EPSDT Personal Care Services – Social Assessment Form

Recipient Name	Age	Medicaid #

Section I – Household Composition

Name	Age	Relationship	Works/Attends School
			☐ work ☐ school ☐ home
			☐ work ☐ school ☐ home
			☐ work ☐ school ☐ home
			☐ work ☐ school ☐ home
			☐ work ☐ school ☐ home

Section II – Primary Caregiver Assessment

Name of Primary Caregiver	Age	Relationship	Phone #

Does the Primary Caregiver have a physical or mental limitation which would affect his/her ability to care for the recipient?
☐ **No** ☐ **Yes**

If YES, *explain* **AND** *attach* ***medical documentation*** of limitations: **(Documentation of the primary caregiver's limitations is needed to support the level of care being requested)**

Will the primary caregiver supervise the PCS worker when services are being provided to the recipient? ☐ **No** ☐ **Yes**

Section III – Childcare Arrangements

If recipient is 14 years of age or younger, explain who has been caring for recipient and who will be caring for recipient when the primary caregiver is away from the home (i.e., before/after school when caregiver works or when caregiver is away on errands.)

Name of person providing childcare:

Section IV – Recipient Assessment

Does recipient attend school or work?
☐ **No** ☐ **Yes**

If **YES**, time :
_____ am / pm **TO** _____ am / pm
Days: Mon Tues Wed Thurs Fri Sat Sun

Name of school or employer:

Recipient is:
☐ **verbal**
☐ **non-verbal**

Does recipient take medication?
☐ **No** ☐ **Yes**

If **YES**, who gives medication?

Is recipient 15 or older?
☐ **No** ☐ **Yes**

If **YES**, can he/she direct his/her own care?
☐ **No** ☐ **Yes**

If **NO**, who will be in the home when services are provided?

Does recipient utilize adaptive equipment?
☐ **No** ☐ **Yes**

If YES, what type of equipment?

Section V – Dietary Factors

Is there a medical reason (i.e., a special diet) that requires the recipient's meals to be prepared separately from the family's meals?
☐ **No** ☐ **Yes** If **YES,** specify**:**

Who prepares the recipient's meals and what is their relationship to the recipient?

Does the recipient use assistive devices for eating (i.e., feeding tube, other)? ☐ **No** ☐ **Yes**

If YES, specify:

Indicate the number of meals and snacks prepared for recipient daily:
_____ meals _____snacks

Is the recipient able to feed him/herself without assistance?
☐ **No** ☐ **Yes**

If NO, specify the type of assistance required:

Section VI – Home Environment

Describe access to home (i.e., stairs, doors, walks, etc.)

Describe home living space (i.e. number of bedrooms, bathrooms, etc):

Describe home location (i.e., rural, urban, on bus line, etc.)

Where does the family do their laundry? (i.e. washer/dryer in home, laundromat, etc.)

Section VII – Family Responsibilities

Which family members assume major responsibilities for caring for the recipient and what tasks do they perform?

Family member	**Tasks Performed**

Section VIII – Social Support System

List other friends, relatives, neighbors that assist in caring for the recipient or in giving relief to the primary care giver.

Name	**Type of Assistance Provided**

Section IX – Other Services

Does the recipient have a case manager/support coordinator?
☐ **No** ☐ **Yes**

If **YES**, list his/her name, agency and contact number:

What other service is the recipient receiving at this time and how often are the services received?

☐ **Home Health**	☐ **Waiver**	☐ **OCDD** (respite, family support)	☐ **Other**
Days of week: Time:	Days of week: Time:	Days of week: Time:	Days of week: Time:

Signatures

Agency representative:	Date:
Name of PCS Agency:	Contact #:
Parent/guardian:	Date:
Relationship to Recipient:	Contact #