Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

EPSDT Personal Care Services – Plan of Care

☐ **New** ☐ **Renewal** ☐ **Reconsideration** **Date Services Requested to Start: _____**

Identifying Information		**Provider Information**	
Name		Provider Agency Name	
ID#	DOB	Provider Number	Phone #
Address		Address	
Home Phone #	Cell Phone #	Contact Person e-mail	

Medical Reasons Supporting the Need for PCS (Must be accompanied by appropriate medical documentation for recipient and parent/caregiver, if the parent/caregiver is disabled)

Other In-Home Services Requested or Currently Receiving		
☐ New Opportunities Waiver	☐ Home Health Nursing Services	☐ Home Bound Teacher
☐ Children's Choice Waiver	☐ Home Health Aide Services	☐ Mental Health Rehab
☐ OCDD Family Support/Respite	☐ Home Health Therapy	☐ Other:

Recipient Name:	Recipient ID #:

Personal Care Tasks

Specify the personal care activities the parent/caregiver requires the assistance of the PCS provider due to an inability to perform these services alone.

PCS Activity	Goal	# of Days Requested per Week	Time Requested to Complete Activity	Total Time Requested for Week (# days x minutes)
Bathing			minutes	_____Hours _____Minutes
Dressing			minutes	_____Hours _____Minutes
Grooming			minutes	_____Hours _____Minutes
Toileting			minutes	_____Hours _____Minutes
Eating			minutes	_____Hours _____Minutes
Meal Prep			minutes	_____Hours _____Minutes
Incidental Household Services			minutes	_____Hours _____Minutes

Total Weekly Hours Requested for Activities of Daily Living: _____

Accompanying to Medical Appointments		**Frequency of Medical Appointments:** **Weekly Monthly Quarterly** **Other:**_____	**Time per trip**

Recipient Name:	Recipient ID #:

Child Care Arrangements
For children 14 years of age or younger, or for those 15 years of age or older and unable to self direct their own care, specify child care arrangements. ***Note: For the children who meet this criteria, when the PCS worker is in the home, another adult must be present.***

Signatures		
Parent/guardian	Provider Representative	Physician
Date	Date	Date