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

<table>
<thead>
<tr>
<th>Applicant Name:</th>
<th>Mid#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Ph#</td>
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<td></td>
<td>(    )</td>
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<tr>
<td></td>
<td>D Male</td>
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</tbody>
</table>

2. Responsible Party/Curator:

<table>
<thead>
<tr>
<th>Relationship:</th>
<th>Address:</th>
<th>Home Phone #</th>
<th>Work or Cell Phone #</th>
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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 practitioner.

1. Patient Name:

2. Primary Diagnosis:

   Secondary Diagnosis:

3. Physical Examination:

<table>
<thead>
<tr>
<th>General</th>
<th>Head and CNS</th>
<th>Mouth</th>
</tr>
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<tbody>
<tr>
<td>and EENT</td>
<td>Chest</td>
<td>Heart</td>
</tr>
<tr>
<td>and Circulation</td>
<td>Abdomen</td>
<td>Genitalia</td>
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<tr>
<td>Extremities</td>
<td>Skin</td>
<td>Height</td>
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<tr>
<td>Wt.</td>
<td>Pulse</td>
<td>Resp</td>
</tr>
<tr>
<td>Temp</td>
<td>B/P</td>
<td>Bowel/Bladder</td>
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</tbody>
</table>

   Control: ___________________________

   Impaired Vision: ___________________________ Impaired Hearing: ___________________________

   D Glasses | D 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

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

Assistive Device: ___________________________

5. Medications

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Route</th>
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</table>
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

8. Impairments: Please rate the following: 1- Mild, 2-Moderate, 3-Severe

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

Based on the beneficiary’s impairment, the attending practitioner should check the appropriate box as it applies to the beneficiary’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 – beneficiary able to perform task without assistance

Limited Assistance – beneficiary aids in task, but receives help from other persons some of the time

Extensive Assistance – beneficiary aids in task, but receives help from other persons all of the time

Maximal Assistance – beneficiary 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 practitioners with determining the level of assistance beneficiaries 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 beneficiary.
III. LEVEL OF CARE DETERMINATION (Continued)

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not Independent at this Age</th>
<th>Independent</th>
<th>Limited Assistance</th>
<th>Extensive Assistance</th>
<th>Maximal Assistance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
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<tr>
<td>Dressing</td>
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<tr>
<td>Grooming</td>
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<td>Toileting</td>
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<tr>
<td>Eating</td>
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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.

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

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

Bathing D Yes D No
Dressing D Yes D No
Toileting D Yes D No

Medical Appointments:
Will the beneficiary need the PCS worker to accompany him/her to medical appointments? D Yes D No
How often will the beneficiary have scheduled medical appointments? D weekly D monthly D quarterly D other ______________________
Reason for PCS worker to accompany child to medical appointments:

IV. PRACTITIONER’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.

Practitioner’s Name (type or print):

Phone: ( )

Address:

I certify/recertify that I am the attending practitioner 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 beneficiary and practitioner.

Practitioner’s Signature ______________________ Date ______________________

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