UnitedHealthcare Community Plan

EPSDT Personal Care Services – Social Assessment Form

Member Name:	Age:	Member ID #:

Section I – Household Composition

Name	Age	Relationship	Works/Attends School
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home
			☐ Work ☐ School ☐ Home

Section II – Primary Caregiver Assessment

Name of Primary Caregiver	Age	Relationship	Phone #

Section III – Member Assessment

Does the member attend school or work? ☐ No ☐ Yes	If YES, time: ____ a.m./p.m. to ____ a.m./p.m. Days: Mon Tues Wed Thurs Fri Sat Sun	Name of school or employer:
Does the member have an Individualized Education Plan (IEP) in place? ☐ No ☐ Yes	Does the member have help at school with Activities of Daily Living (ADLs?) ☐ No ☐ Yes	If YES, who helps member at school with ADLs?
Member is : ☐ Verbal ☐ Non-verbal	Does the member take medications? ☐ No ☐ Yes	If YES, who gives the member medications?
Is the member age 15 or older? ☐ No ☐ Yes	If YES, can he/she direct his/her own care? ☐ No ☐ Yes	If NO, who will be in the home when services are provided?
Does the member use adaptive equipment? ☐ No ☐ Yes	If YES, what type of equipment?	

Section IV – Dietary Factors

Is there a medical reason (e.g., a special diet) that requires the member's meals to be prepared separately from the family's meals?

☐ No ☐ Yes If YES, please specify:

Who prepares the member's meals?	What is their relationship to the member?

Does the member use assistive devices for eating (e.g., feeding tube, etc.)? ☐ No ☐ Yes If YES, specify:

Please indicate the number of meals and snacks the PCS worker will prepare for the member daily: _____ Meals _____ Snacks	Is the member able to feed him/herself without assistance? ☐ No ☐ Yes	If NO, specify the type of assistance required:

Section V – Home Environment

Describe access to home (e.g., stairs, doors, walks, etc.):

Describe home living space (e.g., number of bedrooms, bathrooms, etc.):

Describe home location (e.g., rural, urban, on bus line, etc.):
Where does the family do their laundry? (e.g., washer/dryer in home, laundromat, etc.):

Section VI – Family Responsibilities

Which family members assume major responsibilities for caring for the member, and what tasks so they perform?

Family Member	Tasks Performed

Section VII – Social Support System

List other friends, relatives or neighbors that assist in caring for the member or in giving relief to the primary caregiver.

Name	Type of Assistance Provided

Section VII – Other Services

Does the member have a case manager/support coordinator? ☐ No ☐ Yes	If YES, list his/her name, agency and contact number:

What other service is the member receiving at this time, and how often is the service received?

☐ Home Health	☐ Waiver	☐ OCDD (e.g., respite, family support)	☐ Other:
Days of week: Times:	Days of week: Times:	Days of week: Times:	Days of week: Times:

Signatures

Agency Representative:	Date:
Name of PCS Agency:	Phone #:
Parent/Guardian:	Date:
Relationship to Member:	Phone #: