Coordination of Hospice and Waiver or Personal Care Services (PCS)

Upload this request through the Provider Web Portal.

Purpose: For hospice agencies to facilitate care coordination between hospice and waiver or Personal Care Services (PCS).

Attachments: Individualized Hospice Care Plan (required), Physician's Certification (conditional, see page 2).

Date of Request:	
NOTES:	
RECIPIENT INFORMATION	
Last Name, First Name, Middle Initial:	
Recipient ID:	☐ Translator Required Language:
DOB:	Phone:
Address:	
Name of person to contact to schedule assessment, if other than the recipient:	
Contact Phone:	
Has this recipient utilized personal care services in the past? ☐ Yes ☐ No	
HOSPICE AGENCY INFORMATION	
Name:	NPI:
Phone:	Fax:
Case Manager Name:	Case Manager Phone:
PCS AGENCY INFORMATION *(if applicable)*	
Name:	NPI:
Phone:	Fax:
WAIVER SERVICES INFORMATION *(if applicable)*	
Waiver Name:	
Administering Agency:	
Waiver Case Manager Name:	
Contact Phone:	Contact Fax:

ACTIVITIES OF DAILY LIVING *In the appropriate row/column combination, enter an "H" for services performed by Hospice, "F" for services performed by the family and "O" for services performed by another party other than the recipient. "AM" signifies that services are performed 8:00 am-Noon, "Mid" signifies Noon-4:00 pm and "PM" signifies 4:00 pm-8:00 pm.*

	Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		
	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM
Bathing																					
Dressing																					
Grooming																					
Toileting																					
Transfer/Positioning																					
Mobility/Ambulation																					
Eating																					
Housekeeping																					
Laundry																					
Essential Shopping																					
Meal Preparation																					

Coordination of Hospice and Waiver or Personal Care Services (PCS)

Recipient Last Name, First Name, Middle Initial:	
Date of Request:	

LEGALLY RESPONSIBLE ADULT (LRA) INFORMATION

☐ Not Applicable (No LRA) *If not applicable, skip the remainder of this section and go to "Rationale for Services."*

LRA Name:	LRA Phone:

Is the LRA available and capable of assisting with all necessary ADLs/IADLs? ☐ Yes ☐ No

If no, check the box that applies:

☐ The LRA is <u>not available</u> due to employment and/or school attendance. *(Complete fields below.)*

Employer/School Name and Address: _____

Employer/School Phone: _____

Hours of Employment/School Attendance: _____

☐ The LRA is <u>not capable</u> of assisting with necessary ADLs/IADLs. *If this box is checked, a physician's certification describing the LRA's incapacity must be submitted with this form.*

RATIONALE FOR SERVICES

PCS or waiver services may be covered when unrelated to services for the terminal condition.

Enter the terminal diagnosis:
Enter non-terminal condition:
Enter date the recipient began receiving hospice services:
Describe requested services and give rationale for each. (Services must be related to non-terminal condition.)

Nevada Medicaid uses this form and the hospice care plan to conduct a PCS assessment, determine the authorized services and units and assign an authorization number to the request. Nevada Medicaid will phone the PCS or waiver agency with the authorization number and number of units authorized. Official approval will follow via mail 2-3 business days later.

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.