UnitedHealthcare Community Plan

EPSDT Personal Care Services – Plan of Care

☐New ☐Renewal ☐Reconsideration Date Services Requested to Start:

Member Information		Provider Information	
Name		Provider Agency Name	
Member ID #	Date of Birth	Provider ID #	Phone #
Address		Address	
Home Phone #	Cell Phone #	Contact Name Email Address	

Medical reasons supporting the need for EPSDT Personal Care Services (PCS)

(must be accompanied by appropriate medical documentation for the member)

Other In-Home Services Requested or Currently Receiving		
☐New Opportunities Waiver	☐Home Health Nursing Services	☐Home Bound Teacher
☐Children's Choice Waiver	☐Home Health Aide Services	☐Mental Health Rehab
☐OCDD Family Support/ Respite	☐Home Health Therapy	☐Other:_____

Personal Care Tasks

Please specify the personal care activities for which the parent/caregiver requires the assistance of the PCS provider due to an inability to perform these services alone.

PCS Activity	Goal	Number of days requested per week	Time requested to complete activity (in minutes)	Total time requested per week (# days x minutes, in hours : minutes)
Bathing				:
Dressing				:
Grooming				:
Toileting				:
Eating				:
Meal Prep				:
Incidental Household Service				:
Total Weekly Hours Requested for Activities of Daily Living: _____				

PCS Activity	Frequency of medical appointments	Time per trip
Accompanying to Medical Appointments	☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other	:

Signatures		
Parent/Guardian	Provider Representative	Physician
Date	Date	Date