PCA/CFSS Assessment Request Form

Reset Form

FYI: Incomplete, illegible, or inaccurate forms will be returned to sender. Please complete the entire form.

Fax form and any relevant clinical documentation to: **612-884-2094**.

For questions, **call**: **612-676-6705.** or **1-877-523-1515**.

PATIENT INFORMATION

Member Name _____ Member ID _____

Member Address _____ PMI _____

Member City, State, Zip _____ Date of Birth _____

Member Phone _____

ICD-10 _____

RESPONSIBLE PARTY

Does the member require a Responsibly Party? ☐ **Yes** ☐ **No**

***If a Responsible Party (RP) is required, the RP must be present during Face to Face PCA/CFSS Assessment. The PCA/Support Worker cannot be appointed as the RP. ***

Responsible Party _____

RP Phone Number _____

Relationship _____

ASSESSMENT SCHEDULING

Appointment Contact _____ Relationship to Member _____

Phone _____ Best Time to Contact _____

Interpreter Needed? ☐ Yes ☐ No _____ Language _____

Prior Authorization – PCA/CFSS Services Form (continued)

CURRRENT AUTHORIZATION INFORMATION

☐ Initial Assessment *(not to be used by PCA/CFSS Agencies)*

☐ Annual Reassessment

☐ Early Assessment due to Change in Condition *(supporting medical documentation required)*

Start Date _____ UCare Auth No. _____

End Date _____

PCA/CFSS Agency Name _____

PCA/CFSS Agency Phone _____ Fax _____

Notes:

1. PCA/CFSS provider agencies may not make a referral for an initial Assessment (only recipients/responsible parties (RP) may request initial Assessments).
2. For annual reassessments, complete and send this form at least 60 days prior to the end of the PCA/CFSS authorization.