

# PA LINK-PCC 10-1-21

## 1. PA LINK-PERSON CENTERED COUNSELING (PCC)

### 1.A. THE PERSONAL INTERVIEW

1. Date of First Contact (MMDDYYYY)

\_\_\_\_/\_\_\_\_/\_\_\_\_

2. Type of Contact (select only ONE)

- Call-in  
 Call-out  
 Email  
 Walk-in  
 Warm transfer in  
 Other-Document Details in Notes

3. Is this a referral? (select only ONE)

- Yes  
 No (skip to question #8)

4. If yes, what type of referral (select only ONE)

- Independent Enrollment Broker (IEB)  
 Call Center  
 Other-Document Details in Notes

5. If referral, date of First Attempt to Contact (MMDDYYYY)

\_\_\_\_/\_\_\_\_/\_\_\_\_

6. If referral, date of Second Attempt to Contact (MMDDYYYY)

\_\_\_\_/\_\_\_\_/\_\_\_\_

7. If referral, date of Third Attempt to Contact (MMDDYYYY)

\_\_\_\_/\_\_\_\_/\_\_\_\_

8. What is the cause for this application? (select ALL that apply)

- Individual is over age 60  
 Disability

9. Last Name of Person-Centered Counselor

\_\_\_\_\_

10. First Name of Person-Centered Counselor

\_\_\_\_\_

11. Last Name of Caller

\_\_\_\_\_

12. First Name of Caller

\_\_\_\_\_

13. Last Name of Individual Needing Help

\_\_\_\_\_

14. First Name of Individual Needing Help

\_\_\_\_\_

15. Is the individual in need also a family caregiver?

- Yes  
 No

16. Residential Street Address

\_\_\_\_\_

17. Residential Street Address Second Line (if needed)

\_\_\_\_\_

18. Residential City/ Town

\_\_\_\_\_

19. Residential Zip Code

\_\_\_\_\_

**20. Residential County**

- Adams
- Allegheny
- Armstrong
- Beaver
- Bedford
- Berks
- Blair
- Bradford
- Bucks
- Butler
- Cambria
- Cameron
- Carbon
- Centre
- Chester
- Clarion
- Clearfield
- Clinton
- Columbia
- Crawford
- Cumberland
- Dauphin
- Delaware
- Elk
- Erie
- Fayette
- Forest
- Franklin
- Fulton
- Greene
- Huntingdon
- Indiana
- Jefferson
- Juniata
- Lackawanna
- Lancaster
- Lawrence
- Lebanon
- Lehigh
- Luzerne
- Lycoming
- McKean
- Mercer
- Mifflin
- Monroe
- Montgomery
- Montour

- Northampton
- Northumberland
- Perry
- Philadelphia
- Pike
- Potter
- Schuylkill
- Snyder
- Somerset
- Sullivan
- Susquehanna
- Tioga
- Union
- Venango
- Warren
- Washington
- Wayne
- Westmoreland
- Wyoming
- York
- Out of State

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**21. Individual's Date of Birth (DOB) (MMDDYYYY)**

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**22. Individual's Social Security Number (SSN)  
(XXX-XX-XXXX)**

\_\_\_\_-\_\_\_\_-\_\_\_\_

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**23. Primary Phone Number (XXX-XXX-XXXX)**

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**24. E-mail Address**

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**25. What is the individual's current gender identity (defined as one's inner sense of one's own gender)? (Select one)**

- Female
- Male
- Non-Binary
- Transgender Female (male to female)
- Transgender Male (female to male)
- Something else that was not named. Please specify (Document Details in Notes)
- Choose not to disclose

**26. What sex was the individual assigned on their birth certificate at birth? (Select one)**

- Female
- Male
- Something else that was not named. Please specify (Document Details in Notes)
- Choose not to disclose

**27. What is the individual's sexual orientation (defined as one's identification of emotional, romantic, sexual, or affectional attraction to another person) (Select one)**

- Bisexual
- Lesbian, Gay or Homosexual
- Straight or Heterosexual
- Something else that was not named. Please specify (Document Details in Notes)
- Don't know
- Choose not to disclose

**28. Was the individual in need involved during the person-centered counseling process?**

- Yes (skip to question #31)
- No

**29. Did you obtain permission from the individual in need to work with someone else on his or her behalf in accordance with his or her needs, values and preferences?**

