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Personal Care Authorization Request Form

- Please submit this completed form and any supporting clinical documentation through the Identifi Authorization portal or via fax (800) 878-8264. Incomplete information may delay the process.
- If you have any questions about this form, please contact Utilization Management at (855) 429-1028.
- If this is a re-authorization, please submit the last 2 weeks of notes.
- Please note that members 21+ are only eligible for 64 hours per month, per DHS.

Member Information	
Member's Name:	Empower ID #:
Member's Phone:	DOB:
Guardian's Name (if not member):	

Provider Information	
Contact Name:	Phone:
Agency Name:	Fax:
Address:	
NPI:	TIN:

Authorization Information for T1019	
Dates of Services:	Units Requested:
This is a: ☐ New Request ☐ Re-Authorization Request (Auth Number):	
Review Priority: ☐ Routine ☐ Expedited/Urgent ☐Modifier Needed:	
ICD-10 Diagnosis:	

Activities of Daily Living (ADLs and IADLs)		
Based on the member's impairment, the medical professional should check the appropriate box as it applies to the member's ability to perform these age-appropriate tasks.		
Task	Level of Support Required	
Bathing	☐Not applicable, less than 5 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Dressing	☐Not applicable, less than 5 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Grooming and Skin Care	☐Not applicable, less than 5 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Ambulation	☐Not applicable, less than 3 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent

Activities of Daily Living (ADLs and IADLs) continued		
Task	Level of Support Required	
Transferring	☐Not applicable, less than 3 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Positioning	☐Not applicable, less than 3 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Continence/Toileting (bowel and/or bladder)	☐Not applicable, less than 3 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Eating/Feeding	☐Not applicable, less than 5 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Meal Preparation	☐Not applicable, less than 18 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
House Cleaning (cleaning kitchen/bath, etc.)	☐Not applicable, less than 18 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Grocery Shopping	☐Not applicable, less than 18 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent
Laundry	☐Not applicable, less than 18 years of age ☐Independent (includes supervision or prompting) ☐Independent with use of Assistive Technologies	☐Limited Assistance ☐Extensive Assistance ☐Entirely Dependent

Behavioral Support (18+ only)		
Based on the member's impairment, the medical professional should check the appropriate box as it applies to the frequency of the member's behaviors and the level of intervention required by caregivers to minimize impact.		
Task	Frequency	Support Needed:
Wandering	☐ Not applicable ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	Describe:
Verbally or Physically Abusive	☐ Not applicable ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	Describe:
Resists Care	☐ Not applicable ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	Describe:
Communication Deficit (Unable to express needs)	☐ Not applicable ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	Describe:
Forgetful (age-appropriate)	☐ Not applicable ☐ Monthly ☐ Daily ☐ Occasionally	Describe:

Additional Supports	
Medical Support	If the member CANNOT self-administer medications: 1. Can they be trained to self-administer medications? ☐ Yes ☐ No 2. What arrangements have been made for the administration of medication if that is a goal of the member? 3. Does the member require assistance with, or provision of, skilled tasks (i.e. monitoring of vital signs, dressing changes, glucose monitoring, etc.)? ☐ Yes ☐ No If yes, please describe:

Assessment Narrative
Please describe assistance required by the member due to their physical dependency, including tasks that require assistance.

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Personal Care Assistance Guide					
PCS Tasks	Levels of Assistance				Mobility/Transfer Requirement
	Independent	Limited Assistance	Extensive Assistance	Entirely Dependent	
Bathing	0	10 mins	20 mins	30 mins	Add 15 min
Dressing	0	10 mins	15 mins	15 mins	Add 15 min
Grooming	0	10 mins	20 mins	30 mins	
Toileting	0	15 mins	30 mins	45 mins	Add 15 min
Eating	0	10 mins/meal	20 mins/meal	30 mins/meal	
Meal Prep	0	15 mins	15 mins	15 mins	
Laundry, Grocery, Housekeeping (18+)			30 minutes		

Hours Requested							
Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Maximum							
Minimum							
**If utilizing over the daily maximum, then please document needs clearly.							
If member will not receive personal care every day, then document alternative plan in narrative.							

Member Attestation

To help assure a complete and accurate assessment of my physical dependency needs and an individualized service plan to address those needs, I hereby authorize the release of any medical information by or to the attending physician and/or PCP ordering this care below. I understand that I will receive only medically necessary assistance with my physical dependency needs. I accept this personal care service plan.

Signature:	Date:

Agency Attestation

Referral Completed by (name):

Date of Assessment Completed:

Personal Care Attendant Services are not provided by:

- Minor's Parent
- Minor's Stepparent
- Anyone acting as a minor's parent
- Foster Parent
- Legal Guardian of the Member
- Member's Spouse

Print Name:

Signature:	Date:

Provider Order and Attestation

I have examined this member within the past 60 days. I have reviewed the assessment, and I confirm its accuracy. I authorize the personal care assistance detailed in this service plan, including additions and modifications dated and initiated by myself and excluding deletions dated and initialed by myself. I am aware that all personal care must be medically necessary and that the Utilization Management Department may review this assessment and service plan.

Print Name:	NPI:
Provider Signature (no stamps) and credentials (MD, APRN, or PA only):	Date: