

**STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES**

**CONNECTICUT HOME CARE PROGRAM**

W-1532 (Rev 4/18)

(Rev 12/14)

 **Supervisory Review for Justification of PCA for Overnight and Live-In Services**

Client Name: Client ID #:

Access Agency: Telephone #:

Care Manager: Date of Request:

[ ]  New Client [ ]  Existing Client [ ]  Overnight [ ]  Live-In

 **Yes No**

|  |  |  |
| --- | --- | --- |
| 1. Does the client have intermittent hands on care needs? | 🞎  | 🞎  |
| 2. If this is a change, what precipitated the change in the plan of care?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎  | 🞎  |
| 3. Was assistive technology considered to mitigate the need for PCA? Please address in memo queue.4. Will PCA Live in prevent institutionalization?  | 🞎  | 🞎  |
| 5. Do the client’s cognitive impairments present unacceptable risks to health and safety? Provide documentation of cognitive deficits and describe risks. | 🞎  | 🞎  |
| 6. Are there substantial health and safety risks due to the client’s impaired judgment? Will the requested services mitigate client safety/risk issues? | 🞎  | 🞎  |
| 7. Does the client have frequent, recurring health care problems due to diminished capacity to address hygiene issues? | 🞎  | 🞎  |
| 8. Is the client unable to get out of bed or perform any self-care independently? | 🞎  | 🞎  |
| 9. Does the client’s history of fall risk present an unacceptable health and safety risk? Does PCA service mitigate this risk? | 🞎  | 🞎  |
| 10. Are there family members, friends or others available to provide care and are there any limitations to their availability/ability to provide care? | 🞎  | 🞎  |
| 11. Is Adult Family Living a reasonable alternative to PCA Live In? | 🞎  | 🞎  |
| 12. Can services be provided within the 115% cost cap? | 🞎  | 🞎  |
| 13. Is the client willing and able to provide 3 meals per day to the live in PCA? | 🞎  | 🞎  |
| 14. Will PCA be able to obtain a total of 8 hours of sleep per day, 5 of which are uninterrupted? | 🞎  | 🞎  |
| 14. Is there a support system who will provide time off relief to the live in? | 🞎  | 🞎  |

Supervisor Signature Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Community Options Approval Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_