



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 _____

PCA SERVICES

SERVICES REQUESTED

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):

CHANGE OF PCA PROVIDER/NEW PROVIDER NOTIFICATION

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

SERVICES REQUESTED

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** _____