FORWARDHEALTH

PERSONAL CARE SCREENING TOOL (PCST)

Instructions: Print or type clearly. Refer to the Personal Care Screening Tool (PCST) Completion Instructions, F-11133A, for information on completing this form.

SECTION I – BASIC INFORMATION – SCREENER

1a. Name – Screening Agency	2. Screen Completion Date
1b. Telephone Number – Screening Agency	

3a. Name – Screener (First Name, Middle Initial, Last Name)

3b. Qualifications – Screener ☐ Registered Nurse (RN) ☐ Certified Adult LTC Functional Screener ☐ Other

SECTION II – BASIC INFORMATION – MEMBER

4. Name and Title – Member (Title, First Name, Middle Initial, Last Name [Middle Initial and Title Optional])

5. Gender – Member	6. Date of Birth – Member	7. Social Security Number – Member
☐ Male ☐ Female		

8. Living Situation – Member

Own Home or Apartment
- ☐ Alone; includes person living alone who receives in-home services
- ☐ With spouse / partner / family
- ☐ With nonrelative / roommates; includes dormitory, convent, or other communal setting
- ☐ With live-in paid caregiver(s); includes service in exchange for room and board

Someone Else's Home or Apartment
- ☐ Family
- ☐ Nonrelative
- ☐ 1-2 bed adult family home (certified) or other
- ☐ Paid caregiver's home
- ☐ Home / apartment for which lease is held by support services provider

Apartment with Services
- ☐ Residential care apartment complex
- ☐ Independent apartment community-based residential facility

Group Residential Care Setting
- ☐ Licensed adult family home (three to four-bed home)
- ☐ Community-based residential facility with 1-20 beds
- ☐ Community-based residential facility with more than 20 beds
- ☐ Children's group home

Health Care Facility / Institution
- ☐ Nursing home; includes rehabilitation facility
- ☐ Intermediate care facility for individuals with intellectual disabilities
- ☐ Developmental disability center / state institution for developmental disabilities
- ☐ Mental health institute / state psychiatric institution
- ☐ Other institution for mental disease
- ☐ Child caring institution
- ☐ Hospice
- ☐ No permanent residence (e.g., a homeless shelter)

Other
- ☐ Specify (e.g., jail) _____

Continued

SECTION II – BASIC INFORMATION – MEMBER (Continued)

9. Address – Member (Street, City, State, ZIP Code)

10. Telephone Number – Member (Optional)

Home _____ Work _____ Cell _____

11. County / Tribe of Residence – Member	12. County / Tribe of Responsibility – Member

SECTION III – INSURANCE AND CONTACT INFORMATION – MEMBER

13. Medical Insurance

Check all that apply:

Medicare (Specify ID number.) _____

Part A Effective Date (If known.) _____

Part B Effective Date (If known.) _____

Medicare Managed Care

ForwardHealth (Specify member number.) _____

Private insurance (Includes employer-sponsored [job benefit] insurance)

Private Long-Term Care Number _____

Railroad Retirement (Specify number.) _____

Other insurance

No medical insurance at this time

14. Responsible Party Contact if Not "Member" (Optional)

- ☐ Adult Child
- ☐ Ex-spouse
- ☐ Guardian of Person
- ☐ Parent / Stepparent
- ☐ Power of Attorney
- ☐ Sibling
- ☐ Spouse
- ☐ Other Informal Caregiver / Support _____

15. Name – Responsible Party (First, Middle Initial, Last) (Optional)	16. Telephone Number(s) – Responsible Party (Optional) Home _____ Work _____ Cell _____ Best time to call _____

17. Address – Responsible Party (Street, City, State, ZIP Code) (Optional)

Continued

SECTION IV – ACTIVITIES OF DAILY LIVING

18. Scheduled Activities Outside the Residence (Include a schedule of activities in the member's medical file.)

Does the member regularly attend scheduled activities outside the residence? ☐ Yes ☐ No

If yes, how many days per week do regularly scheduled activities occur? _____

19. Bathing

"Bathing" means cleansing **all** surfaces of the body and includes assistance with changing clothing, getting in and out of the tub or shower, wetting, soaping, and rinsing skin, shampooing hair, drying body, applying lotion to skin, applying deodorant, and routine catheter care. Do not select bathing for activities that are grooming, washing hands and face only, and clean-up following incontinence and meals.

