EPSDT Personal Care Services
Functional Status Assessment (DMAS-7)

Complete when personal care is ordered
This form must be completed by a Physician, Physicians Assistant or Registered Nurse Practitioner

Name:	**Medicaid Number:**
Date of Birth:	**Primary Diagnosis:**
Parent/Guardian's Name:	**Phone #:**
Date of Last Assessment:	

Care needs must be related to a health condition and cannot be due to functional limitations associated with the normal attainment of developmental milestones

Indicate how the individual performs the following support needs:

ADLS/Mobility Supports	Needs Help		Performed by Others	
	No	Yes	No	Yes
Bathing				
Dressing				
Toileting				
Transferring				
Eating/Feeding				
Continence-bowel				
Continence-bladder				
Ambulation				

Indicate how often the individual engages in the following activities:

Behavioral Supports	Harm Self or Others	Makes Threats or Acts of Aggression	Attempt Elopement
Daily			
Weekly			
Monthly			
Every 3-4 months			

Physician, Physicians Assistant or Nurse Practitioner Name (please print):	
MD/PA/RNP Signature/ Date:	
Provider ID #:	

Fax completed form to: Keystone Peer Review Organization (KePRO).
Fax: 1-877-OKBYFAX or 1-877-652-9329
For questions about EPSDT email: EPSDT@dmas.virginia.gov

Receipt of personal care will depend on the Service Authorization Contractor decision based on EPSDT Personal Care Services Criteria.