Waiver Staff / Case Managers
Authorization Request for Personal Care Services (PCS)

(This form is to be used by Waiver Staff / Case Managers only. Completed forms must be submitted to nv.mmis.pcs@gainwelltechnologies.com)

SECTION 1: FOR NEVADA MEDICAID USE ONLY		
☐ FE WAIVER ☐ PD WAIVER ☐ ID WAIVER		
Assigned PT/OT:		**Due Date:**
At Risk Authorization: ☐ Yes ☐ No	Authorization Number:	Authorized Hours:

SECTION 2: DATE OF REQUEST AND REQUEST TYPE			
Date of Request: ___/___/_____			
Request Type: ☐ Initial ☐ Significant Change (new assessment) ☐ Temporary Increase			
SECTION 3: CONTACT INFORMATION			
RECIPIENT INFORMATION			
Last Name:		First Name:	
Recipient Medicaid ID:		Date of Birth:	
Translator Required: ☐ Yes ☐ No		Language:	
Address:			
City:	State:	Zip Code:	Phone #:
Current Living Arrangement: ☐ Lives alone ☐ Lives w/spouse ☐ Family ☐ Roommate ☐ Hospital ☐ ICF/IID ☐ Supported Living Arrangement (SLA) ☐ Host Home ☐ Licensed Group Home ☐ Mental Health Facility ☐ Assisted Living Facility ☐ Nursing Facility ☐ Other *(specify)*: _____			
LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION *(if applicable*)* **Complete this section if this definition of an LRI is met: Individuals who are 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.* ***If LRI is not available or capable, complete and attach form FA-24B (LRI Availability Determination for the Personal Care Services Program).***			
Does recipient have an LRI? *(see definition above)* ☐ Yes ☐ No ☐ Unknown			
LRI Name:		Phone #:	
Relationship to Recipient:		Does LRI reside with the recipient? ☐ Yes ☐ No	
Is the LRI also on the PCS Program: ☐ Yes ☐ No Receives_____ hrs./wk.			
LRI Employment Status: ☐ Employed # Hrs./wk._____ Days Off _____ ☐ Unemployed ☐ Disabled ☐ Other			
ALTERNATE CONTACT INFORMATION *(An alternate contact is needed for scheduling purposes in the event the recipient and/or LRI are unavailable.)*			
Alternate Contact Name:			
Phone #:	Relationship to Recipient:		
Can this person be contacted in case we are unable to contact the recipient? ☐ Yes ☐ No			
PCS AGENCY INFORMATION			
PCS Agency Name:		NPI/API:	
Phone #:			
CASE MANAGER INFORMATION *(Enter the name and direct phone number for the recipient's case manager. If the individual is associated with a business (i.e., hospital, government agency, etc.), enter the business or entity name.)*			
Case Manager Name:		Phone #:	
Entity Name:		Phone #:	

SECTION 4: REASON FOR REFERRAL

What tasks does the individual need assistance with?

☐ Bathing ☐ Dressing ☐ Grooming ☐ Toileting ☐ Transferring ☐ Positioning ☐ Ambulation ☐ Eating
☐ Meal Preparation ☐ Laundry ☐ Light Housekeeping ☐ Essential Shopping
☐ Other: _____

Is this recipient at risk of institutionalization if services are not provided as soon as possible? ☐ Yes ☐ No

SECTION 5: DIAGNOSES, INCIDENTS AND SERVICES RECEIVED

DIAGNOSIS / DIAGNOSES AFFECTING THE INDIVIDUAL'S ABILITY TO COMPLETE TASKS:

Is anyone else in the home receiving PCS at this time? ☐ Yes - Who: _____ ☐ No ☐ Unknown

INCIDENTS WITHIN PAST 90 DAYS *(check all that apply)*

☐ Hospitalization Discharged date or anticipated discharge date: _____

☐ Recent Fall	☐ Surgery Type: _____	☐ Loss of non-paid caregiver

☐ New Medical Condition/Diagnosis *(specify):*

☐ Addition of other services *(specify):*

☐ Other (*specify*):

OTHER SERVICES CURRENTLY RECEIVED *(regardless of funding source)*

☐ Adult Day Care	☐ Attendant Care	☐ Home Delivered Meals	☐ Homemaker
☐ PERS	☐ Respite	☐ Day Habilitation	☐ Prevocational Services
☐ Hospice	☐ Supported Employment	☐ Private Duty Nursing	☐ Residential Habilitation, Direct Services and Support
☐ Other Services *(not already listed)*:			

SECTION 6: COMMENTS *(General comments that would assist an assessor in completing an accurate assessment, include reason for request):*

SECTION 7: PERSON COMPLETING FORM *(This person will be contacted with questions or if additional information is needed to process this request.)*

Name:	Date:
Entity Name:	Phone #:

SECTION 8: CLINICAL REVIEWER DETERMINATION *(if applicable)*

☐ I consider the recipient to be at risk. *(Refer to page 1 for authorization)*	☐ I consider the recipient NOT at risk.

Comments:

Clinical Reviewer Name:	Date: