Personal Care Screening Tool (PCST)

Instructions

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

Section 1 – Basic information – Screener

1a. Name – Screening agency: _____

1b. Phone number – Screening agency: _____ 2. Screen completion date: _____

3a. Medicaid billing provider ID: _____

3b. Name – Screener (First, middle initial, last): _____

3c. Qualifications – Screener

- ☐ Certified adult long-term care functional screener (LTC FS)
- ☐ Registered nurse (RN) _____
- ☐ Other

Section 2 – Basic information – Member

4. Name and title – Member (Title, first name, middle initial, last name [middle initial and title optional]):

_____

5. Gender – Member: ☐ Male ☐ Female

6. Date of birth – Member: _____ 7. Social Security number – Member: _____

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 (for example, a homeless shelter)

Other

- ☐ Specify (for example, jail): _____

9. Address – Member – Street: _____

   City: _____ State: _____ ZIP code: _____

10. Phone number – Member (optional)

    Home: _____ Work: _____ Cell: _____

11. County / Tribe of residence – Member: _____

12. County / Tribe of responsibility – Member: _____

Section 3 – 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 ID number): _____
- ☐ Private insurance (Includes employer-sponsored [job benefit] insurance)
- ☐ Private LTC number: _____
- ☐ Railroad Retirement (Specify ID number): _____
- ☐ Other insurance
- ☐ No medical insurance at this time

14. Responsible party contact if not member (Optional)

- ☐ Adult child
- ☐ Ex-spouse
- ☐ Power of attorney
- ☐ Sibling

☐ Guardian of person ☐ Spouse
☐ Parent / stepparent ☐ Other informal caregiver / support: _____

15. Name – Responsible party (First name, middle initial, last name) (Optional):

_____

16. Phone number(s) – Responsible party (Optional):

Home: _____ Work: _____

Cell: _____ Best time to call: _____

17. Address – Responsible party (Optional) – Street: _____

City: _____ State: _____ ZIP code: _____

Section 4 – Activities of daily living (ADL)

18. Scheduled activities outside the residence (Include a schedule of activities in the Personal Care Addendum, F-11136.)

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 getting undressed, getting in and out of the tub or shower, wetting, soaping, and rinsing skin, shampooing hair, drying body, applying lotion to skin, applying deodorant, routine catheter care, and getting dressed. Do not select bathing for activities that are grooming, washing hands and face only, or clean-up following incontinence and meals.

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

☐ A. Member is able to bathe themselves in the shower or tub, with or without an assistive device.
☐ B. Member is able to bathe themselves in the shower or tub but requires the presence of another person intermittently for supervision or cueing.
☐ C. Member is able to bathe themselves in shower or tub but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for a least one step of the activity while the task is being completed.
☐ D. Member is able to bathe in the 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 aged 5 years or younger.

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

Comments (Required if screener selects any responses from C–F.)

20. Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device). 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 (for example, shirt, sweater, pajama top, t-shirt, and dress). Select the response, A–F, that best describes the member's level of function when dressing their upper body.

- ☐ A. Member is able to dress their upper body without assistance or is able to dress themselves if clothing is laid out or handed to them.
- ☐ B. Member is able to dress the upper body by themselves but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to dress the upper body by themselves but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for a least one step of the activity while the task is being completed.
- ☐ D. Member needs partial physical assistance from another person to dress their upper body.
- ☐ E. Member depends entirely upon another person to dress their upper body.
- ☐ F. Member's ability is age appropriate for a child aged 5 years or younger.

If bathing is requested in Element 19, one episode of dressing is included. For members receiving more than one PCW visit per day, indicate any additional time of day upper body dressing assistance is requested.

☐ A.M. ☐ P.M. ☐ Not required

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

_____

Comments (Required if screener selects any responses from C–F.)

Lower body

Lower body dressing includes dressing activities related to garments covering the torso from the waist down (for example, pants, underpants, skirt, socks, and shoes). Select the response, A–F, that best describes the member's level of function when dressing their lower body.

- ☐ A. Member is able to dress their lower body without assistance or is able to dress themselves if clothing is laid out or handed to them.
- ☐ B. Member is able to dress the lower body by themselves but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to dress the lower body by themselves but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for at least one step of the activity while the task is being completed.
- ☐ D. Member needs partial physical assistance from another person to dress their lower body.
- ☐ E. Member depends entirely upon another person to dress their lower body.
- ☐ F. Member's ability is age appropriate for a child aged 5 years or younger.

If bathing is requested in Element 19, one episode of dressing is included. For members receiving more than one PCW visit per day, indicate any additional time of day lower body dressing assistance is requested.
☐ A.M. ☐ P.M. ☐ Not required

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

_____

Comments (Required if screener selects any responses from C–F.)

21. Prescription prosthetics, braces, splints, and/or anti-embolism hose

Indicate whether PCW assistance is needed with placement or removal of a prescribed Medicaid-covered prosthetic, brace, splint, transcutaneous electrical nerve stimulation (TENS) unit, or anti-embolism hose. If "Yes" is selected, indicate which items the PCW is placing or removing in the Comments below.
☐ Yes ☐ No

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

_____

Comments (Required if screener selects "Yes".)

22. Grooming

"Grooming" means the ability to tend to personal hygiene needs. Grooming activities include washing face and hands; combing, brushing, and shampooing hair; shaving; nail care; applying deodorant; and oral or denture care. Grooming should not be selected for activities (for example, shampooing or deodorant application) that can be completed during bathing and bathing is selected in Element 19.