- Yes (skip to question #31)
- No

**30. Why was permission to work with someone else not obtained from the individual in need?**

- Advanced or end-stage Alzheimer's Disease or other related dementia
- Brain Injury
- Other severe cognitive impairment
- Person Centered Counselor (PCCer) did not ask for the individual's permission

**31. Time it took (in MINUTES) to complete this section**

**1.B. OVERVIEW OF OPTIONS/RESOURCES**

**1. Primary Type of Disability (select only ONE)**

- Physical Disability
- Mental Health/Behavioral Health
- Intellectual Disability
- Developmental Disability
- Brain Injury
- Autism
- Dementia
- Substance Misuse

- Other-Document Details in Notes
- None

**2. Secondary Type of Disability (select only ONE)**

- Physical Disability
- Mental Health/Behavioral Health
- Intellectual Disability
- Developmental Disability
- Brain Injury
- Autism
- Dementia
- Substance Misuse
- Other-Document Details in Notes
- None

**3. Has the individual ever served in the US Military/U.S. Armed Forces?**

- No (skip to question #9)
- Yes
- Unable to Determine (skip to question #9)

**4. If Yes to B3, did you assist him/her to sign up on the PA VETERANS REGISTRY?**

- Yes (skip to question #6)
- No

**5. If No to B4, why not?**

- Already registered
- Took info and will consider registering on own
- Declined or refused offer to register

**6. If Yes to B3, did you offer a referral to the County Director of Veteran Affairs office?**

- No
- Yes – contact information for County Director provided to individual
- Yes – referral to County Director made on behalf of individual
- Yes – warm transfer to County Director completed with individual present

**7. If Yes to B3, did you offer a referral to the VA (Federal Veterans Affairs system)?**

- No
- Yes – contact information for VA provided to individual
- Yes – referral to VA made on behalf of individual
- Yes – warm transfer to VA completed with individual present

**8. If Yes to B3, other veteran's services and supports discussed or referred to:**

- PA Department of Military and Veterans Affairs
- National Homeless Veterans Helpline
- National Veterans Crisis Line
- Local veterans program
- Other
- None

**9. Is the individual in need the spouse/widow or dependent child of a veteran?**

- No (skip to question #11)
- Unsure (skip to question #11)
- Yes

**10. For spouse/widow or dependent child of veteran, did you offer a referral to the County Director of Veteran Affairs office?**

- No
- Yes – contact information for County Director provided to individual
- Yes – referral to County Director made on behalf of individual
- Yes – warm transfer to County Director was completed with individual present

**11. Is the Individual MA Eligible? (select only ONE)**

- Has MA
- Likely MA Eligible
- Not Likely MA Eligible
- Denied Eligibility
- Application Pending

**12. Type of Caller (select only ONE)**

- Agency
- Self
- Spouse
- Other Family-Document Details in Notes
- Other-Document Details in Notes

**13. If Agency caller, name of organization**

\_\_\_\_\_

**14. Does this person have a Care Manager/Support Coordinator?**

- No-skip to question #17
- Yes

**15. If so, with what organization?**

\_\_\_\_\_

**16. Name of Care Manager/Supports Coordinator**

\_\_\_\_\_

**17. Is the individual transitioning from an institution or hospital?**

- No
- Yes

**18. Did this PCC session assist with applying for Long Term Services and Support (LTSS) in the community?**

- No (skip to question #25)
- Yes

**19. If Yes to B18, was the person enrolled in OPTIONS or ACT 150 at the start of this PCC session?**

- No
- Yes-OPTIONS (document Case/Care Manager Name and Agency in Notes)
- Yes-ACT 150 (document Case/Care Manager Name and Agency in Notes)

**20. If Yes to B18, did this PCC session provide assistance with the Physician Certification?**

- No (skip to question #22)
- Yes

**21. If Yes to B20, were there any complications related to the Physician Certification?**

- None
- Inaccurately completed
- MD did not sign off
- MD office did not return timely
- Multiple communications with MD office needed

