



Provider Referral Form: LTSS Request for PCS Assessment

Instructions:

This form is to request evaluation of a WellCare member for possible personal care services to allow the member to remain safely at home.

Requirements:

- Member must have documentation of a physical or developmental disability, cognitive impairment, or a chronic health condition that has resulted in ADL limitations.
- Member must be medically stable and not require continuous monitoring by an RN or other licensed health professional.
- The form does not require a provider's signature.

Referral process options:

- Provider's office can call in a referral to **833-298-4301** and request to speak with LTSS Care Coordination.
- Provider can fax/email a WellCare provider referral form or a copy of DMA3051 requesting evaluation of member for need of personal care services.
- Member and/or family member can call into **833-298-4301** and request evaluation for personal care services.

PCP INFORMATION

PCP/Practice name:	
Street address:	
Telephone number:	Fax number:
Office Email address:	NPI:
Date of last provider visit:	

MEMBER INFORMATION:

Member name:	
Street address:	
DOB:	Medicaid ID:
Is the member medically stable? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current residential setting: <input type="checkbox"/> Private home <input type="checkbox"/> Group home <input type="checkbox"/> Nursing facility <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Adult Care home <input type="checkbox"/> Other	
Alternate contact:	
Alternate contact number:	
Medical Dx (ICD10) with impact to ADLs:	

(continued)

ADL IMPACTS:					
Bathing	<input type="checkbox"/> Independent	<input type="checkbox"/> Cueing or Supervision	<input type="checkbox"/> Hands-on Assistance	<input type="checkbox"/> Extensive Assistance	<input type="checkbox"/> Totally Dependent
Toileting	<input type="checkbox"/> Independent	<input type="checkbox"/> Cueing or Supervision	<input type="checkbox"/> Hands-on Assistance	<input type="checkbox"/> Extensive Assistance	<input type="checkbox"/> Totally Dependent
Dressing	<input type="checkbox"/> Independent	<input type="checkbox"/> Cueing or Supervision	<input type="checkbox"/> Hands-on Assistance	<input type="checkbox"/> Extensive Assistance	<input type="checkbox"/> Totally Dependent
Transfer	<input type="checkbox"/> Independent	<input type="checkbox"/> Cueing or Supervision	<input type="checkbox"/> Hands-on Assistance	<input type="checkbox"/> Extensive Assistance	<input type="checkbox"/> Totally Dependent
Walking/Wheeling	<input type="checkbox"/> Independent	<input type="checkbox"/> Cueing or Supervision	<input type="checkbox"/> Hands-on Assistance	<input type="checkbox"/> Extensive Assistance	<input type="checkbox"/> Totally Dependent
Eating	<input type="checkbox"/> Independent	<input type="checkbox"/> Cueing or Supervision	<input type="checkbox"/> Hands-on Assistance	<input type="checkbox"/> Extensive Assistance	<input type="checkbox"/> Totally Dependent

Additional details:

If any additional information is required, a Care Manager will follow-up with the office. After contacting the member to consent for care management, the Care Manager will schedule a face-to-face assessment with the member for completion of a comprehensive assessment. Please do not hesitate to contact WellCare of NC Care Management at **1-833-298-4301**. You may return the completed referral form using one of the following:

Please Return Via Email to:
SM_NC_CareCoordination@wellcare.com