HEALTH CARE AUTHORITY

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 Term of Plan from _____ to _____

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 | ☐M ☐F Gender | _____ Primary Diagnosis

_____ Recipient Address (include city, state and zip code) | _____ Recipient Phone | _____ Signature of Case Manager / Agency RN

AGENCY INFORMATION

_____ Agency Name | _____ Provider Number | _____ Provider Address (include city, state and zip code) | _____ Provider Phone

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)								

Distribution: Original – UR Agent
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