**22. If Yes to B18, did this PCC session provide assistance with the PA 600L?**

- No (skip to question #24)
- Yes

**23. If Yes to B22, what type of assistance was provided?**

- Understanding the PA 600L
- Filling out the PA 600L
- Submitting the completed PA 600L
- Collecting supporting documentation (e.g. bank statements, other paperwork)
- Submitting supporting documentation

**24. If Yes to B18, was the desired Home and Community Based Services (HCBS) program successfully obtained by the close of this PCC session?**

- Yes - approved for HCBS program
- No – application still pending, but individual does not want further assistance
- No – denied for HCBS and individual does not want to appeal
- No – denied for HCBS and appeal was denied
- No – denied for HCBS, but other resources were chosen
- No – denied for HCBS and no other resources are available to assist
- No longer requires or requests HCBS-Document Details in Notes

**25. Time it took (in MINUTES) to complete this section**

**1.C. DECISION SUPPORT PROCESS AND CREATION OF ACTION PLAN**

**1. First Prioritized Need (select only ONE)**

- Abuse/Neglect
- Advocacy
- Assistance Coordinating Care
- Assistive Technology
- Bill Pay/Financial Assistance
- Communication Needs
- Community Integration
- Domestic Violence
- Food
- Healthcare
- Health Literacy
- Home Repair
- Housing
- Housing Modifications
- Immigration Services
- In-Home Support
- Language Assistance
- Legal Assistance
- LGBTQ Services
- Mental Health/Behavioral Health
- Peer Support
- Personal Care Help
- Relationship Building
- Social Recreation
- Social Security
- Substance Misuse Support
- Transitioning From a Hospital
- Transitioning From a Nursing Home
- Transitioning From Secondary Education

- Transitioning, Other
- Transportation
- Veteran's Services
- Vocational Services
- Other-Document Details in Notes

**2. Action(s) (select ALL that apply)**

- Application Assistance-PA 600 L
- Application Assistance-Doctor Script
- Discussion of Choices
- Application Assistance-Other (specify in Notes)
- E-intro to Staff
- Emailed Information
- Mailed Information
- Referred to Organization
- Warm Transfer
- Other-Document Details in Notes

**3. Type of Organization Referred to (select ALL that apply)**

- Advocacy Organization
- APPRISE
- Center for Independent Living
- Food Stamps
- Low-Income Home Energy Assistance Program (LIHEAP)
- Medicaid
- Medicare
- Older Americans Act-AAA, Senior Center
- Private Pay
- Public Transportation Organization
- Social Security (SSI or SSDI)
- Temporary Assistance for Needy Families (TANF)
- Veterans Directed Home and Community Based Services (VD-HCBS)
- Other State-Funded and County-Funded Programs
- Other-Document Details in Notes

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**4. Second Prioritized Need (select only ONE)**

- Abuse/Neglect
- Advocacy
- Assistance Coordinating Care
- Assistive Technology
- Bill Pay/Financial Assistance
- Communication Needs
- Community Integration
- Domestic Violence
- Food
- Healthcare
- Health Literacy
- Home Repair
- Housing
- Housing Modifications
- Immigration Services
- In-Home Support
- Language Assistance
- Legal Assistance
- LGBTQ Services
- Mental Health/Behavioral Health
- Peer Support
- Personal Care Help
- Relationship Building
- Social Recreation
- Social Security
- Substance Misuse Support
- Transitioning From a Hospital
- Transitioning From a Nursing Home
- Transitioning From Secondary Education
- Transitioning, Other
- Transportation
- Veteran's Services
- Vocational Services
- Other-Document Details in Notes

**6. Type of Organization Referred to (select ALL that apply)**

- Advocacy Organization
  - APPRISE
  - Center for Independent Living
  - Food Stamps
  - Low-Income Home Energy Assistance Program (LIHEAP)
  - Medicaid
  - Medicare
  - Older Americans Act-AAA, Senior Center
  - Private Pay
  - Public Transportation Organization
  - Social Security (SSI or SSDI)
  - Temporary Assistance for Needy Families (TANF)
  - Veterans Directed Home and Community Based Services (VD-HCBS)
  - Other State-Funded and County-Funded Programs
  - Other-Document Details in Notes
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**5. Action(s) (select ALL that apply)**

