PRINT FORM

DHS Oregon Department of Human Services

Medicaid Personal Care Assessment

Date: _____

Applicant: _____ Medicaid/Prime #: _____

Date of Birth: _____ Age: _____

CHILD ASSESSMENT

Assess the needs of the child by evaluating level of assistance required for each of the following ADLs. Place an **X** in appropriate age box. ● = Considered met by natural supports.

Age	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Basic Personal Hygiene/Bathing – What special help does the child need due to his/her disability with personal hygiene and grooming relative to chronological age expectations? Check the level that applies.																		
Independent or supervision: Child must be reminded and supervised at least some of the time. **(age 12 or older)**				●	●	●	●	●	●	●	●	●	●	☐	☐	☐	☐	☐	☐
Limited or Extensive – Regularly requires direct assistance with such tasks as combing hair, brushing teeth, menses care and shaving. **(age 8 or older)**				●	●	●	●	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐
Total: All personal hygiene must be done by someone else. **(age 5 or older)**				●	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toileting, Bowel/Bladder Care – What additional help in toileting is needed for this child due to the child's disability and relative to chronological age expectations? Check the level that applies.																		
Independent or supervision: Unusual verbal cueing is needed and/or occasional/ infrequent daytime toileting accidents and/or toileting program must be followed **OR**, needs occasional physical assistance for one or more of the following: clothing adjustment, washing hands, wiping and cleansing. **(age 4 or older)**				●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Limited or Extensive – Cannot get to the toilet without assistance, or needs substantial physical assistance at least daily with part of the task. **(age 4 or older)**				●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Total: Requires total cleansing; unable to use toilet; or requires protective garments/ diapers. **(age 4 or older)**				●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OR, Child ***of any age*** has a medical condition requiring more frequent, scheduled diaper changes on a 24 hour basis.				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Age	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
	OR, Child who is incontinent and requires diaper changes at night only **(age 8 or older)**																		
	●	●	●	●	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Nutrition – What additional help is needed for this child to eat, relative to chronological age expectations?																			
Independent or Supervision – Child 4 years or older and needs verbal prompting to maintain adequate intake.																			
	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	OR, Child **10 years of age or older** and needs assistance with such things as cutting up food, buttering bread or pouring liquids.																		
	●	●	●	●	●	●	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	
Extensive: A child **3 years of age or older** who can feed itself, but *(1) needs standby assistance for occasional gagging, choking or swallowing difficulty, or (2) must be fed some of the time by mouth by another person, or (3) must be totally fed by another person.*																			
	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Mobility, Transfers, Repositioning, Assisting with Mobility – What special help is needed for this child to be mobile and/or transferred due to the child's disability and relative to chronological age expectations?																			
Ambulation: What special help is needed for this child to be mobile relative to age and disability?																			
Independent or Supervision: Needs hand held on stairs or uneven surfaces or uses adaptive devices with minimal assistance. **(age 4 or older)**																			
	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Limited or Extensive: Is mobile inside but needs assistance of another person outside. **(age 4 or older)**																			
	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Total: Only mobile with regular assistance of another person, or needs ongoing assistance with adaptive devices. No carrying or lifting of child or equipment required. **(age 4 or older)**																			
	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	OR, always requires total physical assistance, i.e. needs to be carried or provided physical assistance to walk, or caregiver must push or carry manual wheelchair or other ambulation equipment. **(age 2 or older)**																		
	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Transfers – What additional assistance with transferring is needed for the child?																			
Independent, Supervision: A child **age 4 or older** needs daily assistance, and *(1) can bear some weight and assist with their transfer, or (2) weighs less than 30 pounds.*																			
	●	●	●	●	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Total: A child of **any age** who weighs more than 30 pounds and requires total physical support of the caregiver to transfer.																			
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

ELIGIBILITY

APPLICANT IS ELIGIBLE FOR SERVICES IF *BOTH* OF THE FOLLOWING APPLY:

- ☐ Applicant is a current recipient of EXT, MAA, MAF, OHP, OSIPM, TANF or REF. These terms are defined in OAR 461-101-0010.
- ☐ Applicant requires assistance from qualified provider with one or more of the Personal Assistance Services identified in OAR 411-034-0020.
    - ♦ Children 0-17 years: as supported by the children's assessment indicating at least 1 ADL need.

APPLICANT IS NOT ELIGIBLE FOR SERVICES IF ANY *ONE* OF THE FOLLOWING APPLIES:

- ☐ All of the applicant's personal care needs are met through natural supports.
- ☐ Applicant receives services from a licensed or certified residential service program that provides personal care services, *(i.e. foster home, assisted living facility, group home or other residential care program)*.
- ☐ Applicant is in prison, hospital, sub-acute care facility, nursing facility or other institution.
- ☐ Applicant is in prison, hospital, sub-acute care facility, nursing facility or other institution.
- ☐ Child has been found non-eligible as determined by the child assessment.
- ☐ Child is not a current recipient of EXT, MAA, MAF, OHP, OSIPM, TANF or REF.

ELIGIBILITY DETERMINATION

- ☐ **YES**, Applicant is eligible for State Plan Personal Care Services. Complete this form and place in the individual's file.
- ☐ **NO**, Applicant is not eligible for services. **Stop here.** Send notification of denial to applicant, sign and date this form and place in applicant's file.

Signature _____ Date _____

Maintain a complete copy of this form in the individual's file. Fax only page 4 to the SPD Provider Payment Unit (503) 947-5357.

DHS
Oregon Department of Human Services

Medicaid Personal Care Service
Authorization

Applicant: _____ Medicaid/Prime #: _____

Date of Birth: ___/___/_____
MM DD YYYY

Category of Service:

☐ Developmental Disability Services

☐ Addictions and Mental Health Services

CDDP/AMHD/Brokerage Name: _____ Branch #: _____

Printed name of Case Manager: (required)

Phone: (___) ___-_____

Email address: _____

Applicant is eligible for State Plan Personal Care Services. I authorize Personal Care Services for a maximum of 20 hours each month for the period specified. *If 2 recipients live in the same residence, services must be provided on a one-to-one basis if they use the same provider.*

Number of hours/month: _____ Start date: ___/___/_____

***End date: ___/___/_____

***_If provider is working under probationary status, plan cannot exceed two months and a new plan must be submitted prior to the end date of this plan_. If the recipient is a child, the provider cannot work under probationary status.

*Dates for services must **not** exceed 12 months.*

_____ ___/___/_____

Authorizing Signature of Service Coordinator, Case Manager or Personal Agent — Date

CONFIRMATION THAT SERVICE WAS PROVIDED

*The **signature** of one of these person(s) must be on vouchers to confirm work has been completed. The person is not the provider, nor is he or she in a position to benefit financially from saying the service has been provided.*

_____ _____

Signature (applicant/representative) — Signature (applicant/representative)

_____ _____

Print Name — Print Name

Fax to the SPD Provider Payment Unit (503) 947- 5357.