

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 # ()	
	<input type="checkbox"/> Male <input type="checkbox"/> 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:		4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate	
General _____	Head and CNS _____	<input type="checkbox"/> Trach Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN <input type="checkbox"/> Respiratory: <input type="checkbox"/> Ventilator <input type="checkbox"/> Daily <input type="checkbox"/> Other _____ <input type="checkbox"/> Suctioning/Oral Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN <input type="checkbox"/> Glucose Monitoring: <input type="checkbox"/> Insulin Injections <input type="checkbox"/> Daily <input type="checkbox"/> Other <input type="checkbox"/> Restraints (positioning) <input type="checkbox"/> Dialysis <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Seizure Precautions <input type="checkbox"/> Ostomy <input type="checkbox"/> IV <input type="checkbox"/> Decubitus/Stage _____ <input type="checkbox"/> Diet/Tube Feeding <input type="checkbox"/> Rehab (OT,PT,ST) Assistive Device: <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Bed/Chair <input type="checkbox"/> Lift <input type="checkbox"/> Other _____	
Mouth and EENT _____	Chest _____		
Heart and Circulation _____	Abdomen _____		
Genitalia _____	Extremities _____		
Skin _____	Height _____		
Wt. _____	Pulse _____		
Resp _____	Temp _____		
B/P _____	Bowel/Bladder Control _____		
Impaired Vision _____ <input type="checkbox"/> Glasses	Impaired Hearing _____ <input type="checkbox"/> Hearing Aid		
Lab Results: HCT _____	HCB _____		
U/A _____	Radiology _____		
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	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Depressed	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Cooperative	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Passive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Physically Abusive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Verbally Abusive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Verbal	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Comatose	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Hostile	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Forgetful	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Confused	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Combative	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No
Non-responsive	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> No	Injures Self/Others	<input type="checkbox"/> Yes (1 2 3)	<input type="checkbox"/> 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:	
<p>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.</p>	
Physician's Signature _____	Date _____