Select the response, A–F, that best describes the level of function the member possesses when bathing.

☐ A. Member is able to bathe him- or herself in the shower or tub, with or without an assistive device.
☐ B. Member is able to bathe him- or herself in the shower or tub but requires the presence of another person intermittently for supervision or cueing.
☐ C. Member is able to bathe him- or herself in shower or tub but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.
☐ D. Member is able to bathe in shower, tub, or bed with partial physical assistance from another person.
☐ E. Member is unable to effectively participate in bathing and is totally bathed by another person.
☐ F. Member's ability is age appropriate for a child age 5 or younger.

Indicate the number of days per week personal care worker (PCW) assistance is medically necessary with bathing: _____

Comments (Required if Bathing "C" is selected.)

20. Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device). Dressing assistance does not include activities with garment closures (e.g., zippers, buttons) at the back of the garment. Typical clothing changes are from sleepwear to daywear and from daywear to sleepwear.

Upper Body
Upper body dressing includes dressing activities related to garments covering the torso above the waist (e.g., shirt, sweater, pajama top, T-shirt, and dress). Select the response, A-F that best describes the level of function the member possesses when dressing his or her upper body.

☐ A. Member is able to dress the upper body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.
☐ B. Member is able to dress the upper body by him- or herself but requires the presence of another person intermittently for supervision or cueing.
☐ C. Member is able to dress the upper body by him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.
☐ D. Member needs partial physical assistance from another person to dress the upper body.
☐ E. Member depends entirely upon another person to dress the upper body.
☐ F. Member's ability is age appropriate for a child age 5 or younger.

Indicate when PCW assistance with dressing the upper body is medically necessary. ☐ A.M. ☐ P.M. ☐ Both

Indicate the number of days per week PCW assistance with dressing the upper body is medically necessary. _____

Comments (Required if Dressing Upper Body "C" is selected.)

Continued

SECTION IV – ACTIVITIES OF DAILY LIVING (Continued)

20. Dressing (Continued)

Lower Body
Lower body dressing includes dressing activities related to garments covering the torso from the waist down (e.g., pants, underpants, skirt, socks, and shoes). Select the response, A–F that best describes the level of function the member possesses when dressing his or her lower body.

- ☐ A. Member is able to dress the lower body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.
- ☐ B. Member is able to dress the lower body by him- or herself but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to dress lower body by him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.
- ☐ D. Member needs partial physical assistance from another person to dress the lower body.
- ☐ E. Member depends entirely upon another person to dress the lower body.
- ☐ F. Member's ability is age appropriate for a child age 5 or younger.

Indicate when PCW assistance with dressing the lower body is medically necessary. ☐ A.M. ☐ P.M. ☐ Both

Indicate the number of days per week PCW assistance with dressing the lower body is medically necessary. _____

Comments (Required if Dressing Lower Body "C" is selected.)

21. Prescription Prosthetics, Braces, Splints, and/or Anti-Embolism Hose

Indicate whether or not PCW assistance is needed with placement and/or removal of a prescribed Medicaid covered prosthetic, brace, splint, or anti-embolism hose if medically necessary. If "Yes" is selected, indicate which item(s) the PCW is placing and/or removing in the Comments below.

☐ Yes ☐ No

Indicate the number of days per week PCW assistance with placement and/or removal of a prescribed Medicaid-covered prosthetic, brace, splint, or anti-embolism hose is medically necessary.

Comments (Required if "Yes" is selected.)

22. Grooming

"Grooming" means the ability to tend to personal hygiene needs. Grooming activities include washing face, hands, and feet; combing, brushing, and shampooing hair; shaving; nail care; applying deodorant; and oral or denture care. Grooming should not be selected for activities (e.g., shampooing or deodorant application) that can be completed during bathing.

Select the response, A–G, that best describes the level of function the member possesses when grooming.

- ☐ A. Member is able to groom him- or herself, with or without the use of assistive devices or adapted methods.
- ☐ B. Member is able to groom him- or herself but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to groom him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.
- ☐ D. Member needs physical assistance to set up grooming supplies, but can groom him- or herself.
- ☐ E. Member needs partial physical assistance to groom him- or herself.
- ☐ F. Member depends entirely upon another person for grooming.
- ☐ G. Member's ability is age appropriate for a child age 5 or younger.

