Medical Assistance Division

EPSDT - PERSONAL CARE SERVICE PLAN

DATE ____/____/____ **TYPE OF REVIEW:** ___ INITIAL ___ REVISION ___ ANNUAL

PROCEDURE CODE: S5125 (15 minute unit)

UTILIZATION REVIEW INFORMATION

_____ _____ _____

AUTHORIZATION # **REVIEWER** **TOTAL ANNUAL UNITS**

Approved from ____/____/____ **to** ____/____/____

TERM OF PLAN

SERVICE SPAN OF DATES - BEGIN DATE: ____/____/____ **END DATE:** ____/____/____ **TOTAL UNITS FOR ENTIRE SPAN OF DATES:** _____

RECIPIENT INFORMATION

_____ |___|___|___|___|___|___|___|___|___|___| ____/____/____ _____ _____

RECIPIENT NAME RECIPIENT **SOCIAL SECURITY NUMBER** **DATE OF BIRTH** **GENDER** **PRIMARY DIAGNOSIS**

_____ (____)_____ _____

RECIPIENT ADDRESS (include city, state, and ZIP code) **RECIPIENT TELEPHONE** **SIGNATURE OF CASE MANAGER / Agency RN**

AGENCY INFORMATION

_____ _____ _____ (____)_____

AGENCY NAME **PROVIDER NUMBER** **PROVIDER ADDRESS (include city, state, and ZIP code)** **PROVIDER TELEPHONE**

TASK	M	T	W	TH	F	S	S	COMMENTS
Assistance With Self-Administered Medication								
Cognitive Assistance (Cuing and Prompting)								
Eating (feeding, cuing, prompting, serving food – does not include any type of feeding that requires professional training)								
Household Services								
Hygiene/Grooming/Bathing								
Meal Preparation								
Minor Maintenance of Assistive Device(s) and DME								
Mobility Assistance								
Skin Care								
Support Services (transporting, caring for service animals, shopping)								
TOTAL UNITS (15 minute increments)								

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