INDEPENDENT CARE HEALTH PLAN
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# 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: _____

Number for Member or Contact Person: _____

Member's Personal Care Worker (PCW): _____

Phone Number for Member's PCW: _____

## The Requesting PCW agency is:

Name of PCW Agency:_____

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 email this form and completed PNA to:**

Holistic Health: Tessa.Decker@Holistichh.com (for members WITHIN Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties)

**----- OR -----**

*i*Care PNA screeners: iCarePCWPNA@iCarehealthplan.org (for members OUTSIDE of the counties above)

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