Indicate when PCW assistance with grooming is medically necessary. ☐ A.M. ☐ P.M. ☐ Both

Indicate the number of days per week PCW assistance is needed with grooming. _____

Comments (Required if Grooming "C" is selected.)

Continued

SECTION IV – ACTIVITIES OF DAILY LIVING (Continued)

23. Eating

"Eating" means the ability to use conventional or adaptive utensils to ingest meals by mouth. Do not select "eating" if only assistance with meal preparation is needed. Time for meal preparation is included with time for services incidental to activities of daily living (ADL). Refer to Element 30 for time for meal preparation.

Select the response, 0 or A–H, that best describes the level of function the member possesses when eating. Complete the daily tube feedings under Element 29 as appropriate.

- ☐ 0. Member's nutritional needs are met primarily through tube feedings or intravenously.
- ☐ A. Member is able to feed him- or herself, with or without use of assistive device or adapted methods.
- ☐ B. Member is able to feed him- or herself but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to feed him- or herself but requires physical assistance at meal time with set up.
- ☐ D. Member is able to feed him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "D" is selected. Do not select "D" for a member who requires monitoring to assure the member does not overeat or "play" with food or for a member who requires a special diet.
- ☐ E. Member has recent history of choking or potential for choking, based on documentation. Complete Comments below if "E" is selected. Include in the comments the supporting medical diagnosis and the reason this level of assistance from a PCW is medically necessary.
- ☐ F. Member needs partial physical feeding from another person.
- ☐ G. Member needs total feeding from another person.
- ☐ H. Member's ability is age appropriate for a child age 3 or younger.

Indicate the meals for which PCW assistance is medically necessary. ☐ Breakfast ☐ Lunch ☐ Dinner ☐ None

Indicate the number of days per week PCW assistance is medically necessary for each meal.

Breakfast _____ Lunch _____ Dinner _____ ☐ Not Required

Comments (Required if Eating "D" or "E" is selected.)

24. Mobility in the Home

"Mobility in the home" means the ability to move about (ambulate) the member's living environment, including the kitchen, living room, bathroom, and sleeping area. **This excludes basements, attics, yards, and any equipment used outside the home.**

Select the response, 0 or A–E, that best describes the level of function the member possesses when moving between locations in the home with or without help from an assistive device. Assistive devices include, but are not limited to, canes, crutches, walkers, scooters, and wheelchairs.

- ☐ 0. Member remains bedfast.
- ☐ A. Member is able to move about by him- or herself.
- ☐ B. Member is able to move about by him- or herself but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to move about by him- or herself but requires the constant presence of PCW to provide immediate physical intervention during the performance of the task. Complete Comments below if "C" is selected.
- ☐ D. Member needs physical help from another person.
- ☐ E. Member's ability is age appropriate for a child 18 months or younger.

Indicate the number of days per week PCW assistance is medically necessary with mobility in the home. _____

Comments (Required if Mobility in the Home "C" is selected.)

Continued

SECTION IV – ACTIVITIES OF DAILY LIVING (Continued)

25. Toileting

Toileting includes transfers on and off the toilet or other container for collection of waste, cleansing affected body surfaces, changing personal hygiene products used for incontinence, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers related to toileting.

Select the responses, A–G, that best describe the level of function the member possesses when toileting. Select all responses that apply and, as requested, include the frequency per day.

- ☐ A. Member is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device.
- ☐ B. Member is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to toilet him- or herself or provide his or her own incontinence care but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task.

  Estimated frequency per day that PCW assistance is needed with toileting. _____
  Complete Comments below if "C" is selected.
- ☐ D. Member needs physical help from another person to use the toilet and/or change a personal hygiene product.

  Estimated frequency per day that PCW assistance is needed with toileting.
- ☐ E. Member needs physical help from another person for incontinence care. (Does not include stress incontinence.)

  Estimated frequency per day that PCW assistance is needed with incontinence care. _____
- ☐ F. Member needs physical help from another person to empty an ostomy or catheter bag.

