

EPSDT Personal Care Services Functional Status Assessment (DMAS-7)

Complete when personal care is ordered
This form must be completed by a Physician, Physicians Assistant or Registered Nurse
Practitioner

Name:	Medicaid Number:
Date of Birth:	Primary Diagnosis:
Parent/Guardian's Name:	Phone #:

Care needs must be related to a health condition and cannot be due to functional limitations associated with the normal attainment of developmental milestones

Indicate how the individual performs the following support needs:

ADLS/Mobility Supports	Needs Help		Performed by Others	
	No	Yes	No	Yes
Bathing				
Dressing				
Toileting				
Transferring				
Eating/Feeding				
Continence-bowel				
Continence-bladder				
Ambulation				

Indicate how often the individual engages in the following activities:

Behavioral Supports	Harm Self or Others	Threaten or Act Aggressive	Attempt Elopement
Daily			
Weekly			
Monthly			
Every 3-4 months			

Physician, Physicians Assistant or Nurse Practitioner Name (please print):	
MD/PA/RNP Signature/ Date:	
Provider ID #:	

Fax completed form to: Maternal and Child Health Division /Fax – 804.225.3961
For questions about EPSDT email epsdt@dmas.virginia.gov

Receipt of personal care will depend on DMAS prior authorization based on EPSDT Personal Care Services Criteria.