

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		
<input type="checkbox"/> New Opportunities Waiver	<input type="checkbox"/> Home Health Nursing Services	<input type="checkbox"/> Home Bound Teacher
<input type="checkbox"/> Children's Choice Waiver	<input type="checkbox"/> Home Health Aide Services	<input type="checkbox"/> Mental Health Rehab
<input type="checkbox"/> OCDD Family Support/Respite	<input type="checkbox"/> Home Health Therapy	<input type="checkbox"/> Other:

Beneficiary's Name:	Beneficiary's ID #:
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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:	Time per trip
		Weekly Monthly Quarterly	
		Other: _____	

Beneficiary's Name:	Beneficiary's ID #:
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Beneficiary's Name:	Beneficiary's ID #:
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Signatures		
Parent/guardian	Provider Representative	Practitioner
Date	Date	Date