  Estimated frequency per day that PCW assistance is needed with ostomy or catheter care. _____
- ☐ G. Member's ability is age appropriate for a child age 4 or younger.

Indicate the number of days per week PCW assistance is medically necessary for toileting. _____

Comments (Required if Toileting "C" is selected.)

26. Transferring

"Transferring" means physically moving from one surface to another (e.g., from bed to wheelchair and from scooter to bed or usual sleeping place) and the ability to use assistive devices for simple transfers. Complete "Other" in Element 29 for all complex transfers. Transferring excludes transfers related to bathing and toileting.

Select the response, A–G, that best describes the level of function the member possesses when transferring.

- ☐ A. Member is able to transfer him- or herself, with or without an assistive device.
- ☐ B. Member is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments if "C" is selected.
- ☐ D. Member needs the physical help of another person but is able to participate (e.g., member can stand and bear weight).
- ☐ E. Member needs constant physical help from another person and is unable to participate (e.g., member is unable to stand and pivot or is unable to bear weight).
- ☐ F. Member needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring. Complete "Other" in Element 29 if "F" is selected in this element.
- ☐ G. Member's ability is age appropriate for a child age 3 or younger.

Indicate the number of days per week PCW assistance is needed with transferring. _____

Comments (Required if Transferring "C" is selected.)

Continued

SECTION V – MEDICALLY ORIENTED TASKS – DELEGATING NURSING ACTS

27. (**Part I**) Medication Assistance Delegated to a PCW

Select the option that best describes the member's level of need for PCW assistance with prescription medications that are usually self-administered. (Do not include giving injections.)

- ☐ 0. Not applicable
- ☐ A. Independent with medications, with or without the use of a device
- ☐ B. Needs reminders
- ☐ C. Needs the physical help of another person, not a PCW
- ☐ D. Needs the physical help of a PCW

Frequency per day _____

Indicate the number of days per week PCW assistance is needed with medication assistance. _____

Comments

28. (**Part II**) Delegated Nursing Acts to Be Performed by a PCW

Select the tasks to be completed by a PCW. Indicate the frequency per day and days per week each task will be performed.

Glucometer Readings (Allowed when medical condition supports the need for ongoing, frequent monitoring for the early detection of glucose readings outside parameters established by the physician.)

PCW Frequency Per Day _____ PCW Days Per Week _____

Skin Care (Application of prescription medications. Do not include application of dressings involving prescription medication and use of aseptic techniques.)

Name of Prescription Medication (Required if Skin Care is selected.) _____

Frequency Prescribed (Required if Skin Care is selected.) _____

PCW Frequency Per Day _____ PCW Days Per Week _____

Catheter Site Care (Only for suprapubic catheters. Do not include insertion and sterile irrigation of catheters.)

PCW Frequency Per Day _____ PCW Days Per Week _____

Feeding Tube Site Care (Do not select if the site care needed is only cleansing with soap and water.)

PCW Frequency Per Day _____ PCW Days Per Week _____

Complex Positioning

PCW Frequency Per Day _____ PCW Days Per Week _____

Comments

Continued

SECTION V – MEDICALLY ORIENTED TASKS – DELEGATING NURSING ACTS (Continued)

29. (**Part III**) Delegated Nursing Acts to Be Performed by a PCW **(ForwardHealth review and manual approval may be required.)**

Select the tasks to be completed by a PCW as delegated by the RN. Indicate the frequency per day and days per week each task will be performed. For tasks indicated in this element, manual review of the prior authorization (PA) request will be required only when the total amount of time computed by the PCST is insufficient for a PCW also to provide the delegated medical tasks identified in this element **and** additional time is being requested for those delegated medical tasks. Include the Personal Care Addendum, F-11136, the plan of care (POC), and other documentation as directed when submitting the PA request.

Daily Tube Feedings (Nasogastric, Gastrostomy, or Jejunostomy)

Continuous Feeding	PCW Frequency Per Day _____	PCW Days Per Week _____
Intermittent (Bolus) Feeding	PCW Frequency Per Day _____	PCW Days Per Week _____

Respiratory Assistance (Check all that apply.)

