



WellSpring Home Health Center Referral for PCA Services

**201 E. Swanson Avenue, Suite 7
Wasilla, Alaska 99654**

Office: (907)357-3654/3655 Fax: (907)357-3656



DATE OF REFERRAL	Initial Assessment OR Reassessment	DATE Current service Agreement Ends	DATE OF Assessment
Recipient information			
Name		Gender Male Female	DATE OF BIRTH
Address			MR#
CITY	County	State	ZIP
Primary Contact/Responsible PARTY			Phone number
EVS VERIFICATION		DATE: ___/___/___	Major Program
You Can Also verify Recipient Eligibility Online VIA Alaska Medicaid/Senior & Disability office.			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			
LANGUAGE 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	PHONE NUMBER:	
	LIVES WITH RECIPIENT Y N		
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:	