EPSDT Personal Care Services – Social Assessment Form

Beneficiary Name	Age	Medicaid #

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

Section II – Childcare Arrangements

Who will be caring for the beneficiary when the primary caregiver is away from the home (i.e., before/after school when caregiver works or when caregiver is away on errands.)	Name of person providing childcare:

Section III – Beneficiary Assessment

Does the beneficiary attend school or work? ☐ No ☐ Yes	If YES, time : _____ am / pm TO _____ am / pm Days: Mon Tues Wed Thurs Fri Sat Sun	Name of school or employer:

Beneficiary is: ☐ verbal ☐ non-verbal	Does beneficiary take medication? ☐ No ☐ Yes	If YES, who gives medication?

Does beneficiary utilize adaptive equipment?	If YES, what type of equipment?

Section IV – Dietary Factors

Is there a medical reason (i.e., a special diet) that requires the beneficiary's meals to be prepared separately from the family's meals?
☐ No ☐ Yes If YES, specify:

Who prepares the beneficiary's meals and what is their relationship to the beneficiary?

Does the beneficiary use assistive devices for eating (i.e., feeding tube, other)? ☐ No ☐ Yes	If YES, specify:

Indicate the number of meals and snacks prepared for beneficiary daily: _____ meals _____ snacks	Is the beneficiary 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 (i.e., stairs, doors, walks, etc.)

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

Describe home location (i.e., rural, urban, on bus line, etc.)

Where does the family do their laundry? (i.e. washer/dryer in home, laundromat, etc.)

Section VI – Family Responsibilities

Which family members assume major responsibilities for caring for the beneficiary and what tasks do they perform?

Family member	Tasks Performed

Section VII – Other Services

Does the beneficiary have a case manager/support coordinator?

☐ No ☐ Yes

If YES, list his/her name, agency and contact number:

What other service is the beneficiary receiving at this time and how often are the services received?

☐ Home Health	☐ Waiver	☐ OCDD (respite, family support)	☐ Other
Days of week: Time:	Days of week: Time:	Days of week: Time:	Days of week: Time:

Signatures

Agency representative:	Date:
Name of PCS Agency:	Contact #:
Parent/guardian:	Date:
Relationship to Beneficiary:	Contact #