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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 804-786-8056 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.

MEMBER INFORMATION	
Member's Name: LAST NAME, FIRST NAME	Medicaid ID #: ########### (12 digits)
DOB: MM-DD-YYYY	Gender: ☐ Male ☐ Female (PLEASE SELECT ONE)
Address: # YOUR STREET, YOUR TOWN, STATE ZIP CODE	Member's Phone #: (area code)-###-####
Parent/Guardian's Name: LAST NAME, FIRST NAME	Parent Phone #: (area code)-###-####
Address: # YOUR STREET, YOUR TOWN, STATE ZIP CODE	Active Protective Services case? ☐ Yes ☐ No
Primary Care Physician: DR. FIRST NAME LAST NAME, MD	PCP Phone #: (area code)-###-####

REFERRAL SOURCE — PLEASE SELECT ONE BELOW	
Referral Completed by (name): LAST NAME, FIRST NAME ☐ MD/DO ☐ PA ☐ NP ☐ RN/LPN	
Phone #: (area code)-###-####	Address: # YOUR STREET, SUITE # (if applicable), YOUR TOWN, STATE ZIP COD
Date of Assessment/Referral Completed: MM/DD/YYYY THIS MUST BE THE DATE YOU ARE COMPLETING THIS DOCUMENT	
Date of last visit to practitioner (PCP or specialist) or of last exam (**Note*:** Must be <90 days from the request date): MM/DD/YYYY	
This is a: ☐ New Request ☐ Re-authorization Request ☐ Request Due to Status Change	
PLEASE SELECT ONE ABOVE	More information: (additional information if needed)

MEDICAL DIAGNOSES — PLEASE SELECT ALL THAT APPLY BELOW

	Medical Diagnosis	*ICD-10 code (complete)*	*Functional Impacts*
1)	Please list ALL medical diagnoses in order of importance as it impacts the clients/patients day-to-day (If additional space is needed, please attach a separate sheet of paper labeled "additional diagnoses"	ICD-10 codes required	☐ Physical ☐ Behavioral ☐ N/A Describe: PLEASE DESCRIBE
2)		ICD-10 codes required	☐ Physical ☐ Behavioral ☐ N/A Describe: PLEASE DESCRIBE
3)		ICD-10 codes required	☐ Physical ☐ Behavioral ☐ N/A Describe: PLEASE DESCRIBE
4)		ICD-10 codes required	☐ Physical ☐ Behavioral ☐ N/A Describe: PLEASE DESCRIBE
5)		ICD-10 codes required	☐ Physical ☐ Behavioral ☐ N/A Describe: PLEASE DESCRIBE

Recent Hospitalizations	
Dates of service: if applicable	Primary Diagnosis: PLEASE LIST REASON/Diagnoses
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PLEASE DISCUSS THE LEVEL OF CARE NEED WITH THE PRIMARY CAREGIVER OF THE CLIENT/PATIENT.
PLEASE DO NOT LEAVE ANY OF THE ADLs LEVEL OF SUPPORT ITEMS BLANK
(select one from each task)

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

PLEASE DISCUSS THE LEVEL OF CARE NEEDS WITH THE PRIMARY CAREGIVER OF THE CLIENT/PATIENT.
PLEASE DO NOT LEAVE ANY OF THE BEHAVIORAL SUPPORT ITEMS BLANK
(select ONE from "Frequency" & ONE from EACH environment where "Support Needed")

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 ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Verbally Abusive	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive

PLEASE DISCUSS THE LEVEL OF CARE NEEDS WITH THE PRIMARY CAREGIVER OF THE CLIENT/PATIENT.
PLEASE DO NOT LEAVE ANY OF THE BEHAVIORAL SUPPORT ITEMS BLANK
(select ONE from "Frequency" & ONE from EACH environment where "Support Needed")

BEHAVIORAL SUPPORT CONT'D

Task	*Frequency*	*Support Needed*
Physically Abusive	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Resists Care	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Suicidal	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Homicidal	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Disruptive Behavior/Socially Inappropriate	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Injurious to: Self Others Property	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Communication Deficit (Unable to express needs or wants)	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	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 ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Sensory Impairment	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	School/Work: ☐ None ☐ Some ☐ Extensive Home: ☐ None ☐ Some ☐ Extensive Public/Social: ☐ None ☐ Some ☐ Extensive
Forgetful (age-appropriate)	☐ N/A ☐ Monthly ☐ Daily ☐ Occasionally ☐ Weekly	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:

PLEASE DISCUSS THE LEVEL OF CARE NEEDS WITH THE PRIMARY CAREGIVER OF THE CLIENT/PATIENT.
PLEASE DO NOT LEAVE ANY OF THE ADDITIONAL SUPPORT ITEMS BLANK (below)

ADDITIONAL SUPPORTS

Medical Support	If the member CANNOT self-administer medications: a) Can he/she be trained to self-administer medications? ☐ Yes ☐ No b) What arrangements have been made for the administration of medications?	
	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.)? ☐ Yes ☐ Not necessary	If yes, describe:
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 2) Device: Condition: ☐ New Need/Order ☐ Owns and functional ☐ Repair/Replace 3) Device: Condition: ☐ New Need/Order ☐ Owns and functional ☐ Repair/Replace	

Please discuss with the Primary Caregiver of the Client the Personal Care Services the Client currently receives

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:

SEE EXAMPLE

Personal Care Services for # of HOURS hours per day, # of DAYS days per week. Shift requested is ##:## am/pm to ##:## am/pm. PLEASE SELECT AM or PM

Provider Signature (no stamps) and credentials (MD/DO, NP or PA only):

SIGNATURE REQUIRED, please do not use a stamp

NPI #: NPI # REQUIRED

Date: DATE YOU ARE SIGNING THIS DOCUMEN

"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

**Example must detail DAYS OF THE WEEK that hours are intended for use:
"7" hours per day,
"5" days per week ("MONDAY through FRIDAY").
Shift requested is "1:00 pm" to "8:00 pm"**

PLEASE DISCUSS WITH THE PRIMARY CAREGIVER THE CURRENT PLAN OF CARE TO DETERMINE THE LEVEL OF CARE NEEDS OF THE CLIENT/PATIENT

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.

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.					