Clear Service Information

PCA/CFSS COMMUNICATION FORM

Incomplete, illegible, or inaccurate forms will be returned to sender. All applicable information must be included for timely processing of the request. Allow up to 14 calendar days for processing of this request. Refer to the instructions for the guidelines in completing this form. **Form must be completed by UCare care coordinator.**

Submit form and relevant documentation via:
Fax: 612-884-2094
Email: pca_cfss@ucare.org

For questions, **call: 612-676-6705**
To reach a representative, choose option 2, then option 4

Member Information	
Name:	Date of birth:
Member ID:	PMI:
Diagnosis code:	MnCHOICES assessment date:
MnCHOICES/EW date span:	to

Care Coordinator Information	
Care coordinator name:	
Phone:	Fax:
Email:	

Reason for request – select all that apply				
Approve ☐	Deny ☐	Terminate ☐	Reduce ☐	Change in model ☐
Reduced in lieu of waiver services ☐	Change in service provider ☐	Deny early reassessment ☐		

Description of request - required
Provide a description for all service requests. If multiple reasons for requests are selected above, please clarify each selection. Provide a detailed description of the request if the assessment results in denial, termination, or reduction of services. If a member receives CFSS from 2 agencies, please include 2nd agency information and the amount of hours for each service/procedure code here.

PCA Services - 6 month transition (T1019)		See page 4 for extended PCA
Provider Name:		
Provider NPI/UMPI:	Phone number:	Fax number:
Start date:	End date::	Units per day:
Request for extension of 6 month PCA transition-3 additional months. Description required above. ☐		

Consultation Services – required for CFSS (T1023)			
Initial ☐ Additional ☐			
Provider Name:			
Provider NPI/UMPI:	Phone number:		Fax number:
Start date:	End date:	Total units:	Cost per unit:

Agency Model			
Service Delivery Plan approval date:			
CFSS agency services Provider name:			
Provider NPI/UMPI:	Phone number:	Fax number:	
CFSS personal care services (T1019 U9)			
Start date:	End date:	Total units:	
CFSS worker training and development agency training (S5116 U9) * Required if receiving T1019 U9			
Start date:	End date:	Total cost:	
CFSS worker training and development formal training (S5116 U9 UD)			
Start date:	End date:	Total cost:	
Extended CFSS (T1019 U9 UC) Elderly Waiver only			
Start date:	End date:	Total units:	
CFSS temp increase (T1019 U9 U6)			
Start date:	End date:	Total units:	
CFSS 45-day temp start (T1019 U8)			
Start date:	End date:	Total units:	
Personal emergency response system (PERS) Provider name:			
Provider NPI/UMPI:	Phone number:	Fax number:	
PERS installation and testing (S5160 U9)			
Start date:	End date:	Total units:	Cost per unit:
PERS monthly fee (S5161 U9)			
Start date:	End date:	Total units:	Cost per unit:
PERS purchase (S5162 U9)			
Start date:	End date:	Total units:	Cost per unit:
Goods and services (T5999 U9) includes FMS fees FMS provider name:			
FMS NPI/UMPI:	Phone number:	Fax number:	
Start date:	End date:	Total dollar amount:	
List of goods and services:			

Budget Model			
Service Delivery Plan approval date:			
Financial management service (FMS) provider FMS name:			
FMS NPI/UMPI:	Phone number:	Fax number:	
FMS monthly fees (T2040 UB UA)			
Start date:	End date:	Number of months:	Monthly fee:
CFSS personal care services (T1019 UB)			
Start date:	End date:	Total dollar amount:	
CFSS worker training and development formal training (S5116 UB UD)* Required if receiving T1019 UB			
Start date:	End date:	Total dollar amount:	
Goods and services (T5999 UB)			
Start date:	End date:	Total dollar amount:	
List of goods and services:			
FMS failed background study (T2040 U6)			
Start date:	End date	Total units:	Total dollar amount:
Extended CFSS (T1019 UB UC) Elderly Waiver only			
Start date:	End date:	Total units:	
CFSS 45-day temp increase (T1019 UB U6)			
Start date:	End date:	Total units:	
Personal emergency response system (PERS) Provider name:			
Provider NPI/UMPI:	Phone number:	Fax number:	
PERS installation and testing (S5160 UB)			
Start date:	End date:	Total units:	Cost per unit:
PERS monthly fee (S5161 UB)			
Start date:	End date:	Total units:	Cost per unit:
PERS purchase (S5162 UB)			
Start date:	End date:	Total units:	Cost per unit:

PCA Authorizations			
PCA services (T1019) Assessment completed prior to 10/1/24 only Provider name:			
Provider NPI/UMPI:	Phone number:	Fax number:	
Start date:	End date:	Units per day:	Home care rating:
PCA temp Increase (T1019 TG U6) Assessment completed prior to 10/1/24 only Provider name:			
Provider NPI/UMPI:	Phone number:	Fax number:	
Start date:	End date:	Units per day:	
Extended PCA (T1019 UC) Elderly Waiver only Provider name:			
Provider NPI/UMPI:	Phone number:	Fax number:	
Start date:	End date:	Total units:	