

**N.C. Department of Health and Human Services – Division of Medical Assistance  
PERSONAL CARE SERVICES (PCS) FOR LICENSED ADULT CARE HOME RESIDENTS  
INDEPENDENT ASSESSMENT REQUEST FOR NEW ADMISSIONS**

**Licensed Adult Care Home Provider:** Use this form to report Medicaid beneficiaries admitted to your facility after CCME's initial visit to conduct independent eligibility assessments for the January 1, 2013 Consolidated PCS program. Report only Medicaid recipients admitted to your facility who require a PCS eligibility assessment. Do not use this form if CCME's initial visit to your facility is still in the future.

Send completed form to CCME via fax at **877-272-1942**, or mail to:

**CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.**

Receipt may be confirmed with CCME at **800-228-3365**. E-mail questions to **PCSAssessment@thecarolinascenter.org**.

**PLEASE COMPLETE ALL FIELDS.**

**Section A. Facility Information** *Complete all fields.*

Today's Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Facility Name: \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_ Contact Position: \_\_\_\_\_

Facility Fax Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Facility Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ County: \_\_\_\_\_

**Section B. New Admissions** *List each new admission on a separate line, and complete all fields.*

	Medicaid ID#	First Name	Last Name	Date of Birth (mm/dd/yyyy)	Admission Date (mm/dd/yyyy)
1.	_____	_____	_____	___/___/___	___/___/___
2.	_____	_____	_____	___/___/___	___/___/___
3.	_____	_____	_____	___/___/___	___/___/___
4.	_____	_____	_____	___/___/___	___/___/___
5.	_____	_____	_____	___/___/___	___/___/___
6.	_____	_____	_____	___/___/___	___/___/___
7.	_____	_____	_____	___/___/___	___/___/___
8.	_____	_____	_____	___/___/___	___/___/___
9.	_____	_____	_____	___/___/___	___/___/___
10.	_____	_____	_____	___/___/___	___/___/___
11.	_____	_____	_____	___/___/___	___/___/___
12.	_____	_____	_____	___/___/___	___/___/___
13.	_____	_____	_____	___/___/___	___/___/___
14.	_____	_____	_____	___/___/___	___/___/___
15.	_____	_____	_____	___/___/___	___/___/___
16.	_____	_____	_____	___/___/___	___/___/___
17.	_____	_____	_____	___/___/___	___/___/___
18.	_____	_____	_____	___/___/___	___/___/___
19.	_____	_____	_____	___/___/___	___/___/___
20.	_____	_____	_____	___/___/___	___/___/___

*Attach additional sheet to report more than 20 New Admissions.*

**IMPORTANT:**

Also initiate completion of the PCS Medical Attestation Form (DMA Form-3065) immediately for each New Admission listed above. The required PCS Medical Attestation Form is available at <http://www.ncdhhs.gov/DMA/pas/pas.html>.