Nevada Medicaid and Check Up

Authorization Request for Personal Care Services (PCS)

Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

For information on completing this form, see the instructions online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu, then click on Form Number FA-24-I).

DATE OF REQUEST: ___/___/_____

SECTION 1: REQUEST TYPE		
☐ Initial ☐ At Risk Recipients (see Section 5 for requirements) ☐ Annual Update	☐ Transfers – complete Section 2: A and page 3 ☐ Significant Change in Condition ☐ Temporary Service	☐ Cancel Authorization Agency's last date of service: ____/_____/_____ Reason: ☐ Recipient Ineligible ☐ Recipient Expired ☐ Other:

SECTION 2: CONTACT INFORMATION

A. RECIPIENT INFORMATION

Last Name:		First Name:	
Recipient Medicaid ID:		Date of Birth:	
Translator Required: ☐ Yes ☐ No		Language:	
Address:			
City:	State:	Zip Code:	Phone:

B. LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION *(if applicable*)*

The definition of an LRI is: An individual who is legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents.

See the FA-24 Instructions on the Forms webpage at www.medicaid.nv.gov for additional instructions regarding this section.

Does recipient have an LRI? *(see definition above)* ☐ Yes ☐ No ☐ Unknown			
LRI Name:		Phone:	
Relationship to Recipient:		Does LRI reside with recipient? ☐ Yes ☐ No	
LRI Employment Status: ☐ Employed # Hrs/wk:_____Days Off:_____ ☐ Unemployed ☐ Disabled ☐ Other			

C. ALTERNATE CONTACT INFORMATION OR PERSONAL CARE REPRESENTATIVE (PCR)
(Needed for scheduling purposes in the event the recipient and/or LRI are unavailable.)

Name:	Relationship to Recipient:	Phone:
PCR Name:	Relationship to Recipient:	Phone:

SECTION 3: HOUSEHOLD INFORMATION

Is the LRI also on the PCS Program: ☐ Yes ☐ No Receives hrs/wk

Is anyone else in the home receiving PCS at this time

☐ Yes – Who: ☐ No ☐ Unknown

For non-agency Personal Care Attendants (PCA), please indicate one of the following:

☐ PCA is a relative and resides in the home. Relationship to the recipient: _____

☐ PCA is a relative but does not reside in the home. Relationship to recipient: _____

☐ PCA is **not** a relative but resides in the home.

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SECTION 4: DIAGNOSES AFFECTING THE INDIVIDUAL'S ABILITY TO COMPLETE TASKS:		

SECTION 5: WHAT TASKS DOES THE INDIVIDUAL NEED ASSISTANCE WITH?

Activities of Daily Living (ADLs):

☐ Bathing/Dressing/Grooming ☐ Toileting ☐ Transferring ☐ Mobility/Ambulation ☐ Eating

Instrumental Activities of Daily Living (IADLs) *Only authorized in conjunction with ADL services, and when an LRI is not available or capable of performing the IADLs***:**

☐ Light housekeeping ☐ Laundry ☐ Essential Shopping ☐ Meal Preparation

SECTION 6: AT RISK RECIPIENTS *(For Initial requests only)*

In order to qualify for an immediate service authorization, a recipient must live alone and be unable to independently perform one of the following ADLs:

☐ Toilet ☐ Ambulate ☐ Feed themselves

SECTION 7: SUMMARY OF MAJOR INCIDENTS INCLUDING SERIOUS OCCURRENCES AND CHANGES IN CONDITION WITHIN THE LAST 120 DAYS

☐ Please provide a summary of all significant changes or incidents:

SECTION 8: COMMENTS *(General comments that would assist an assessor in completing an accurate assessment; include reason for request):*

SECTION 9: PERSONAL CARE AGENCY

PCS Agency Name:		City:
NPI:	Phone:	Email:

PERSON COMPLETING/SUBMITTING THIS REQUEST *(This person will be contacted with questions or if additional information is needed to process this request.)*

Name:	Phone:

FOR NEVADA MEDICAID USE ONLY

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SECTION 10: TRANSFER REQUESTS ONLY

Reason for transfer of service to new provider:

_____

Recipient/LRI/PCR must initial, complete the following and sign below:

_____I/LRI/PCR understand that services will be terminated with my current personal care services agency: (agency name) _____and I have notified my current agency of my last date of service with them. I understand that I am authorized to receive service from only one agency at a time.

_____I/LRI/PCR understand that selecting a new agency may result in a new personal care assistant.

_____I/LRI/PCR understand that a request for transfer will not result in a change in my current personal care hours.

_____I/LRI/PCR have NOT been offered nor have I received financial incentives to authorize this transfer.

_____I/LRI/PCR for the Medicaid recipient identified above certify that I have completed this form and understand the actions that will take place upon my signature.

Recipient/LRI/PCR: (print name) _____
Relationship to Recipient: _____

Recipient/LRI/PCR Signature: _____ Date: _____

SECTION 11: NEW PROVIDER INFORMATION

New Provider Name:	
New Provider Agency NPI:	New Provider Agency Phone Number:
Last Date with Current Provider:	
Start Date with New Requesting Provider (the day after the last date with current provider):	
Additional comments or contact information not specified above (that would assist in the completion of this request):	

The Individual Representative from the New Provider must initial the following and sign below:

_____I have met with the recipient and provided the recipient with a copy of our agency's policies and procedures.

_____No information has been provided to the recipient implying that a failure to transfer will result in consequences such as a decrease in PCS hours, loss of Medicaid eligibility or that the current/existing agency is now unable to provide services.

_____No financial incentives have been made or offered in relation to this transfer request.

_____No assurances regarding an increase in PCS hours have been made to the recipient.

Individual Representative from New Provider (print name):

_____

Provider Signature: _____ Date: _____