REQUEST FOR PERS
(Personal Emergency Response System)

Recipients cannot have both PERS and Supervision time approved on the same Plan of Care.

Recipient Name: _____ Medicaid ID: _____

Primary Provider: _____ Provider Number: _____

PERS Provider: _____ Provider Number: _____

I. RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY PERS

A. **Cognitive Status:** Describe the recipient's cognitive status and impact it has on his/her behavior. If the recipient is confused at different times of the day, please explain. State whether the recipient can/cannot be left alone. If the recipient can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the recipient have appropriate judgment/decision-making abilities? *(Be as detailed as possible. It is important that the RN make a correct appraisal of the cognitive status of the recipient. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.)*

B. **Physical Incapacity:** Describe the degree of physical incapacity and how it creates a need for PERS.

1. Incontinence:
   Bowel: _____ Frequency of Changes: _____
   Bladder: _____ Frequency of Changes: _____
2. Can the recipient change position/shift/transfer without assistance?
3. Skin Breakdown (*Note areas affected/recently documented problems within the last year, including dates*):
4. Potential for skin breakdown (*Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.*):
5. Falls [*Describe any falls that have occurred during the past 3 months, including dates and times of fall(s), and the scenario of the fall(s). Interactions and side effects of medications that may have contributed to the fall(s) must be included. Document what interventions, if any, have been put in place to prevent future falls.*]:

6. Unstable Medical Condition(s) [*List the recipient's current medical diagnoses and needs in relation to any unstable medical condition(s).*]

7. Seizures (*Note the frequency and severity within the past 3 months.*):

8. Mobility (*Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.*):

II. CURRENT SUPPORT SYSTEM

A. Primary Caregiver Information

Name: _____ Home Phone: _____

Does the primary caregiver live with the recipient? ___ **Yes** ___ **No**

If no, the caregiver's address: _____

_____

Does the caregiver work out of the home? ___ **Yes** ___ **No**

If yes, employer's name: _____ Employer's Phone #: _____

Work Hours: _____

Leave Home: _____ Returns Home: _____

B. List the Support System / Backup System for the primary caregiver. *(The recipient must have a support system if the PERS system becomes disabled. If the recipient is authorized for PERS, it is not necessary for a caregiver to live in the home with the recipient in the absence of a nursing aide. List the names of the persons who are a part of the support system. The provider agency must be able to contact the recipient's support system in case of an emergency.)*

C. The amount of additional support time required that cannot be provided by recipient's support system.
This time is important to ensure that the recipient will not be left without an active and involved support system.
# of Hours: _____ Between the time of: _____ and _____

_____
Agency / Screening Team

_____ _____
RN Supervisor/Service Facilitator or PAS Team Member Date

Instructions

If a recipient is requesting PERS (Personal Emergency Response System), the provider must fill this form out completely and submit it to DMAS' preauthorization contractor for authorization. DMAS' preauthorization contractor must approve PERS with an authorization number before DMAS will reimburse for this service.