Personal Needs Assessment (PNA) Referral Form

A PNA is needed for the following Member:

Member Name: _____

Member DOB: _____ Member Medicaid ID #: _____

Current Authorization End Date: _____

Diagnosis Code: _____

Member Address: _____

_____

City State Zip Code

Primary Language(s) Spoken: _____

Phone Number for Member or Contact Person: _____

Name of Member's Personal Care Worker (PCW): _____

Phone Number for Member's PCW: _____

The Requesting PCW agency is:

Name of PCW Agency:_____

PCW Agency Contact: _____

PCW Agency Contact Phone: _____

Note: For members who are non-English speaking, please ensure a professional interpreter is available during the PNA review. Assistance requesting interpreter or translator agency for a member can be found Translation Instructions for Providers & Agencies

Please send this form and completed PNA to:

Fax:_____

email: _____

Thank you for helping to provide excellent quality care to our members

email:iCarePCW@icarehealthplan.org
Phone: 414-223-4847
Fax: 414-231-1026
www.iCareHealthPlan.org