Personal Care Attendant
Reevaluation Form (No Change)

MassHealth

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Use this form when there is no change in PCA hours.

Consumer Name: _____

Personal care management (PCM) agencies may use this reevaluation form when submitting a request for personal care attendant (PCA) services where the prior authorization (PA) is due to expire, and the PA request is for the same number of PCA hours per week and per night that MassHealth had authorized at the start date of the current prior authorization. PCM agencies must submit the *MassHealth Evaluation for Personal Care Attendant Services* form (PCA-2) when the number of PCA hours being requested per week or per night are greater or less than the number of PCA hours MassHealth authorized at the start date of the current PA.

Note: All PCA reevaluations must be submitted at least 21 days before the expiration date of the PA to ensure no interruption of PCA services.

SECTION I: Consumer Information

Consumer Name	MassHealth ID no:	PCM agency name:

Date PA request submitted to MassHealth:	Current PA no:	Current PA expiration date:

Number of day/evening PCA hours authorized per week at start date of the current PA:	Number of night PCA hours authorized per night at start date of the current PA:

Was the current PA authorized for two or more years? . . . . . ☐ Yes ☐ No

Was there an adjustment in PCA hours since the start of the PA?: . . . . . ☐ Yes ☐ No

If **yes**, please complete and submit the *MassHealth Evaluation for Personal Care Attendant Services* form (PCA-2).

SECTION II: Surrogate Assessment

A. I have conducted an assessment of the consumer's ability to independently manage the PCA program, in accordance with 130 CMR 422.222(A), and have determined that (Check **one** below.):

☐ 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. (**Complete C only.**)

☐ 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. (**Complete B and C below.**)

B. Surrogate name, address, and phone number: _____

_____

Surrogate's relationship to consumer: _____

C. Name of PCM agency staff member who conducted the assessment: _____

Title: _____ Date of assessment: _____

SECTION III: RN Evaluation and Signature

Note: The PCM agency registered nurse (RN) is required to conduct a full evaluation of the consumer's need for medically necessary PCA services, in the presence of the consumer, before the expiration of the current PA. This evaluation must be performed for each consumer even if it is determined that there is no change in the consumer's PCA services.

I, (PCM RN name) _____, have conducted a full evaluation of the consumer's need for medically necessary PCA services on (date) _____. The evaluation was conducted in the presence of the consumer in one of the following locations:

☐ home ☐ nursing facility ☐ hospital ☐ other (describe): _____

Print Reset

Consumer Name

Based on my evaluation, I have determined that the consumer is managing well with the PCA hours authorized at the start date of the current PA, and requires the same number of hours per week or per night of physical assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that MassHealth authorized at the start of the PA identified in **Section I** above. I have reviewed and agree with the surrogate assessment as stated in **Section II** above.

I am requesting: _____ hours of day/evening PCA services per week and _____ hours of night PCA services per night (midnight to 6:00 A.M.)

Beginning: _____ and ending: _____

RN additional comments/remarks: _____

RN signature: _____ Signature date: _____

SECTION IV: Consumer or Legal Guardian Signature

I was reevaluated in person and the PCM agency has explained to me the number of PCA hours being requested for me per week or per night, and has assessed my need for a surrogate as stated in **Section II** above. I understand that the PCM agency is requesting no change in the number of PCA hours.

Consumer signature: _____ Date: _____

Reason if unable to sign: _____

Legal guardian signature (required if consumer has a legal guardian): _____ Date: _____

Surrogate signature (as appropriate): _____ Date: _____

SECTION V: Physician or Nurse Practitioner Signoff

Enclosed is (Check **one**.):

☐ Documentation that the PCM agency's RN has obtained verbal authorization from the member's physician or nurse practitioner in accordance with 130 CMR 422.416(A)(4)(b). The PCM agency must obtain physician or nurse practitioner sign off within 60 days after the request for prior authorization is sent to MassHealth. (The physician or nurse practitioner signature is not required below at the time the PA request is submitted to MassHealth, but the PCM agency must obtain the completed and signed physician or nurse practitioner sign off of Section VI below within 60 calendar days of the date that the PA request is sent to MassHealth.)

☐ Physician or nurse practitioner sign off (Physician or nurse practitioner must sign below.).

SECTION VI: Certification and Signature

I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

☐ The consumer requires _____ hours per week of day/evening PCA services

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

Physician or nurse practitioner signature: _____ Date: _____

Printed name of ☐ physician or ☐ nurse practitioner: _____ Date: _____

Physician/nurse practitioner address: _____

Telephone number: _____

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