REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES

(Personal Care Services are to be provided in the home and not in an institution)

I. IDENTIFYING INFORMATION

1. Applicant Name:	**MID#**	
Address:	**Ph #** ( )	
	☐ **Male** ☐ **Female**	**DOB:**
2. Responsible Party/Curator:	**Relationship:**	
Address:	**Home Phone #** ( )	
	Work or Cell Phone # ( )	

By signing this form I give my consent for my medical information to be released to the Department of Health and Hospitals to be used in determining eligibility for Personal Care Services.

Signature: _____ **Date:**_____

II. MEDICAL INFORMATION

NOTE: The following information is to be completed by the applicant's attending physician.

1. Patient Name:

2. Primary Diagnosis:	**Diagnosis Code:**
Secondary Diagnosis:	**Diagnosis Code:**

3. Physical Examination:

General _____ Head and CNS _____

Mouth and EENT_____ Chest _____

Heart and Circulation _____ Abdomen _____

Genitalia_____ Extremities _____

Skin _____ Height _____

Wt. _____ Pulse _____

Resp _____ Temp _____

B/P _____ Bowel/Bladder Control _____

Impaired Vision _____ Impaired Hearing_____

☐Glasses ☐Hearing Aid

Lab Results:

HCT _____ HCB_____

U/A _____ Radiology_____

4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate

☐ Trach Care: ☐ Daily ☐ PRN
☐ Respiratory: ☐ Ventilator ☐ Daily ☐ Other_____
☐ Suctioning/Oral Care: ☐ Daily ☐ PRN
☐ Glucose Monitoring: ☐ Insulin Injections ☐ Daily ☐ Other
☐ Restraints (positioning)
☐ Dialysis
☐ Urinary Catheter
☐ Seizure Precautions
☐ Ostomy
☐ IV
☐ Decubitus/Stage _____
☐ Diet/Tube Feeding
☐ Rehab (OT,PT,ST)

Assistive Device:
☐Walker ☐Cane

☐Bed/Chair ☐Lift

☐Other_____

5.

Medications	Dosage	Frequency	Route

II. MEDICAL INFORMATION (Continued)

6. Recent Hospitalizations: (include psychiatric):								
7. Mental Status/Behavior: Check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always								
Oriented	□ Yes (1 2 3)	□ No	Depressed	□ Yes (1 2 3)	□ No	Cooperative	□ Yes (1 2 3)	□ No
Passive	□ Yes (1 2 3)	□ No	Physically Abusive	□ Yes (1 2 3)	□ No	Verbally Abusive	□ Yes (1 2 3)	□ No
Verbal	□ Yes (1 2 3)	□ No	Comatose	□ Yes (1 2 3)	□ No	Hostile	□ Yes (1 2 3)	□ No
Forgetful	□ Yes (1 2 3)	□ No	Confused	□ Yes (1 2 3)	□ No	Combative	□ Yes (1 2 3)	□ No
Non-responsive	□ Yes (1 2 3)	□ No	Injures Self/Others	□ Yes (1 2 3)	□ No			
8. Impairments: Please rate the following. 1- Mild , 2-Moderate, 3-Severe								
Walking	(1 2 3)		Chronic heart failure	(1 2 3)		Vision impairment	(1 2 3)	
Spasticity	(1 2 3)		Speech impairment	(1 2 3)		Oral feeding	(1 2 3)	
Limb weakness	(1 2 3)		Seizure Disorder	(1 2 3)		Bladder and bowel incontinence	(1 2 3)	
Hypotonia	(1 2 3)		Developmental delay	(1 2 3)		Intellectual impairment	(1 2 3)	
Chronic Resp distress	(1 2 3)		Hearing impairment	(1 2 3)				

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

***Based on the recipient's impairment*,** the attending physician should check the appropriate box as it applies to the recipient's ability to perform this age appropriate tasks using the following definitions and PCS Level of Assistance Guide:

Not Independent at this Age – not age appropriate to perform this task independently
Independent – recipient able to perform task **without assistance**
Limited Assistance – recipient aids in task, but receives help from other persons **some of the time**
Extensive Assistance – recipient aids in task, but receives help from other persons **all of the time**
Maximal Assistance – recipient is **entirely dependent** on other persons
Note: An additional 15 minutes can be added to bathing, dressing and toileting if mobility/transfer assistance is required

(EPSDT – PCS Level of Assistance Guide)

This is a **general guide** to assist physicians with determining the level of assistance recipients require to complete their activities of daily living (ADL). Additional time to complete the tasks will be considered if there is sufficient medical documentation provided. Please use the comments section below and attach documentation to support the need for additional time to complete the ADL's. In addition to the PCS tasks listed, assistance with incidental household chores may be approved. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the recipient.

PCS Task	Levels of Assistance				Mobility/Transfer Requirement
	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	
Bathing	0	15 min	30 min	45 min	Additional 15 min
Dressing	0	15 min	30 min	45 min	Additional 15 min
Grooming	0	15 min	15 min	15 min	
Toileting	0	15 min	30 min	45 min	Additional 15 min
Eating	0	15 min	30 min	45 min	
Meal Prep	0	30 min	30 min	30 min	

III. LEVEL OF CARE DETERMINATION (Continued)

NOTE: The following information is to be completed by the applicant's attending physician. Check the appropriate box using the definitions and EPSDT PCS Level of Assistance Guide to assist with determining the level of care.

Activity	Not Independent at this Age	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	Comments
Bathing						
Dressing						
Grooming						
Toileting						
Eating						

Level of care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. **Please select one of the following:**

This individual's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. May include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

□ Yes, this individual requires this level of care.
□ No, this individual does not require this level of care.

Mobility/Transfer Requirements: Please indicate below the activities of daily living for which the recipient will require assistance with mobility/transfer.

Bathing □ Yes □ No **Dressing** □ Yes □ No **Toileting** □ Yes □ No

Medical Appointments:

Will the recipient need the PCS worker to accompany him/her to medical appointments? □ Yes □ No

How often will the recipient have scheduled medical appointments? □ weekly □ monthly □ quarterly □ other _____

Reason for PCS worker to accompany child to medical appointments: _____

IV. PHYSICIAN'S ORDER

The above named patient is in need of EPSDT PCS due to his/her current medical condition. I am prescribing

Personal Care Services for _____ hours, _____ days a week as determined by the level of care determination.

Physician's Name (type or print):	Phone: ( )
Address:	

I certify/recertify that I am the attending physician for this patient and that the information provided is accurate and correct to the best of my knowledge. I authorize these EPSDT personal care services and will periodically review the plan. In my professional opinion, the services listed on this form are medically necessary and appropriate due to the child's medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face to face evaluation must be held between recipient and physician.

Physician's Signature _____ **Date** _____