- Application Assistance-PA 600 L
  - Application Assistance-Doctor Script
  - Application Assistance-Other (specify in Notes)
  - Discussion of Choices
  - E-intro to Staff
  - Emailed Information
  - Mailed Information
  - Referred to Organization
  - Warm Transfer
  - Other-Document Details in Notes
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**7. Third Prioritized Need (select only ONE)**

- Abuse/Neglect
- Advocacy
- Assistance Coordinating Care
- Assistive Technology
- Bill Pay/Financial Assistance
- Communication Needs
- Community Integration
- Domestic Violence
- Food
- Healthcare
- Health Literacy
- Home Repair
- Housing
- Housing Modifications
- Immigration Services
- In-Home Support
- Language Assistance
- Legal Assistance
- LGBTQ Services
- Mental Health/Behavioral Health
- Peer Support
- Personal Care Help
- Relationship Building
- Social Recreation
- Social Security
- Substance Misuse Support
- Transitioning From a Hospital
- Transitioning From a Nursing Home
- Transitioning From Secondary Education
- Transitioning, Other
- Transportation
- Veteran's Services
- Vocational Services
- Other-Document Details in Notes

**9. Type of Organization Referred to (select ALL that apply)**

- Advocacy Organization
  - APPRISE
  - Center for Independent Living
  - Food Stamps
  - Low-Income Home Energy Assistance Program (LIHEAP)
  - Medicaid
  - Medicare
  - Older Americans Act-AAA, Senior Center
  - Private Pay
  - Public Transportation Organization
  - Social Security (SSI or SSDI)
  - Temporary Assistance for Needy Families (TANF)
  - Veterans Directed Home and Community Based Services (VD-HCBS)
  - Other State-Funded and County-Funded Programs
  - Other-Document Details in Notes
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**8. Action(s) (select ALL that apply)**

- Application Assistance-PA 600 L
  - Application Assistance-Doctor Script
  - Application Assistance-Other (specify in Notes)
  - Discussion of Choices
  - E-intro to Staff
  - Emailed Information
  - Mailed Information
  - Referred to Organization
  - Warm Transfer
  - Other-Document Details in Notes
-

**10. What are Additional Needs (select ALL that apply)**

- Abuse/Neglect
- Advocacy
- Assistance Coordinating Care
- Assistive Technology
- Bill Pay/Financial Assistance
- Communication Needs
- Community Integration
- Domestic Violence
- Food
- Healthcare
- Health Literacy
- Home Repair
- Housing
- Housing Modifications
- Immigration Services
- In-Home Support
- Language Assistance
- Legal Assistance
- LGBTQ Services
- Mental Health/Behavioral Health
- Peer Support
- Personal Care Help
- Relationship Building
- Social Recreation
- Social Security
- Substance Misuse Support
- Transitioning From a Hospital
- Transitioning From a Nursing Home
- Transitioning From Secondary Education
- Transitioning, Other
- Transportation
- Veteran's Services
- Vocational Services
- Other-Document Details in Notes

**11. Time it took (in MINUTES) to complete this section**

**1.D. FOLLOW UP**

**1. First Date of Follow-Up (MMDDYYYY)**

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**2. Is a second follow-up needed?**

- Yes
- No (skip to question #7)

**3. Second Date of Follow-Up (MMDDYYYY)**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**4. Is a third follow-up needed?**

- Yes
- No (skip to question #7)

**5. Third Date of Follow-Up (MMDDYYYY)**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**6. Additional Date of Follow Up (MMDDYYYY)**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**7. Was the individual helped by the first action?**

- No
- Yes
- Unknown

**8. Was the individual helped by the second action?**

- No
- Yes
- Unknown

**9. Was the individual helped by the third action?**

- No
- Yes
- Unknown

**10. Does the individual feel like PCC helped them to stay independent in their own home?**

- No
- Yes

**11. Is the individual willing to complete a satisfaction survey about this process?**

- No
- Yes

**12. Time it took (in MINUTES) to complete this section**

**13. What components were completed? (select ALL that apply)**

- 1.A. The Personal Interview
- 1.B. Overview of Options/Resources
- 1.C. Decision Support Process and Creation of Action Plan
- 1.D. Follow-Up

**14. Date the PCC was Complete (MMDDYYYY)**

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Title :

\_\_\_\_\_

Date

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Title :

\_\_\_\_\_

Date