**Department of Medical Assistance Services**

**Medical Necessity Assessment and Personal Care**

**Service Authorization Form**

***(DMAS-7)***

***Final eligibility for personal care services will be determined by DMAS, according to medical necessity, as documented in the member’s clinical documentation.***

*If you have questions about this form contact DMAS Medical Services Unit at 804-786-805*6 or see <https://dmas.kepro.com>.

**Please submit this completed referral form and supporting clinical documentation (see additional guidance)**

**through the Atrezzo portal, at** [**https://atrezzo.kepro.com**](https://atrezzo.kepro.com)**.**

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| **MEMBER INFORMATION** | |
| Member’s Name: | Medicaid ID #: |
| DOB: | Gender:  Male  Female |
| Address: | Member’s Phone #: |
| Parent/Guardian’s Name: | Parent Phone #: |
| Address: | Active Protective Services case?  Yes  No |
| Primary Care Physician: | PCP Phone #: |

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| **REFERRAL SOURCE** | | |
| Referral Completed by (name):        MD/DO  PA  NP  RN/LPN | | |
| Phone #: | Address: | |
| Date of Assessment/Referral Completed: | | |
| Date of last visit to practitioner (PCP or specialist) or of last exam (**Note\*:** Must be <90 days from the request date): | | |
| This is a:  New Request  Re-authorization Request  Request Due to Status Change | | |
|  | | More information: |

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| **MeDICAL DIAGNOSES** | | |
| *Medical Diagnosis* | *ICD-10 code (complete)* | *Functional Impacts* |
|  |  | Physical  Behavioral  N/A  Describe: |
|  |  | Physical  Behavioral  N/A  Describe: |
|  |  | Physical  Behavioral  N/A  Describe: |
|  |  | Physical  Behavioral  N/A  Describe: |
|  |  | Physical  Behavioral  N/A  Describe: |
| *Recent Hospitalizations* | | |
| Dates of service: | Primary Diagnosis: | |
| Dates of service: | Primary Diagnosis: | |
| Dates of service: | Primary Diagnosis: | |

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| **ACTIVITIES OF DAILY LIVING (ADLs and IADLs)** | | |
| *Based on the member’s impairment, the medical professional should check the appropriate box as it applies to the member’s ability to perform these age-appropriate tasks using the definitions provided in the “Additional Guidance” section of this form.* | | |
| *Task* | *Level of Support Required* | |
| Bathing | Not applicable, less than 5 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Dressing | Not applicable, less than 5 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Transferring | Not applicable, less than 3 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Eating/Feeding | Not applicable, less than 5 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Continence/Toileting (bowel and/or bladder) | Not applicable, less than 5 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Ambulation | Not applicable, less than 3 years of age  Independent ((incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Meal Preparation | N/A, less than 18 years of age  Independent ((incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| House Cleaning (cleaning kitchen/bath, laundering bed linens, etc.)\* | N/A, less than 18 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Grocery Shopping | N/A, less than 18 years of age  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |
| Transportation | N/A, less than 18 years old  Independent (incl. supervision or prompting)  Limited Assistance | Extensive Assistance  Entirely Dependent  Independent with Use of Assistive Technologies |

*\* See additional guidance*

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| **BEHAVIORAL SUPPORT** | | | |
| *Based on the member’s impairment, the medical professional should check the appropriate box as it applies to the frequency of the member’s behaviors and the level of intervention required by caregivers to minimize impact.* | | | |
| *Task* | *Frequency* | | *Support Needed* |
| Wandering | N/A  Daily  Weekly | Monthly  Occasionally | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive |
| Verbally Abusive | N/A  Daily  Weekly | Monthly  Occasionally | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive |

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| **BEHAVIORAL SUPPORT CONT’D** | | | | | | | | |
| *Task* | *Frequency* | | | | | *Support Needed* | | |
| Physically Abusive | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| Resists Care | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| Suicidal | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| Homicidal | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| Disruptive Behavior/Socially Inappropriate | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| Injurious to: Self Others Property | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| Communication Deficit (Unable to express needs or wants) | N/A  Daily  Weekly | | Monthly  Occasionally | | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | |
| If the member could benefit from assistive technologies, has a referral/order been made?  Yes  Not yet | | | | | | | |
| Disorientation or confusion | N/A  Daily  Weekly | | Monthly  Occasionally | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | | |
| Sensory Impairment | N/A  Daily  Weekly | | Monthly  Occasionally | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | | |
| Forgetful (age-appropriate) | N/A  Daily  Weekly | | Monthly  Occasionally | | School/Work: None  Some  Extensive  Home: None  Some  Extensive  Public/Social: None  Some  Extensive | | | |
| Does the member have a history of (check all that apply)? | | | | | | | | |
| Substance Use Disorder (SUD) | | Intellectual or Developmental Disabilities | | | | | Mental Illness | |
| Is the member currently receiving medications for mental illness/behavior? | | | | | | | | Yes  No |
| Is the member currently receiving Mental Health, ID/DD or Substance Use Disorder (SUD) Services? | | | | | | | | Yes  No |
| OR, has a referral been made? | | | | Yes  No  Date of Referral:       Agency: | | | | |

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| **ADDITIONAL SUPPORTS** | | | |
| Medical Support | If the member CANNOT self-administer medications: |  | |
|  | 1. Can he/she be trained to self-administer medications? | Yes  No | |
|  | 1. What arrangements have been made for the administration of medications? | | |
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|  | Will the care provider be expected to accompany the member to medical appointments? | | |
|  | Yes  Not necessary | If yes, approx. #/month: | |
|  | Does the member require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)? | | If yes, describe: |
|  | Yes  Not necessary | |
| Support Services | Please describe additional supportive services that the member receives through their Medicaid benefits, such as Home Health, Skilled Nursing (if ID/DD), School-based services or Private Duty Nursing (including hours per week)? | | |
| Description of additional services: | | |
| Assistive Devices (sensory, mobility, communication, etc.) | 1. Device:   Condition:  New Need/Order  Owns and functional  Repair/Replace   1. Device:   Condition:  New Need/Order  Owns and functional  Repair/Replace   1. Device:   Condition:  New Need/Order  Owns and functional  Repair/Replace | | |

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| PROVIDER ORDER AND ATTESTATION | |
| The above named patient is in need of Personal Care Services due to his/her current medical condition. Based on the member’s medical necessity and preferences, I am prescribing:  Personal Care Services for       hours per day,       days per week. Shift requested is      am/pm to      am/pm. | |
| **Provider Signature (no stamps) and credentials (MD/DO, NP or PA only):** | NPI #: |
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| *“I hereby attest that the information contained herein is current, complete and accurate to the best of my knowledge and belief. I understand that my attestation may result in provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws.”* | |

**Instructions for completing the Personal Care Medical Needs Assessment and Referral (DMAS-7)**

***Supporting clinical documentation required to be submitted along with this DMAS-7 includes:***

* *DMAS 7A, or equivalent plan of care, and DMAS 99*
* *Records of the Department of Education’s last Individual Education Plan) IEP, if member is receiving or seeking Personal Care or PDN services delivered in a school setting and paid for by Medicaid; and*
* *Recent clinical documentation. Examples include: Hospital or facility discharge summary, last 3 physician visit notes (primary or specialty care), etc.*
  + *If a reauthorization review, include the most recent 2 weeks of Personal Care Services progress notes*
  + *If a new request, examples include: hospital or facility discharge summary, last 3 Physician visit notes (primary or specialty care), etc.*

**Personal Care Assistance Guide:**

This is a general guide to assist physicians with determining the number of Personal Care hours to order, as indicated by the level of assistance recipients require to complete their activities of daily living (ADL). Additional time to complete the tasks may be considered if there is sufficient medical documentation provided. Please attach documentation to support the need for additional time to complete the ADL’s.

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| **PCS Tasks** | **Levels of Assistance** | | | | **Mobility/Transfer Requirement** |
| Independent | Limited Assistance | Extensive Assistance | Entirely Dependent |
| Bathing | 0 | 15 min | 30 min | 45 min | Additional 15 min |
| Dressing | 0 | 15 min | 30 min | 45 min | Additional 15 min |
| Grooming | 0 | 15 min | 15 min | 15 min |  |
| Toileting | 0 | 15 min | 30 min | 45 min | Additional 15 min |
| Eating | 0 | 15 min | 30 min | 45 min |  |
| Meal Prep | 0 | 30 min | 30 min | 30 min |  |
| \*Household cleaning should arise as a result of providing assistance with personal care to the recipient, not to include routine chores such as regular laundry, ironing, mopping, dusting, etc. | | | | | |