

MODULE 1: OVERVIEW OF CONSOLIDATED FORM DMA 3051

Personal Care Services (PCS) Request for Services forms have been consolidated into one form as of 10/1/13:

PCS Request for Services DMA 3051

- All PCS providers, regardless of setting, will use the DMA 3051 form.
- DMA 3051 is the only form that will allow physicians to provide written attestation to the medical necessity for up to 50 additional PCS hours.
- Download the current form at: <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3051-ia.pdf>

N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS) REQUEST FOR SERVICES FORM

Completed form should be sent to Liberty Healthcare Corporation-NC via fax at 484-434-1571 or 855-740-1600 (toll free) or mail: ATTN: Liberty Healthcare Corporation, PCS Program 5540 Centerview Dr. Suite 114, Raleigh, NC 27606-3366. For questions, contact 855-740-1400 or 919-322-5944 or send an email to NC-InfoSupport@libertyhealth.com. **DISCLAIMER: Adherence to the INSTRUCTIONS for the Request for Services Form is REQUIRED. If a request for services form is submitted incomplete, an unable to process notification will be issued and a new request for services form will be required.**

PROVIDER TYPE (select one)	DATE OF REQUEST: _____ (mm/dd/yyyy)
<input type="checkbox"/> Home Care Agency <input type="checkbox"/> Family Care Home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Adult Care Bed in Nursing Facility <input type="checkbox"/> SLF-5600a <input type="checkbox"/> SLF-5600c <input type="checkbox"/> Special Care Unit (stand-alone Special Care Unit or SCU bed)	

SECTION A. RECIPIENT DEMOGRAPHICS

Medicaid ID#: _____

Recipient's Name (as shown on Medicaid Card) First: _____ MI: _____ Last: _____

Date of Birth: _____ (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other

Address: _____ City: _____

County: _____ Zip: _____ (zip code + 4 digit extension) Phone: _____

Alternate Contact/Parent/Guardian (required if patient under 18): First: _____ Last: _____

Relationship to Patient: _____ Phone: _____

Provider Name (if applicable) _____ Provider Phone: _____

SECTION B. RECIPIENT'S MEDICAL HISTORY – complete this section only if submitting a NEW REFERRAL or CHANGE OF STATUS request.

List **both** the current medical diagnoses and ICD-9 codes that currently limit patient's ability to independently perform Activities of Daily Living (bathing, dressing, mobility, toileting, and eating), prepare meals, and manage medications.

Medical Diagnosis	ICD-9 Code	Enter "O" for Onset or "E" for Exacerbation	Date (mm/yyyy)

SECTION C. NEW REFERRAL REQUEST – complete this section if submitting a New Referral.

Check the box to the left and complete sections A, B, and C if submitting a New referral.

Referral Entity (select one): Primary Care Physician Attending MD Physician Assistant (PA) Nurse Practitioner (NP)

Is Recipient Medically Stable: Yes No Is there an active Adult Protective Services (APS) case: Yes No

Date of last visit to Referring Entity: _____ (mm/dd/yyyy)

Other state/federal programs recipient is currently receiving (select all that apply): Medicare Home Health Private Duty Nurse
 CAP Hospice Unknown

Is 24-hour caregiver availability required to ensure recipient's safety? Yes No (e.g., Does patient have unscheduled ADL needs or require safety supervision or structured living, or is patient unsafe if left alone for extended periods?)

Is recipient currently hospitalized or in a medical facility: Yes No If yes, planned discharge date: _____ (mm/dd/yyyy)

Referring Entity's Name: _____ NPI#: _____

Practice Name: _____ (if applicable)

Name of Practice Point of Contact: _____ Position: _____

Phone (including area code): _____ Fax (including area code): _____

Point of Contact's Email Address: _____

Referring Entity/Practitioner Signature: _____ Date: _____ (mm/dd/yyyy)

NOTE: Dated signature is verification that the information in sections A, B, and C is accurate for this recipient and authorization to conduct a PCS eligibility assessment. If requesting an assessment for greater than 80 hours of PCS completion of sections A, B, C, and E with a second signature is REQUIRED on page 2. If not stop here and submit to Liberty.



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Form DMA 3051 replaced the following forms:

Referral	<ul style="list-style-type: none">• DMA 3041 Home Care Agency• DMA 3068 Licensed Residential Facility
Change of Status	<ul style="list-style-type: none">• DMA 3042 Home Care Agency• DMA 3069 Licensed Residential Facility
Change of Provider	<ul style="list-style-type: none">• DMA 3043 Home Care Agency• DMA 3070 Licensed Residential Facility

As of October 31, 2013 these forms are obsolete.

MODULE 1: OVERVIEW OF FORM DMA 3051 10/1/13

Form DMA 3051 Will Now Be Used For These Requests



**NEW
REFERRAL**

**CHANGE
OF
STATUS**

**CHANGE
OF
PROVIDER**

MODULE 1: COMPLETING PCS FORM DMA 3051

Key Information

- The terms Beneficiary and Recipient will be used interchangeably throughout the modules.
- The DMA 3051 form has 6 sections – A through F. You are not required to complete all of the sections of the DMA 3051 form each time you submit the form.
- Complete only the sections for the specific request being submitted on behalf of the recipient.
- Note: Selecting the type of Provider and putting a date on the request form are mandatory for all submittals. Use mm/dd/yyyy formatting.
- Refer to the Personal Care Services (PCS) Request for Services Form – DMA 3051 Instructions (effective 10/1/13) available at: <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3051-tips.pdf>