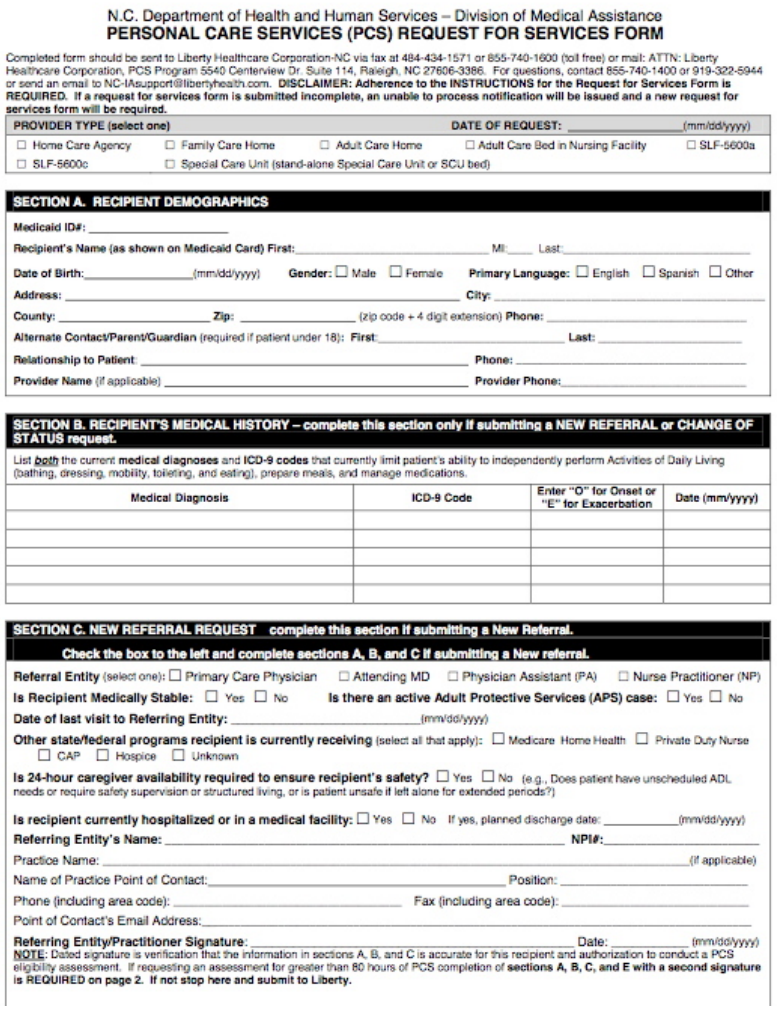
MODULE 1: OVERVIEW OF CONSOLIDATED FORM DMA 3051

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 27606-3386. For questions, contact 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@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)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a
☐ SLF-5600c ☐ 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.**

Liberty Healthcare Corporation of North Carolina

MODULE 1: OVERVIEW OF FORM DMA 3051

Form DMA 3051 replaced the following forms:

Referral	• DMA 3041 Home Care Agency • DMA 3068 Licensed Residential Facility
Change of Status	• DMA 3042 Home Care Agency • DMA 3069 Licensed Residential Facility
Change of Provider	• DMA 3043 Home Care Agency • DMA 3070 Licensed Residential Facility

As of October 31, 2013 these forms are obsolete.

Liberty Healthcare Corporation of North Carolina

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

Liberty Healthcare Corporation of North Carolina

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