Driscoll Health Plan

Personal Care Services (PCS)
Practitioner's Statement of Need

urac ACCREDITED Health Plan Expires: 06/01/2029
urac ACCREDITED Medicaid Health Plan Expires: 06/01/2029

Client Name (Last, First, MI):	Medicaid Number (PCN):
	Date of Birth:

The Practitioner's Statement of Need (PSON) must be signed by a practitioner (physician, advanced practice nurse, or physician assistant) who has personally examined the client in the last twelve (12) months and reviewed all appropriate medical records.

For questions about the PCS benefit for the client listed on this form, please contact the Driscoll Health Plan (DHP) Service Coordinator listed at the bottom of this page.

Step 1: To be completed by Practitioner

A. PROVIDE ICD codes for the client's active (within the last 12 months) medical or behavioral health diagnosis/diagnoses.

ICD code	ICD code	ICD code	ICD code	ICD code

B. DECLARE client's physical, cognitive or behavioral limitation(s) related to medical or behavioral diagnosis/diagnoses.

*This client **HAS** physical, cognitive or behavioral limitation(s) related to the medical or behavioral diagnosis/diagnoses listed in Section A:*

- ☐ *YES. (Complete All Sections)*
- ☐ *NO. (Skip Section C and Complete Section D & E.)*

C. CHECK all symptoms or limitations related to diagnosis/diagnoses listed above.

Limitations	✓	Limitations	✓	Limitations	✓	Limitations	✓
Bed-Fast or Chair-Bound		Difficulty Swallowing		Weakness / Tremors		Impairment of Executive Functions	
Contractures / Spasticity		Recurrent Aspiration		Hearing Impairment		Memory Impairment	
Paralysis / Limited Mobility or ROM		Requires Special Diet		Visual Impairment		Cognitive Impairment	
Seizures / Blackouts		Incontinence		Sensory Impairment		Repetitive Behaviors	
Resistance to Assistance		Wandering / Elopement		Verbal/Physical Aggression		Other	

D. SIGN

I have personally examined this client in the last twelve (12) months and reviewed all appropriate medical records.

By signing this form I certify that I am a Texas Medicaid enrolled provider and the information provided above is accurate. I understand I am not prescribing personal care services.

Signature of Practitioner:		Date:
Printed name of Practitioner:	TPI:	License Number:

E. RETURN the Practitioner Statement of Need:

- Fax the completed form to the Driscoll Health Plan's (DHP) Service Coordinator at the fax number listed.
- A signed and dated Statement of Need must remain in the client's DHP file.

Step 2: To Be Completed by DHP – Service Coordinator

DHP Service Coordinator (SC):		Date:
DHP SA:	SC Phone number:	SC FAX number: