

Request for Reconsideration Form: Personal Care Services



Personal Care Services (PCS) is a Medicaid benefit that helps beneficiaries with disabilities perform Activities of Daily Living (ADLs), including eating, dressing, bathing, using the bathroom, and doing light housework. To qualify for the service, Vaya Health (Vaya) members are assessed by a nurse who determines the amount of support they need. Vaya's Utilization Management Team then issues a PCS authorization.

Members who have received a PCS authorization for fewer than 80 hours per month and are at least 21 years of age may submit this form to request additional PCS hours. To submit a request, **fax this completed form to 828-707-9349** no earlier than 31 days and no later than 60 days from the date of the initial approval notification. Incomplete or illegible forms will not be processed. If you have questions, including about a member's approval notification date, contact Vaya's PCS Assessment Team at 1-877-290-6315.

Section A: Member Information

First name: _____ MI: _____ Last name: _____

Date of birth: _____ Medicaid ID: _____

Phone number: _____

Address: _____

City: _____ County: _____ ZIP code: _____

Legally Responsible Person (if applicable):

First name: _____ MI: _____ Last name: _____

Relationship to member: _____ Phone number: _____

Section B: Information About Activities of Daily Living

Please specify which ADLs are not supported by the current authorized hours of PCS.

Bathing Dressing Mobility Toileting Eating

Other – If other, describe: _____

Section C: Supporting Documentation

Along with this form, include in the faxed request:

- Documentation that supports the member's need for more PCS hours and the ADL(s) and task(s) that are not being met with the current hours (for example, medical records, caregiver work schedule changes, loss of caregiver, or physical therapy evaluations)
- Information about why the previous assessment did not accurately reflect the member's functional needs or is otherwise insufficient.

Signature of Member or Legal Guardian/Power of Attorney

Date

Name (Print), Relationship to Member (if applicable)