DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11133 (11/2024)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.13(2)

FORWARDHEALTH

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 I – BASIC INFORMATION – SCREENER

1a. Name – Screening Agency

1b. Phone Number – Screening Agency

2. Screen Completion Date

3a. Name – Screener (First Name, Middle Initial, Last Name)

3b. Qualifications – Screener
- ☐ Certified Adult Long-Term Care (LTC) Functional Screener (LTC FS)
- ☐ Registered Nurse (RN)
- ☐ Other

SECTION II – 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

DT-PA024-024

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 III – 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 member number.) ____________________
- ☐ Private insurance (Includes employer-sponsored [job benefit] insurance)
- ☐ Private LTC Number ____________________
- ☐ Railroad Retirement (Specify number.) ____________________
- ☐ Other insurance
- ☐ No medical insurance at this time

14. Responsible Party Contact if Not Member (Optional)

☐ Adult Child	☐ Power of Attorney
☐ Ex-spouse	☐ Sibling
☐ Guardian of Person	☐ Spouse
☐ Parent / Stepparent	☐ Other Informal Caregiver / Support ____________________

15. Name – Responsible Party (First, Middle Initial, Last) (Optional)

16. Phone Number(s) – Responsible Party (Optional)

Home ______________________________ Work ______________________________

Cell ______________________________ Best time to call ______________________

17. Address – Responsible Party (Street, City, State, Zip Code) (Optional)

SECTION IV – ACTIVITIES OF DAILY LIVING (ADL)

18. Scheduled Activities Outside the Residence (Include a schedule of activities in the Personal Care Addendum.)

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 or younger.

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

____

Comments (Required if any responses from C–F are selected.)

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 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

If bathing is not requested in Element 19, indicate in the comments how many times per day upper body dressing assistance is requested.

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

Comments (Required if any responses from C–F are selected.)

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 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 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 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

If bathing is not requested in Element 19, indicate in the comments how many times per day lower body dressing assistance is requested.

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

Comments (Required if any responses from C–F are selected.)

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 "Yes" is selected.)

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 upon another person for grooming.
❑ G. Member's ability is age appropriate for a child aged 5 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 any responses from C–G are selected.)

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 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 recent history of choking or 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 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 any responses from C–H are selected.)

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.
- ❑ 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 any responses from C–E are selected.)

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 visit(s) 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. (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 or younger.

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

Comments (Required if any responses from C–G are selected.)

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 a 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) 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 or younger.

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

Comments (Required if any responses from C–G are selected.)

SECTION V – MEDICALLY ORIENTED TASKS – DELEGATING NURSING ACTS

27. (**Part I**) 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 “D” is selected.

28. (**Part II**) 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 (POC).

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 ADLs, such as bathing or toileting.)

PCW Frequency Per Day __________________ PCW Days Per Week __________________

Comments

29. (**Part III**) 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, F-11136, the POC, 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 III.)

SECTION VI – 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 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 ADLs 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. 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, which 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 ADLs or if the member is expected to experience short duration episodes of acute need, will the PCW assist with ADLs or perform delegated nursing acts as indicated in the POC?

❑ Yes ❑ No

35. Notes

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

SECTION VII – REQUIRED PCST SUMMARY SHEET COMPLETION INFORMATION

36. Name – Billing Provider ❑ Check if case sharing. Names – Other Agencies Sharing the Case	37. Billing Provider Number
38. Address – Billing Provider (Street, City, State, Zip+4 Code)	

SECTION VIII – 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.

39. **SIGNATURE** – Authorized Screener	40. Date Signed – Authorized Screener