Tracheostomy Care	PCW Frequency Per Day _____	PCW Days Per Week _____
Suctioning	PCW Frequency Per Day _____	PCW Days Per Week _____
Chest Physiotherapy	PCW Frequency Per Day _____	PCW Days Per Week _____
Nebulizer	PCW Frequency Per Day _____	PCW Days Per Week _____

Bowel Program (Check all that apply.)

Suppository	PCW Frequency Per Day _____	PCW Days Per Week _____
Enema	PCW Frequency Per Day _____	PCW Days Per Week _____
Digital Stimulation	PCW Frequency Per Day _____	PCW Days Per Week _____

Other Program (Check all that apply.)

Wound Care (Excludes basic skin care. Do not include application of dressings involving prescription medication and use of aseptic techniques.)

PCW Frequency Per Day _____ PCW Days Per Week _____

Range of Motion (Ordered by a physician but not part of a prescribed therapy program.)

PCW Frequency Per Day _____ PCW Days Per Week _____

Vital Signs (Allowed when medical condition supports the need for ongoing, frequent monitoring for early detection of an exacerbation of the existing medical condition, the physician has established parameters, and readings outside the established parameters will trigger a medical intervention or change in treatment.)

PCW Frequency Per Day _____ PCW Days Per Week _____

Other (Specify all tasks that apply.)

_____	PCW Frequency Per Day _____	PCW Days Per Week _____
_____	PCW Frequency Per Day _____	PCW Days Per Week _____

Comments (Required for all delegated nursing acts selected in Part III except Vital Signs.)

Continued

SECTION VI – OTHER CONSIDERATIONS

30. Will services incidental to the ADL and delegated nursing acts be performed by the PCW?

Services incidental to ADL and delegated nursing acts include changing the member's bed, laundering the member's bed linens and personal clothing, care of eyeglasses (also contact lenses) and hearing aids, light cleaning in essential areas of the home used during personal care services, purchasing food for the member, preparing the member's meals, and cleaning the member's dishes. (Refer to the Personal Care area of the Online Handbook on the ForwardHealth Portal.)

☐ Yes ☐ No

31. Behaviors

Does the member exhibit more often than once per week behavior that interferes with the PCW's assistance with ADL and delegated nursing acts and makes ADL and delegated nursing acts more time consuming for the PCW to complete?

☐ Yes ☐ No

If "Yes," list the behavior(s) and describe how the behavior(s) interferes and makes the ADL and delegated nursing acts more time consuming for the PCW to complete.

32. Medical Conditions

Does the member have a rare medical condition that makes ADL and delegated nursing acts more time consuming for a PCW to complete, which is expected to result in a long-term need for extra time?

☐ Yes ☐ No

If "Yes," list the rare medical condition(s), the diagnosis code, the protective equipment prescribed for the member (if any), and member-specific precautions (if any) the PCW is required to adhere to in order to accommodate the rare medical condition, and describe how the condition makes the ADL and delegated nursing acts more time consuming for the PCW to complete.

33. Seizures

Does the member have a diagnosis of seizures? ☐ Yes ☐ No

If "Yes," complete the following.

Date of Last Seizure
- ☐ A. 0–90 days ago
- ☐ B. 91–180 days ago
- ☐ C. More than 180 days ago

Specific Seizure Type _____

Frequency of Seizures _____

Date of Last Seizure _____

Does the PCW provide interventions? ☐ Yes ☐ No

If "Yes," list interventions.

Continued

SECTION VI – OTHER CONSIDERATIONS (Continued)

34. Pro Re Nata (PRN)

When the member goes to Medicaid-covered appointments and/or if the member is expected to experience short duration episodes of acute need, will the PCW assist with ADLs and/or perform delegated nursing acts as indicated in the POC?

☐ Yes ☐ No

35. Notes

Enter information that will enhance the nurse consultant's understanding of the member's medical condition and need for PRN time.

SECTION VII – REQUIRED PCST SUMMARY SHEET COMPLETION INFORMATION

36. Name – Billing Provider Check if case sharing. Names – Other Agencies Sharing the Case	37. Billing Provider Number

38. Address – Billing Provider (Street, City, State, ZIP+4 Code)

SECTION VIII – SIGNATURE

As the authorized screener completing this PCST, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

39. **SIGNATURE** – Authorized Screener	40. Date Signed – Authorized Screener

Reset Form