# PERSONAL CARE AND HOMEMAKER SERVICES REFERRAL FORM

Personal care and homemaker services (PCHS) are provided for members who need assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). For more information, review the PCHS Authorization Guide.

Complete and submit this referral form with the *Outpatient Medicaid – Prior Authorization Fax Form* either online (recommended) at **www.CAHealthWellness.com** or by **fax at 866-724-5057**.

☐ **Initial request** ☐ **Extension request**

☐ **Member consented to personal care and homemaker services referral.**

## Member Information

| | | |
|---|---|---|
| **Member name**: | **Date of birth (DOB)**: | |
| **Medi-Cal ID:** | **Phone number:** | **Preferred language:** |
| **Home address:** | | |
| **Contact name (if different than member):** | | **Relationship:** |
| **Phone number:** | | **Preferred language:** |
| **Member's height:** | | **Member's weight:** |
| **Preference for caregiver support:** ☐ Morning ☐ Afternoon ☐ No preference | | |
| **Other needs/requests (i.e., hoyer lift, male caregiver):** | | |
| **Special instructions to enter residence:** | | |

## Community Supports Provider Information (Servicing Organization)

| | |
|---|---|
| **Organization name:** | |
| **Tax identification (ID):** | **National Provider Identifier (NPI):** |
| **Staff name:** | **Title** |
| **Phone number**: | **Fax number**: |

## Eligibility Criteria

**Member must meet one of these two:**

☐ Member needs assistance with ADLs and/or IADL tasks and has no other adequate support system.

☐ Member is at risk for hospitalization or institutionalization in a nursing facility.

**AND meet one of the three following criteria:**

☐ Member was referred for In-Home Services (IHSS) and searching for a caregiver through the Public Authority registry.

IHSS application submission date:_____

IHSS application status: ☐ In review ☐ Approved – IHSS hours per month:_____ ☐ Denied

☐ Member currently receives IHSS and needs additional IHSS hours. The reassessment request is pending, and a caregiver is needed for support in the meantime.

Reassessment request date:_____

IHSS hours per month:_____

☐ Member is not eligible for IHSS and needs services to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Provide the IHSS Notice of Action indicating a denial, if available.

| Required Documents |
|---|
| **Submit with the authorization and referral forms:**<br>☐ Initial assessment including ADLs and IADL needs. |

## Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Please complete the below assessment together with your patient.

| **Do you need help with any of these actions?** | |
|---|---|
| Taking a bath or shower ☐ Yes ☐ No | Going up stairs ☐ Yes ☐ No |
| Eating ☐ Yes ☐ No | Getting Dressed ☐ Yes ☐ No |
| Brushing teeth, brushing hair, shaving ☐ Yes ☐ No | Making meals or cooking ☐ Yes ☐ No |
| Getting out of a bed or a chair ☐ Yes ☐ No | Shopping and getting food ☐ Yes ☐ No |
| Using the toilet ☐ Yes ☐ No | Walking ☐ Yes ☐ No |
| Washing dishes or clothes ☐ Yes ☐ No | Writing checks or keeping track of money ☐ Yes ☐ No |
| Getting a ride to the doctor or to see your friends ☐ Yes ☐ No | Doing house or yard work ☐ Yes ☐ No |
| Managing medications ☐ Yes ☐ No | Driving or using public transportation ☐ Yes ☐ No |
| Going out to visit family or friends ☐ Yes ☐ No | Using the phone ☐ Yes ☐ No |
| Keeping track of appointments ☐ Yes ☐ No | |
| **If yes**, are you getting all the help you need with these actions? ☐ Yes ☐ No | |
| Comments: | |
| Have you fallen in the last month? ☐ Yes ☐ No Are you afraid of falling? ☐ Yes ☐ No | |
| Do friends or family members express concerns about your ability to care for yourself? ☐ Yes ☐ No | |
| Do you use or need any of the following? (Select all that apply.): | |

| | | | |
|---|---|---|---|
| ☐ Glasses<br>☐*Use* ☐*Need* | ☐ Cane<br>☐*Use* ☐*Need* | ☐ Walker<br>☐*Use* ☐*Need* | ☐ Hearing device<br>☐*Use* ☐*Need* |
| ☐ TTY (visual support)<br>☐*Use* ☐*Need* | ☐ Crutches<br>☐*Use* ☐*Need* | ☐ Grab bars<br>☐*Use* ☐*Need* | ☐ Raised toilet seat/chair<br>☐*Use* ☐*Need* |
| ☐Feeding tube<br>☐*Use* ☐*Need* | ☐Wheelchair<br>☐*Use* ☐*Need* | ☐ Food supplements<br>☐*Use* ☐*Need* | ☐ Hospital bed<br>☐*Use* ☐*Need* |
| ☐ Oxygen<br>☐*Use* ☐*Need* | ☐Ostomy supplies<br>☐*Use* ☐*Need* | ☐ CPAP/BiPAP<br>☐*Use* ☐*Need* | ☐ Diabetes supplies<br>☐*Use* ☐*Need* |
| ☐ Large print<br>☐*Use* ☐*Need* | ☐ Sideboard<br>☐*Use* ☐*Need* | ☐ Urinary catheter<br>☐*Use* ☐*Need* | ☐ IV infusions for meds<br>☐*Use* ☐*Need* |
| ☐ Incontinence supplies<br>☐*Use* ☐*Need* | ☐ Trach/suction supplies<br>☐*Use* ☐*Need* | ☐ Lift device (for transferring)<br>☐*Use* ☐*Need* | ☐ Other<br>☐*Use* ☐*Need* |
| Comments: | | | |