

# 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

<b>1. Applicant Name:</b>	<b>MID#</b>	
<b>Address:</b>	<b>Ph #</b> (      )	
	<input type="checkbox"/> <b>Male</b> <input type="checkbox"/> <b>Female</b>	<b>DOB:</b>
<b>2. Responsible Party/Curator:</b>	<b>Relationship:</b>	
<b>Address:</b>	<b>Home Phone #</b> (      )	
	<b>Work or Cell Phone #</b> (      )	
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.		
<b>Signature:</b> _____		<b>Date:</b> _____

## II. MEDICAL INFORMATION

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

<b>1. Patient Name:</b>			
<b>2. Primary Diagnosis:</b>			<b>Diagnosis Code:</b>
<b>Secondary Diagnosis:</b>			<b>Diagnosis Code:</b>
<b>3. Physical Examination:</b>		<b>4. Special Care/Procedures:</b> 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	
Mouth and EENT _____	Chest _____	<input type="checkbox"/> Respiratory: <input type="checkbox"/> Ventilator <input type="checkbox"/> Daily <input type="checkbox"/> Other _____	
Heart and Circulation _____	Abdomen _____	<input type="checkbox"/> Suctioning/Oral Care: <input type="checkbox"/> Daily <input type="checkbox"/> PRN	
Genitalia _____	Extremities _____	<input type="checkbox"/> Glucose Monitoring: <input type="checkbox"/> Insulin Injections <input type="checkbox"/> Daily <input type="checkbox"/> Other	
Skin _____	Height _____	<input type="checkbox"/> Restraints (positioning)	
Wt. _____	Pulse _____	<input type="checkbox"/> Dialysis	
Resp _____	Temp _____	<input type="checkbox"/> Urinary Catheter	
B/P _____	Bowel/Bladder Control _____	<input type="checkbox"/> Seizure Precautions	
Impaired Vision _____	Impaired Hearing _____	<input type="checkbox"/> Ostomy	
<input type="checkbox"/> Glasses	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> IV	
Lab Results:		<input type="checkbox"/> Decubitus/Stage _____	
HCT _____	HCB _____	<input type="checkbox"/> Diet/Tube Feeding	
U/A _____	Radiology _____	<input type="checkbox"/> Rehab (OT,PT,ST)	
		<input type="checkbox"/> Other _____	
<b>5.</b>			
<b>Medications</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Route</b>

## 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	Wanders <input type="checkbox"/> Yes ( 1 2 3 ) <input type="checkbox"/> No
Verbal <input type="checkbox"/> Yes <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

## III. LEVEL OF CARE DETERMINATION

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

### Activities of Daily Living:

**Based on the recipient's impairment**, check the appropriate box as it applies to the recipient's ability to perform these age appropriate tasks using the following definitions:

**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 **totally dependent** on other persons

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.

Physician's Name (type or print)	Phone (    )
Address:	
By signing this form I attest that I am this person's primary physician, and the information provided is accurate and correct to the best of my knowledge.	
Physician's Signature _____	Date _____