Government of the District of Columbia
Department of Health Care Finance
Office of Chronic & Long-Term Care

EPD 2010-1 Guidelines Worksheet for Determining Personal Care Aide Service Hours under the Elderly and Individuals with Physical Disabilities (EPD) Waiver

To qualify for EPD Waiver services, individuals must meet the criteria for a level of care that addresses functional ability with ADLs and IADLs as specified on Form 1728 (Request for Medicaid Nursing Facility Level of Care form).

Instructions:

The EPD 2010-1 Guidelines Worksheet should be used to assist case managers in determining the number of personal care aide service hours an individual receives under the Elderly and Individuals with Physical Disabilities (EPD) Waiver Program. Case managers should include the EPD 2010-1 Guidelines Worksheet as part of a beneficiary's new application, recertification, and change request.

The EPD 2010-1 Guidelines Worksheet outlines four categories (Categories A through D) for the range of hours of personal care aide (PCA) services recommended for different levels of need and functional limitations. For example, individuals who qualify for Category A are more functionally independent than individuals who qualify for Category B.

Case managers should read through the list of limitations in each category and check all boxes that apply to the individual. To advance to the next category, the individual must display limitation(s) listed in the previous category. For example, Mr. Smith would not qualify for the hours associated with Category C if no limitations are checked for him in Category B.

The last category with limitations checked indicates the range of hours of PCA services that are appropriate for the individual. The category determined using the guidelines worksheet must match the information in the Individual Service Plan (ISP). The information documented in the EPD 2010-1 Guidelines Worksheet serves as the supporting documentation to justify the number of hours of PCA services requested in the ISP.

Case managers are not restricted to the limitations listed in this document. If the individual has other limitations not listed, please specify under "other."

Applicant/Beneficiary Information

Please print clearly.

Name of Individual:_____

Medicaid # (if not available, state if pending) _____

Permanent Address:_____

Phone (___) _____ – _____ Date of Birth _____ / _____ / _____ Sex _____

PCA hours individual is now receiving:_____

PCA hours case manager is requesting: _____

Diagnoses: _____

Name: _____ Medicaid #: _____

Categories	Limitations
Category A **1 – 4 hours of PCA services**	1. Level of cognition: □ Alert □ Oriented x3 □ Forgetful □ Short-term memory impairment 2. □ At risk for falls 3. □ Minimal assistance needed to leave home 4. □ Other: _____
Category B **5 – 8 hours of PCA services**	1. Level of cognition □ Dementia 2. Assistance leaving home □ Moderate assistance needed to leave home 3. Impaired movement/mobility □ Bending □ Lifting 4. Difficulty in ambulation □ Supervision needed when walking □ Use of assistive devices 5. Meal preparation □ Dependent on meal preparation □ Will eat non-edible or spoiled foods 6. Difficulty communicating wants, needs and desires □ Aphasia □ Tracheostomy □ Alzheimer's 7. History of unsafe behaviors □ Wandering □ Risk of exploitation 8. □ Vision impairment 9. □ Hearing impairment 10. □ Oxygen dependent □ Continuously □ As needed (PRN) 11. Impaired skin integumentary □ Skin breakdown □ Ulcers □ Wound 12. Limited support systems □ Caregiver not able to provide care due to his/her work schedule □ Caregiver not able to provide care due to his/her health condition □ Responsible party is not available to provide Assistance □ Other: _____

Name: _____ Medicaid #: _____

Categories	Limitations
Category C **9 – 12 hours of PCA services**	1. Level of cognition □ Confused/disoriented x3 2. Impaired movement/mobility □ Transferring to and from bed, portable commode, wheelchair 3. Feeding □ Minimal assistance needed □ Moderate assistance needed □ Gastrointestinal Tube 4. Incontinent of bladder and/or bowel □ Needs assistance changing depends □ Change urinary drainage bag 5. □ Lethargic or may experience periods of lethargy 6. □ Bedbound 7. □ Other: _____
Category D **13 – 16 hours of PCA services**	1. Escort to appointments □ Extensive assistance needed to leave home 2. Difficulty in ambulation □ Inability to independently ambulate 3. Feeding □ Extensive assistance needed 4. Incontinent of bladder and/or bowel □ Needs extensive assistance changing depend 5. Total care □ Feeding □ Transfer dependent □ Turn every 2 hours □ Range of motion □ Elevation of head to prevent aspiration 6. Alteration in respiratory muscles □ Ventilator 7. Medical escort assistance □ Requires stretcher to transport 8. □ Other: _____

Note: The case manager should document alternative supports in the Individualized Service Plan when the PCA leaves the beneficiary's home. The case manager should be sure to include the name, address, phone number, and relationship of the alternative support person.

Name: _____ Medicaid #: _____

This certifies that I, a licensed healthcare professional, have evaluated the functional, social, and environmental status of this individual in his/her home on the date below. This document provides an accurate description of this beneficiary and the need for services.

_____ _____

Health Care Professional (Print Name) Health Care Professional (Signature)

_____ _____

Case Management Provider Agency Case Management Provider Agency Number

_____

Date

Notice: Federal and District law make it a crime and set punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under programs administered by the DC Department of Healthcare Finance (DHCF). In addition, the agency and any individuals responsible for the false statement or representation may be excluded from participation in any DHCF program. DHCF is hereby making you aware of these laws and warning you against making any false statement in an application or in a fact used to determine the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.