Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

EPSDT Personal Care Services – Plan of Care

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

Identifying Information		Provider Information	
Name		Provider Agency Name	
ID#	DOB	Provider Number	Phone #
Address		Address	
Home Phone #	Cell Phone #	Contact Person e-mail	

Medical Reasons Supporting the Need for PCS (Must be accompanied by appropriate medical documentation))

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:

Beneficiary's Name:	Beneficiary's ID #:

Personal Care Tasks				
PCS Activity	Goal	# of Days Requested per Week	Time Requested to Complete Activity	Total Time Requested for Week (# days x minutes)
Bathing			minutes	_____Hours _____Minutes
Dressing			minutes	_____Hours _____Minutes
Grooming			minutes	_____Hours _____Minutes
Toileting			minutes	_____Hours _____Minutes
Eating			minutes	_____Hours _____Minutes
Meal Prep			minutes	_____Hours _____Minutes
Incidental Household Services			minutes	_____Hours _____Minutes

Total Weekly Hours Requested for Activities of Daily Living: _____

Accompanying to Medical Appointments		Frequency of Medical Appointments: Weekly Monthly Quarterly Other:_____	Time per trip

Beneficiary's Name:	Beneficiary's ID #:

Beneficiary's Name:	Beneficiary's ID #:

Signatures		
Parent/guardian	Provider Representative	Practitioner
Date	Date	Date