Select the response, A–G, that best describes the member's level of function when grooming.
☐ A. Member is able to groom themselves, with or without the use of assistive devices or adapted methods.
☐ B. Member is able to groom themselves but requires the presence of another person intermittently for supervision or cueing.
☐ C. Member is able to groom themselves but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for a least one step of the activity while the task is being completed.
☐ D. Member needs physical assistance to set up grooming supplies but can groom themselves.
☐ E. Member needs partial physical assistance to groom themselves.
☐ F. Member depends entirely on another person for grooming.
☐ G. Member's ability is age appropriate for a child aged 5 years 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 screener selects any responses from C–G.)

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 and clean up is included with time for services incidental to ADL. Refer to Element 30 for time for incidental services.

Select the response, 0 or A–H, that best describes the member's level of function 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 themselves, with or without use of assistive device or adapted methods.
☐ B. Member is able to feed themselves but requires the presence of another person intermittently for supervision or cueing.
☐ C. Member is able to feed themselves but requires physical assistance at mealtime with setting up adaptive utensils and/or a clothing protector.
☐ D. Member is able to feed themselves but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for a least one step of the activity while the task is being completed. Do not select "D" for a member who requires monitoring to assure the member does not "play" with food or for a member who requires a special diet.
☐ E. Member has a recent history of choking or a potential for choking based on documentation. 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 aged 3 years 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 screener selects any responses from C–H.)

24. Mobility

"Mobility" means the ability to move about the member's living environment. This includes stairs to enter or leave a residence.

Select the response, 0 or A–E, that best describes the member's level of function when moving between locations, with or without help from an assistive device. Assistive devices may include canes, crutches, walkers, scooters, and wheelchairs.

☐ 0. Member remains bedfast.
☐ A. Member is able to move about by themselves.

- ☐ B. Member is able to move about by themselves but requires the presence of another person intermittently for supervision or cueing.
- ☐ C. Member is able to move about by themselves but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for a least one step of the activity while the task is being completed. Watching the member executing the task by themselves without physical intervention is not constant supervision.
- ☐ 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. _____

Comments (Required if screener selects any responses from C–E.)

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 member's level of function when toileting. Select all responses that apply **during** the PCW visits and include the frequency per day.

- ☐ A. Member is able to toilet themselves or provide their own incontinence care, with or without an assistive device.
- ☐ B. Member is able to toilet themselves or provide their 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 themselves or provide their own incontinence care but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for a least one step of the activity while the task is being completed.

  Estimated frequency per day that PCW assistance is needed with toileting. _____
- ☐ 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. This 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 aged 4 years or younger.

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

Comments (Required if screener selects any responses from C–G.)

26. Transferring

"Transferring" means physically moving from one surface to another (for example, from bed to wheelchair and from scooter to bed or usual sleeping place), transfers in and out of vehicles, 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 member's level of function when transferring.

☐ A. Member is able to transfer themselves, with or without an assistive device.
☐ B. Member is able to transfer themselves, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.
☐ C. Member is able to transfer themselves, with or without an assistive device, but requires the presence of another person throughout the task for constant supervision. The member requires physical intervention for at least one step of the activity while the task is being completed.
☐ D. Member needs the physical help of another person but is able to participate (for example, member can stand and bear weight).
☐ E. Member needs constant physical help from another person and is unable to participate (for example, 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 (for example, Hoyer or EZ Stand lift) when transferring. Complete "Other" in Element 29 if "F" is selected in this element.
☐ G. Member's ability is age appropriate for a child aged 3 years or younger.

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

Comments (Required if screener selects any responses from C–G.)

Section 5 – Medically oriented tasks – Delegating nursing acts

27. (**Part 1**) 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 are required if screener selects "D".

28. (**Part 2**) 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.) Note: Parameters and interventions must be specifically included on the plan of care.

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 (Do not select if the member is already repositioned at least once every two hours through other ADL, such as bathing or toileting.)

PCW frequency per day: _____ PCW days per week: _____

Comments

29. (**Part 3**) 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. Manual review of the prior authorization (PA) request will be required when the total amount of time determined by the PCST is not enough for a PCW to provide the delegated medical tasks identified in this element **and** additional time is being requested for those tasks. Include the Personal Care Addendum, the plan of care, 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** (Medical condition must require the need for ongoing, frequent monitoring to note when there have been changes, the physician has established parameters, **and** readings outside the established parameters require 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 3.)

Section 6 – 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 service area of the ForwardHealth Online Handbook on the ForwardHealth Portal.)

☐ Yes ☐ No

31. Behaviors

Does the member exhibit behavior more than once a week that interferes with ADL and/or medically oriented task (MOT) assistance and makes ADL or MOTs more time-consuming for the PCW to perform?

☐ Yes ☐ No

If "Yes," list the behaviors and describe how the behaviors interfere and make the ADL and delegated nursing acts more time-consuming for the PCW to complete. List interventions used.

32. Rare 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 that 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.

34. Pro Re Nata (PRN)
When the member goes to Medicaid-covered appointments and needs assistance with ADL or if the member is expected to experience short duration episodes of acute need, will the PCW assist with ADL or perform delegated nursing acts as indicated in the plan of care?
☐ Yes ☐ No

35. Notes
Enter information that will help describe the member's medical condition and why PRN time is needed.

Section 7 – Signature

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

36. **Signature** – Authorized screener: _____

37. Date signed – Authorized screener: _____

Reset Form