PERSONAL CARE ASSISTANCE (PCA) COMMUNICATION FORM

Form must be completed by UCare Care Coordinator.

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.

Fax form to 612-884-2094 or
Email to ucarepca@ucare.org.

For questions, **call** 612-676-6705
(option 2, option 4).

MEMBER INFO	
	Member Name ________________________ **Member ID** ________________
	PMI ________________________ **DOB** ________________
	ICD-10 ________________________
CC INFO	**Care Coordinator Name** ________________________ **Phone Number** ________________
	Email ________________________ **Fax** ________________
ATTENDING HEALTH CARE PROFESSIONAL INFO	**Clinician Name** ________________________
	Clinic Name ________________________
	Address ________________________ **City, State, Zip** ________________
	Phone ________________________ **Fax** ________________

PCA Services - This section is used to request and/or deny/terminate/reduce PCA services (E.g. 45 Day Temp Start/Increase, Reduce/Term PCA services, PCA Extended services). Please also use this section to report inability to complete PCA assessment due to member refusal/unable to reach or denial of an early PCA reassessment.

- Provide LTC/EW date span.
- Service description – select from most commonly used.
  **45 day temp authorizations cannot exceed 45 days and cannot be used to cover gap in services.*
- Service frequency – should indicate the amount TOTAL of PCA services *(E.g. Current XX hours daily, increase by XX hours to TOTAL XX hours daily x 45 day).*
- List provider's name and UCare legacy number.
- To better understand your request, provide a detailed description.

As the Care Coordinator and entity responsible to conduct the PCA Assessment, Page 9 of the Supplemental PCA Assessment should be completed at the time of the face to face PCA Assessment to request/recommend less PCA hours (than assessed) in lieu of other waiver services.

In the event a reduction or termination in PCA is being requested after the PCA Assessment has already taken place (days or months later); use this section to reduce/terminate PCA services as requested by the member.

Change of PCA Provider - The member has the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, and medical assistance, or other health program (Mn Home Care Bill of Rights/Mn Statute 144A.44).

- We recommend an allowance of an advance 14 day transfer date to change to new PCA provider.
- PCA Providers are required to communicate these changes with one another to prevent duplicate and overlapping services.
- UCare's PCA Team will provide an official end date notice to the current (old) provider.
- If an advance transfer date cannot be provided, a detailed explanation and description must be included.
- To ensure member's right to choose, member/RP and Care Coordinator acknowledgement and signature should be affixed in this section.

Notification of Chosen Provider - If member did not identify a PCA provider at the time of the assessment and now has chosen one, use this section to report the chosen provider. To ensure member's right to choose, member/RP and Care Coordinator acknowledgement and signature should be affixed in this section.

Form must be completed by UCare Care Coordinator.

Request copy of most recent PCA assessment *Select preference of fax or secure email.*	Fax to CC	Secure email to CC

NEW OR CURRENT LTC/EW DATE SPAN ________________ TO ________________

SERVICES REQUESTED

PCA SERVICES

Service Description ____

Frequency ____

Start Date _______________________________________ End Date __________________________________

PCA Provider Name ________________________________ PCA Provider UCare ID ______________________

Phone ____ Fax ______________________________________

Detailed description of reason for request (E.g. current XX hours daily, increase by XX hours to TOTAL XX hours daily x 45 days):

SERVICES REQUESTED

CHANGE OF PCA PROVIDER/NEW PROVIDER NOTIFICATION

Please allow an advance transfer date of at least 14 days to new provider.

Current PCA Provider Name_____________________________________ PCA Provider ID _______________

New PCA Provider Name _______________________________________ PCA Provider ID _______________

Start/Transfer/Change Date ____

Additional description for request:

***Member acknowledgement** - By affixing my signature below, I have made a decision to switch to the new provider on effective date shown in above. I was informed of the transfer process and all of the information above is accurate to the best of my knowledge. I agree that UCare may use and release information regarding my PCA Services to the new PCA provider above.*

Member or Responsible Party's Signature ____________________________________ Date ______________

CC's Signature ____ Date ______________

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