UTAH DEPARTMENT OF HEALTH

PERSONAL CARE SERVICES

PRIOR AUTHORIZATION CRITERIA WORKSHEET

Member Name	**Medicaid ID#**	**Age**

Date of Request	**Requested Dates of Service**	**Diagnosis**

Requesting Agency Name	**Requesting Agency Phone Number**	**Contact Person Name**

Physician's order (485, Plan of Care)	Yes	No
Patient is bed bound	Yes	No

Documentation of recipient's inability to perform two or more of the following tasks (Check all that apply)

- Needs reminding in self-administration of medications
- Elimination, including the use of a commode, urinal or bedpan
- Bathing or showering, including getting in and out of the tub or shower
- Skin Care
- Ambulation, including use of cane, crutches, walker or wheelchair
- Personal grooming, including oral care, hair care, shaving (electric razor only), dressing, or nail care
- Nutritional requirements, including meal planning, preparation, cleanup, etc.

Documentation that the patient's family is unable or unwilling to provide requested care	Yes	No

Documentation that the patient needs personal care for the following reasons (Choose all that apply)

- Maintain capacity to function, delay disease progression, or prevent regression of an illness
- Achieve a satisfactory level of comfort and dignity during terminal stages of an illness
- Receive assistance while recovering from an acute condition

Does the patient require any of the following home health aide services (Choose all that apply)

- Vital signs or temperature taken
- Urine or stool specimens collected
- Enemas, external catheter applied or removed, external catheter drainage tubing and bag changed or emptied
- Bag changes on well-regulated ostomies
- Active or passive range or motion exercises
- Dry dressing changes

Hours per day	**Days per week**	**Total hours requested for certification period**

To determine total hours: Calculate hours per day x days per week x length of weeks requested (example: 2 hours per day x 3 days per week x 26 weeks = 156 units)