Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Personal Care Services (PCS) - Plan of Care

☐ New ☐ Renewal ☐ Reconsideration	Date services requested to start:

Identify information		
Name:	ID No.	Date of birth:
Address:		
Home phone No.	Cell phone No.	

Provider information	
Provider agency name:	Provider No.
Address:	
Phone No.	Contact person e-mail:
NPI:	TIN:

Medical reasons supporting the need for PCS (Must be accompanied by appropriate medical documentation)

Other In-home services requested or currently receiving		
☐ Children's choice waiver	☐ Home health nursing services	☐ New opportunities waiver
☐ Home bound teacher	☐ Home health therapy	☐ OCDD family support/respite
☐ Home health aide services	☐ Mental health rehab	☐ Other: _____

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Beneficiary's name: _____ Beneficiary's ID No. _____

Personal care tasks				
PCS activity	Goal	No. of days requested per week	Time requested to complete activity	Total time requested for week (No. days x minutes)
Bathing		day(s)	minutes	_____ hours _____ minutes
Dressing		day(s)	minutes	_____ hours _____ minutes
Grooming		day(s)	minutes	_____ hours _____ minutes
Toileting		day(s)	minutes	_____ hours _____ minutes
Eating		day(s)	minutes	_____ hours _____ minutes
Meal prep		day(s)	minutes	_____ hours _____ minutes
Incidental household services		day(s)	minutes	_____ hours _____ minutes

Total weekly hours requested for activities of daily living: _____

Accompanying to medical appointments		Frequency of medical appointments: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other _____	Time per trip

Signatures	
Parent/guardian:	Date:
Provider representative:	Date:
Practitioner:	Date: