Request for Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Personal Care Services (PCS)

(PCS are to be provided in the home and not in an institution)

Section I – Identify information

Applicant name:		Medicaid No.
Address:		
☐ Male ☐ Female	Date of birth:	Phone No.
NPI:	TIN:	
Responsible party/curator:		Relationship:
Address:		
Home phone No.	Work or cell phone No.	

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:**

Section II – Medical information

Note: The following information is to be completed by the applicant's attending practitioner.

Patient name:	
Primary diagnosis:	Diagnosis code:
Secondary diagnosis:	Diagnosis code:

Physical examination:

General _____	Pulse _____
Head and central nervous system (CNS) _____	Resp _____
	Temperture _____
Mouth and eye, ear, nose, and throat (EENT) _____	B/P _____
	Bowel/bladder control _____
Chest _____	Impaired vision _____
Heart and circulation _____	☐ Glasses
Abdomen _____	Impaired hearing _____
Skin _____	☐ Hearing aid
Height, weight _____	

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Section II – Medical information

Special care/procedures: check appropriate box and give type, frequency, size, stage and site when appropriate

☐ Decubitus/stage _____ ☐ Dialysis ☐ Diet/tube feeding ☐ IV

☐ Glucose monitoring: ☐ Insulin injections ☐ Daily ☐ Other _____

☐ Respiratory: ☐ Ventilator ☐ Daily ☐ Other _____

☐ Ostomy ☐ Rehab (OT,PT,ST) ☐ Restraints (positioning)

☐ Suctioning/oral care: ☐ Daily ☐ PRN ☐ Seizure precautions

☐ Trach care: ☐ Daily ☐ PRN ☐ Urinary catheter

Assistive Device: _____

Medications	Dosage	Frequency	Route

Recent hospitalizations (include psychiatric):

Mental status/behavior: Check **Yes** or **No**. If **Yes**, indicate frequency: **1** = Seldom; **2** = Frequent; **3** = Always

Confused	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Injures self/others	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No
Combative	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Nonresponsive	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No
Comatose	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Oriented	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No
Cooperative	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Passive	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No
Depressed	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Physically abusive	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No
Forgetful	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Verbally abusive	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No
Hostile	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No	Verbal	☐ Yes	☐ 1	☐ 2	☐ 3	☐ No

Impairments: Please rate the following. **1** = Mild , **2** = Moderate, **3** = Severe

Bladder and bowel incontinence	☐ 1	☐ 2	☐ 3	Limb weakness	☐ 1	☐ 2	☐ 3
Chronic Resp distress	☐ 1	☐ 2	☐ 3	Oral feeding	☐ 1	☐ 2	☐ 3
Chronic heart failure	☐ 1	☐ 2	☐ 3	Seizure disorder	☐ 1	☐ 2	☐ 3
Developmental delay	☐ 1	☐ 2	☐ 3	Spasticity	☐ 1	☐ 2	☐ 3
Hearing impairment	☐ 1	☐ 2	☐ 3	Speech impairment	☐ 1	☐ 2	☐ 3
Hypotonia	☐ 1	☐ 2	☐ 3	Vision impairment	☐ 1	☐ 2	☐ 3
Intellectual impairment	☐ 1	☐ 2	☐ 3	Walking	☐ 1	☐ 2	☐ 3

Section III – Level of care determination

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.

PCS task	Levels of assistance				Mobility/transfer requirement
	Independent	Limited assistance	Extensive assistance	Maximal assistance	
Bathing	0	15 min.	30 min.	45 min.	Additonal 15 min.
Dressing	0	15 min.	30 min.	45 min.	Additonal 15 min.
Grooming	0	15 min.	30 min.	45 min.	
Toileting	0	15 min.	30 min.	45 min.	Additonal 15 min.
Eating	0	15 min.	30 min.	45 min.	
Meal prep	0	15 min.	30 min.	45 min.	

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.

Activity	Not independent at this age	Independent	Limited assistance	Extensive assistance	Maximal assistance	Comments
Bathing	☐	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	☐	

Section III – Level of care determination (Continued)

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 beneficiary will require assistance with mobility/transfer.

Bathing ☐ Yes ☐ No **Dressing** ☐ Yes ☐ No **Toileting** ☐ Yes ☐ No

Medical appointments:

Will the beneficiary need the PCS worker to accompany him/her to medical appointments?

☐ Yes ☐ No

How often will the beneficiary have scheduled medical appointments?

☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other _____

Reason for PCS worker to accompany child to medical appointments:

Section 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:**