Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Personal Care Services (PCS) – Social Assessment Form

Beneficiary name:	Age:	Medicaid No.
NPI:	TIN:	

Section I – Household composition

Name	Age	Relationship	Works/attends school
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home

Section II – Childcare arrangements

Who will be caring for the beneficiary when the primary caregiver is away from the home (e.g., before/after school when caregiver works or when caregiver is away on errands)?

Name of person providing childcare:

Section III – Beneficiary assessment

Does the beneficiary attend school or work? ☐ Yes ☐ No

If **YES**, time: _____ ☐ a.m. ☐ p.m. TO _____ ☐ a.m. ☐ p.m.

Days: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Name of school or employer:

Beneficiary is: ☐ Verbal ☐ Non-verbal

Does beneficiary take medication? ☐ Yes ☐ No

If **YES**, who gives medication?

Does beneficiary utilize adaptive equipment? ☐ Yes ☐ No

If **YES**, what type of equipment?

Humana
Healthy Horizons®
in Louisiana

Section IV – Dietary factors

Is there a medical reason (e.g., a special diet) that requires the beneficiary's meals to be prepared separately from the family's meals? ☐ Yes ☐ No

If **YES**, specify:

Who prepares the beneficiary's meals and what is their relationship to the beneficiary?

Does the beneficiary use assistive devices for eating (e.g., feeding tube, other)? ☐ Yes ☐ No

If **YES**, specify:

Indicate the number of meals and snacks prepared for beneficiary daily: _____ meals _____ snacks

Is the beneficiary able to feed him/herself without assistance? ☐ Yes ☐ No

If **NO**, specify the type of assistance required:

Section V – Home environment

Describe access to home (e.g., stairs, doors, walks, etc.)

Describe home living space (e.g., number of bedrooms, bathrooms, etc.):

Describe home location (e.g., rural, urban, on bus line, etc.)

Where does the family do their laundry? (e.g., washer/dryer in home, laundromat, etc.)

Section VI – Family responsibilities

Which family members assume major responsibilities for caring for the beneficiary and what tasks do they perform?

Family member	Tasks performed

Section VII – Other services

Does the beneficiary have a case manager/support coordinator? ☐ Yes ☐ No

If **YES**, list his/her name, agency and contact number:

What other service is the beneficiary receiving at this time and how often are the services received?

☐ Home health - Days of week: _____, Time: _____

☐ Waiver - Days of week: _____, Time: _____

☐ OCDD (respite, family support) - Days of week: _____, Time: _____

☐ Other - Days of week: _____, Time: _____

Signatures

Agency representative:	Date:
Name of PCS agency:	Contact No.
Parent/guardian:	Date:
Relationship to beneficiary:	Contact No.