

### Community First Choice Personal Assistance Skill Acquisition, Maintenance, and Enhancement Skills Acquisition Endorsement

To:	Agency/Contact Name:
Individual Name/ Date of Birth	Phone #
Medicaid ID #	Fax #

Dear Skill Acquisition Advocate,

The Community First Choice program offers the service of Skill Acquisition for activities of daily living and instrumental activities of daily living. The individual referenced above has requested this service. The following must occur in order for this service to be authorized:

- Validation from you that the individual has the capability of learning to independently perform the skill indicated below in a three-month timeframe.
- Your endorsement (i.e., this is a service you believe would benefit the individual)
- Your recommendations (regarding techniques or procedures to be followed)

**Please note: This service is provided by a trained personal care attendant and is designed to increase and/or maintain patient independence. The service is authorized for no more than twenty-five hours over a three-month timeframe. The service is expected to result in complete independence in the specified task by the end of the three-months.**

The goal that has been identified by the individual is:

\_\_\_\_\_  
The skill(s) the individual wishes to acquire is:

\_\_\_\_\_  
Keeping in mind the skill and goal outlined above by the individual, please indicate, by checking the appropriate boxes below, all types of assistance that you believe will best support the individual.

- |                                      |  |  |  |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Prompting   | <input type="checkbox"/> Hands on Assistance | <input type="checkbox"/> Written Instructions  | <input type="checkbox"/> Verbal Instructions |
| <input type="checkbox"/> Supervision | <input type="checkbox"/> Visual Cueing       | <input type="checkbox"/> Specialized Equipment | <input type="checkbox"/> Other               |

Please list other recommendations regarding techniques or procedures to be followed:

\_\_\_\_\_  
My signature below indicates my endorsement of this need, as well as my belief that the individual has the capability to learn and independently perform the skill identified above.

\_\_\_\_\_  
Skill Acquisition Advocate Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member/PR Signature

\_\_\_\_\_  
Date