Wellspring Home Health Center Referral for PCA Services

8815 S Tacoma Way Suite 120
Lakewood, WA 98498
Office: (253) 625-7606 Fax: (253) 625-7079

DATE OF REFERRAL	Initial OR Assessment Reassessment	DATE Current service Agreement Ends	DATE OF Assessment

Recipient information

Name			Gender Male Female	DATE OF BIRTH
Address				MR#
CITY	County	State	ZIP	Phone number
Primary Contact/Responsible PARTY				Phone number

EVS VERIFICATION DATE:___/____/_____ You Can Also verify Recipient Eligibility Online VIA Alaska Medicaid/Senior & Disability office.	Major Program PCA Chore/Respite _____ PCA_____ Waiver Chore/Respite _____

PRIVATE PAY: Yes No	Medicaid # Yes No	THIRD PARTY LIABILITY (Insurance) name Yes No	waiver/AC Y N

Physician information

Physician Name	Physician Clinic	NPI:
Address:		
Physician Signature:	Date:	

CITY	State	ZIP	Phone Numbers

PCA/PCS Service hours Needed (Please Circle)

1. 4 hour minimum daily_____(Sun / Mon / Tue / Wed / Thurs / Fri / Sat /)
2. 8 hours daily ____(Sun / Mon / Tue / Wed / Thurs / Fri / Sat /)
3. 12 hours daily ____(Sun / Mon / Tue / Wed / Thurs / Fri / Sat /)
4. 24 hours daily (7am – 3pm/3pm – 11pm/11pm – 7am)_____(Sun / Mon / Tue / Wed / Thurs / Fri / Sat /)

Language

LANGUEGE INTERPRETER NEEDED Y n	LANGUAGE SPOKEN	Sign Language Interpreter needed Y n	OTHER

Direct own care/responsible party

Person APPEARS TO BE ABLE TO DIRECT OWN CARE Y n unknown IF "no" A RESPONSIBLE PARTY MUST BE PRESENT AT THE ASSESSMENTS	RESPONSIBLE PARTY NAME LIVES WITH RECIPIENT Y N	PHONE NUMBER:

Recipient specific information

Diagnosis	Date of Onset (if known)	ICD-9-CM

COMMUNITY LIVING ARRANGEMENT: Yes _ No __ OTHER COMMENTS ABOUT THIS REFERRAL: **MINIMUM OF 4 HOURS DAILY**	Current PLANNED UPO DISCHARGED EXPLAIN: