N.C. Department of Health and Human Services – Division of Medical Assistance

PERSONAL CARE SERVICES (PCS) MEDICAL ATTESTATION FOR LICENSED CARE HOME RESIDENTS

Completed attestation form serves as authorization to conduct PCS eligibility assessment of current licensed care home residents.

Licensed Home Provider: Present completed form to The Carolinas Center for Medical Excellence (CCME) RN Assessor at time of resident assessment. If form is completed after resident's assessment, 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*.
(Forms for more than one resident may be bundled and sent together. Certified mail with delivery confirmation is recommended.)
Receipt may be confirmed with CCME at 800-228-3365. E-mail questions to PCSAssessment@thecarolinascenter.org.

PLEASE COMPLETE ALL FIELDS.

Section A. Resident Demographics—*TO BE COMPLETED BY LICENSED CARE HOME PROVIDER*

Medicaid ID#: __ __ __ __ __ __ __ __ __ __ **Most Recent FL-2/MR-2 Date:** ___/___/_____ (mm/dd/yyyy)

Resident Name (as shown on Medicaid Card) **Last:** _____ **First:** _____ **MI:** ___

Gender: ___Male ___Female **Date of Birth:** ___/___/_____ (mm/dd/yyyy) **Primary Language:** __English __Spanish __Other

Resident Phone: (_____) _____ - _____

Current Residence (Facility Name)**:** _____

Facility License Number: _____ **License Date:** ___/___/_____ (mm/dd/yyyy)

Facility Fax Number: (_____) _____ - _____

Facility Type: ___Family Care Home ___Adult Care Home ___SLF-5600a ___SLF-5600c ___Adult Care bed in Nursing Facility

Does Resident Have a Legal Guardian? ___Yes ___No

If Yes, Guardian Last Name: _____ **First Name:** _____ **Phone:** (_____) _____ - _____

Section B. Resident Information—*TO BE COMPLETED OR VERIFIED BY ATTESTING PRACTITIONER*

List conditions that currently limit resident's ability to independently perform Activities of Daily Living (bathing, dressing, mobility, toileting, eating), prepare meals, and manage medications:

Primary Diagnosis: _____

Secondary: _____ **Secondary:** _____ **Secondary:** _____

Secondary: _____ **Secondary:** _____ **Secondary:** _____

Secondary: _____ **Secondary:** _____ **Secondary:** _____

Conditions listed are: ___Chronic Medical ___Physical Disability ___Mental Illness ___MR/Developmental ___Dementia
(check all that apply)

In the absence of caregivers, is resident at risk of any of the following? (check all that apply):

___Falls ___Malnutrition ___Skin Breakdown ___Adverse Consequences of Medication Non-Compliance

Is 24-hour caregiver availability required to ensure resident safety? ___Yes ___No
(e.g., Does resident have unscheduled ADL needs or require safety supervision or structured living, or is resident unsafe if alone for extended periods?)

Section C. Attesting Practitioner Information—*TO BE COMPLETED BY ATTESTING PRACTITIONER—RETURN SIGNED FORM TO LICENSED HOME PROVIDER*

Practitioner Last Name: _____ **First Name:** _____ **NPI#:** _____

Attesting Practitioner: ___PCP/Attending MD ___NP ___PA

Date of Resident's Last Visit with Attesting Practitioner: ___/___/_____ (mm/dd/yyyy)

Practice Name: _____
(if applicable)

Office Contact Last Name: _____ **First:** _____ **Position:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____ **E-mail:** _____

Practitioner Signature: _____ **Date:** ___/___/_____ (mm/dd/yyyy)

Dated signature is verification that information in Section B is accurate for this patient and authorization to conduct PCS eligibility assessment.