therapist (OT)

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

Consumer/Legal Guardian Signature

Date

Surrogate Signature (if applicable)

Date

Surrogate Name:			
Surrogate Relation to Consumer:			
Surrogate Address			
Surrogate Telephone		Surrogate Email	

Consumer Name: _____

Date Of Evaluation: _____

Section 5: Occupational Therapy Functional Status Report**Required for initial evaluations.**

OT Evaluator's Name and Credentials: _____

1. Does the consumer's diagnosis manifest as a chronic disabling condition?	
☐ No ☐ Yes If yes, please select manifested condition(s) below:	
☐ AROM deficits ☐ Spasticity ☐ Flaccidity ☐ Rigidity ☐ Muscle atrophy ☐ Pain ☐ Decreased strength ☐ Impaired sitting balance ☐ Impaired mobility / weight bearing ☐ Gross motor coordination deficits	☐ Fine motor coordination deficits ☐ Sensory loss: ☐ Vision ☐ Hearing ☐ Other, describe: _____ ☐ Cognition issues ☐ Behavior issues ☐ Endurance / stamina ☐ Other, describe: _____

2. Does the disability impact ADL/IADL performance due to any of the following?	
☐ No ☐ Yes If yes, please select impacted performance(s):	
☐ Standing tolerance ☐ Balance ☐ Bending ☐ Grasping ☐ Sitting tolerance ☐ Coordination	☐ Reaching ☐ PROM ☐ Ability to reposition self ☐ AROM ☐ Squatting ☐ Other, describe: _____

3. What is the Level of Assist required to complete ADL and IADL? Check all that apply.											
ADLs:	Ind	Min	Mod	Max	Dep	IADLs:	Ind	Min	Mod	Max	Dep
Mobility						Meal prep					
Bathing						Housekeeping					
Toileting						Laundry					
Grooming						Shopping					
Dressing						Equip. maintenance					
Eating						Other, describe:					
PROM											
Meds											
Other health care needs											
Transfers:											
In/out of bed											
In/out of tub/shower											
On/off toilet											
Mechanical lift needed:	☐ No		☐ Yes								

4. Is the consumer able to manage stairs?
☐ No ☐ Yes

Consumer Name: _____

Date Of Evaluation: _____

5. Is the consumer capable of driving?
☐ No ☐ Yes
<u>If yes, would a vehicle require modifications for the consumer to drive?</u>
☐ No ☐ Yes, describe: _____

6. Does consumer require use of adaptive equipment / assistive devices to manage ADLs?
☐ No ☐ Yes
<u>If yes, please describe below:</u>

7. Would consumer benefit from adaptive equipment / assistive devices not currently in use?
☐ No ☐ Yes
<u>If yes, please describe below:</u>

8. If needed, please provide any additional comments or summary of findings below.

Occupational Therapist Evaluator Signature

Date

Consumer/Legal Guardian Signature

Date

Surrogate Signature (if applicable)

Date