EPSDT PERSONAL CARE PROGRAM
AGENCY-DIRECTED & CONSUMER-DIRECTED PLAN OF CARE

☐ **AGENCY DIRECTED SERVICES (T1019)** ☐ **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-Bladder							
	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 (24-Aug-18)

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.