

# STATE OF ALASKA

Department of Health and Social Services  
 Division of Senior and Disabilities Services  
 PCA Program –Prescribed Task Form



**This section may be filled out by the PCA Agency, the recipient or the POA/guardian as necessary.**

Recipient's name: Sex: M or F		Ordering Provider's Name:	
Recipient's Medicaid #:		Telephone#:	
Date of Birth/ Current Age:		Fax #:	

**Attention: Physician, Physician's Assistant, or Advanced Nurse Practitioner:**

The Personal Care Assistance program covers physical assistance with **activities of daily living (ADL)**, such as bathing, dressing, repositioning, and transfers from bed to a chair or wheelchair for recipients who experience physical limitations or disabilities. The program also covers assistance with **instrumental activities of daily living (IADL)**, such as with shopping, laundry, meal preparation, and light housekeeping.

The information that you supply is part of the application for Personal Care Services and along with a State assessment, is used at SDS to reach a Personal Care Services coverage decision. Current Medicaid regulation, 7 AAC 125.030, provides coverage for the following tasks **only when they are prescribed by a physician, a physician assistant, or an advanced nurse practitioner:**

1. Foot care, excluding nail care for recipients who are diabetic or have poor circulation
2. Physical assistance with walking or simple exercises
3. Physical assistance with range-of-motion and stretching exercises.

Please address your patient's need for physical "hands-on" assistance with the above prescribed tasks. Indicate the frequency, duration, scope and length of time for the prescribed tasks (ex: ROM 1xDay x 15 minutes x 5 days per week for 6 months).

***If your patient is able to perform these tasks independently, please do not write a prescription.***

**Note:** In order to qualify for Personal Care Assistance services, a person must need:

- 1) **Limited assistance** in at least one **ADL** (person highly involved in activity; physical help in guided maneuvering of limbs of other non-weight bearing assistance 3X times or limited assistance plus weight bearing 1 or 2 times in the past seven days);
- 2) **Assistance** with at least one **IADL** (Person involved inactivity but physical assistance was provided, or total dependence – the person was not involved at all when the activity was performed; or
- 3) **Prescriptions** for foot care, walking for exercise and range-of-motion are PCA services supported by a medical provider prescription only. All other covered services are supported by an SDS home assessment of the recipient and amended by request with documentation of change in condition from the most recent SDS assessment date.

# STATE OF ALASKA

Department of Health and Social Services  
 Division of Senior and Disabilities Services  
 PCA Program – Service Plan Amendment



**This section may be filled out by the PCA Agency, the recipient or the POA/guardian as necessary.**

Recipient's name: Sex: M or F		Ordering Provider's Name:	
Recipient's Medicaid #:		Telephone#:	
Date of Birth/ Current Age:		Fax #:	

**THE FOLLOWING SECTION MUST BE COMPLETED BY THE ORDERING PRESCRIBER ONLY.**

Please fill out the section below to prescribe the previously stated allowable items.

- Please consider whether your client is independent, requires set up assistance only or requires physical assistance to complete the prescribed activities.
- Please *be specific* about the time given for each task, **do not use ranges**. (Ex of ranged time: ROM 20 – 30 minutes daily)
- Please enter the date your client was last seen by your practice.
- Please sign and date.

Prescribed Task or Tasks:

	<u>Independent</u>	<u>Set up only</u>	<u>Physical Assist</u>	<u>Frequency</u>	<u>Scope</u>	<u>Duration</u>	<u>Length of Prescription</u>	<u>Prescriber's Initials</u>
<u>Range of Motion</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ x ___	___ x ___	___	___	_____
<u>Walking Exercise</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ x ___	___ x ___	___	___	_____
<u>Foot Care</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ x ___	___ x ___	___	___	_____

Date of client's most recent visit: \_\_\_\_\_

**A physician, physician assistant, or advanced nurse practitioner licensed in this state or practicing or employed in a federally or tribally owned or leased facility in this state who attests to the medical necessity of the prescribed tasks, who knowingly or willfully makes or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity of information is true, accurate and complete to the best of my knowledge for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.**

Prescriber's Printed Name: \_\_\_\_\_

Prescriber's Medicaid ID or AK License#: \_\_\_\_\_  MD  PA  ANP

Prescriber's Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_