## NC Division of Medical Assistance Notification of Hospice and Personal Care Services (PCS) Coordination Form

Hospice agencies must notify the NC Division of Medical Assistance (NC DMA) when there is a need for concurrent Hospice and PCS services to be provided to beneficiaries. The purpose of this form is to facilitate care coordination between hospice and PCS agencies. This notification form and supporting documentation must be SUBMITTED to NC DMA within five (5) days of hospice admission or referral to avoid delay of service and reimbursement. Submit these documents via fax to 919-715-9025 to NC DMA Attention: Hospice Consultant.

## Current Status:

■ Active PCS Recipient
Required Attachments:
$\square$ Individualized Hospice Plan of Care (e.g., MD order set or 485)
$\square$ Individualized Hospice Aide Care Plan
$\square$ Pending PCS Recipient
$\square$ Online Service Plan from PCS provider if current PCS recipient
$\square$ Other Supporting Documentation

\section*{| Date of Request: |
| :--- |
| RECIPIENT INFORMATION |}

Last Name, First Name, Middle Initial:

| Recipient ID: | Translator Required? __ Yes__ No Language: |
| :--- | :--- |
| DOB: | Phone: |
| Address: |  |
| Adtending MD: | Hospice MD: |
| Responsible Party if other than patient: |  |
| Name of person to contact to schedule assessment, if other than the recipient: |  |
| Contact Phone: |  |
| Has this recipient utilized personal care services in the past? $\quad \ldots \quad$ Yes ___ No ___ Unknown |  |
| HOSPICE AGENCY INFORMATION |  |


| Name: | NPI: |
| :--- | :--- |
| Phone: | Fax: |
| Contact Name: | Contact Phone: |

PCS AGENCY INFORMATION (If not yet in place, DMA will add when assigned)

| Name: | NPI: |
| :--- | :--- |
| Phone: | Fax: |

SERVICE GAP (Describe needs that require two providers to be involved, e.g., decubitus risk due to immobility, wound care, need for additional personal care due to incontinence/skin care, etc.)

ACTIVITIES OF DAILY LIVING: In the appropriate row/column combination, enter an " H " for services performed by Hospice, "F" for services performed by the family and "P" for services performed by the PCS Provider. "AM" signifies that services are performed 8:00 am-Noon, "Mid" signifies Noon-4:00 pm and "PM" signifies 4:00 pm-8:00 pm. * Indicates nurse aide tasks. \# Indicates NA II tasks.

|  | Sunday |  |  | Monday |  |  | Tuesday |  |  | Wednesday |  |  | Thursday |  |  | Friday |  |  | Saturday |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | AM | Mid | PM | AM | Mid | PM | AM | Mid | PM | AM | Mid | PM | AM | Mid | PM | AM | Mid | PM | A | Mid | PM |
| Bathing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mouth Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hair Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nail Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Skin Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Shampoo |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Toileting - Assist with Garments |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Toileting-Hygiene |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Toileting-Clean BSC/Bedpan/Area |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Transfer/Positioning |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobility |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ambulation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Clear/Declutter Pathways |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Eating - Assist |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Meal Preparation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Housekeeping |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Laundry |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Essential Shopping |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BP Monitoring |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Medication Reminders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Special Tasks |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * Blood Glucose Monitoring |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ${ }^{*}$ Foley Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * Wound Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \# Remove Impaction / Enema |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \# Ostomy Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \# Enteral FeedingAssist |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \# Oxygen - Assist |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \# Suctioning |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Beneficiary/Representative Signature Date Hospice Representative Signature Dat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

FOR DMA USE ONLY:
Accepted Effective Date:
End Date:
Rejected Reason:
NC DMA Representative signature: Date:

