

EPSDT PERSONAL CARE PROGRAM
AGENCY-DIRECTED & CONSUMER-DIRECTED PLAN OF CARE
 FAX ALL EPSDT SERVICE REQUESTS TO DMAS @ 804-225-3961

| <input type="checkbox"/> AGENCY DIRECTED SERVICES (T1019) | | <input type="checkbox"/> CONSUMER DIRECTED SERVICES (S5126) | | | | | |
|-------------------------------------------------------------------------------|--------|--------------------------------------------------------------------|---------------|----------|--------|----------|--------|
| Recipient Name: | | | Medicaid ID#: | | | | |
| Provider Agency: | | | Provider ID#: | | | | |
| CHECK EACH TASK TO BE DONE, THEN ENTER THE TOTAL TIME FOR EACH DAILY CATEGORY | | | | | | | |
| Categories/Tasks | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| 1. ADL's | | | | | | | |
| Bathing | | | | | | | |
| Dressing | | | | | | | |
| Toileting | | | | | | | |
| Transfer | | | | | | | |
| Assist Eating/Feeding | | | | | | | |
| Assist Ambulate | | | | | | | |
| Continence-Bowel | | | | | | | |
| Continence-Blader | | | | | | | |
| ADL TIME: | | | | | | | |
| 2. Special Maintenance | | | | | | | |
| Vital Signs | | | | | | | |
| Supervise Meds | | | | | | | |
| Range of Motion | | | | | | | |
| Wound Care | | | | | | | |
| Bowel/Bladder Program | | | | | | | |
| Time: | | | | | | | |
| 3. Special Supervision Time | | | | | | | |
| Supervision Reasons: | | | | | | | |
| Elopement/Wandering | | | | | | | |
| Aggression/Self Harm | | | | | | | |
| Impulsivity | | | | | | | |
| Safety/Destructive | | | | | | | |
| 4. IADLS | | | | | | | |
| Meal Preparation | | | | | | | |
| Clean Kitchen | | | | | | | |
| Make/Change Beds | | | | | | | |
| Clean Areas Used by Recipient | | | | | | | |
| Laundry | | | | | | | |
| IADLS Time: | | | | | | | |
| Total Daily Time: | | | | | | | |

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Reason Plan of Care Submitted: New Admission ↑ In Hours ↓ In Hours Transfer

Reason for change/additional instructions for the aide/attendant: _____

Backup Plan/Person (CD Services): _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Enrollee Signature: _____ RN or SF Signature: _____

Instructions for the DMAS-7A (5-Feb-08)

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor or CD Services Facilitator who has signed the plan of care to discuss the reason you disagree with the change.

Instructions for Completion of the DMAS-7A

Care Determination For Determining Amount of Weekly Care Hours

Enter the time necessary to complete each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the total time under **TOTAL DAILY TIME**.

Provider Notification To Client

Anytime the RN Supervisor or CD Services Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require DMAS approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Client Notification Section and make sure the enrollee gets a copy of both the front and back of the form.

If you have QUESTIONS about filling out this form please contact the Maternal and Child Health Division at (804) 786-6134.