



**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:	Medicaid ID #:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	Member's Phone #:
Parent/Guardian's Name:	Parent Phone #:
Address:	Active Protective Services case? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:	PCP Phone #:

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

MEDICAL DIAGNOSES		
Medical Diagnosis	ICD-10 code (complete)	Functional Impacts
1)		<input type="checkbox"/> Physical <input type="checkbox"/> Behavioral <input type="checkbox"/> N/A Describe:
2)		<input type="checkbox"/> Physical <input type="checkbox"/> Behavioral <input type="checkbox"/> N/A Describe:
3)		<input type="checkbox"/> Physical <input type="checkbox"/> Behavioral <input type="checkbox"/> N/A Describe:
4)		<input type="checkbox"/> Physical <input type="checkbox"/> Behavioral <input type="checkbox"/> N/A Describe:
5)		<input type="checkbox"/> Physical <input type="checkbox"/> Behavioral <input type="checkbox"/> N/A Describe:
Recent Hospitalizations		
Dates of service:	Primary Diagnosis:	
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**ACTIVITIES OF DAILY LIVING (ADLs and IADLs)**

<i>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.</i>		
<i>Task</i>	<i>Level of Support Required</i>	
Bathing	<input type="checkbox"/> Not applicable, less than 5 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Dressing	<input type="checkbox"/> Not applicable, less than 5 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Transferring	<input type="checkbox"/> Not applicable, less than 3 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Eating/Feeding	<input type="checkbox"/> Not applicable, less than 5 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Continence/Toileting (bowel and/or bladder)	<input type="checkbox"/> Not applicable, less than 5 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Ambulation	<input type="checkbox"/> Not applicable, less than 3 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Meal Preparation	<input type="checkbox"/> N/A, less than 18 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
House Cleaning (cleaning kitchen/bath, laundering bed linens, etc.)*	<input type="checkbox"/> N/A, less than 18 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Grocery Shopping	<input type="checkbox"/> N/A, less than 18 years of age <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies
Transportation	<input type="checkbox"/> N/A, less than 18 years old <input type="checkbox"/> Independent (incl. supervision or prompting) <input type="checkbox"/> Limited Assistance	<input type="checkbox"/> Extensive Assistance <input type="checkbox"/> Entirely Dependent <input type="checkbox"/> Independent with Use of Assistive Technologies

\* See additional guidance

<b>BEHAVIORAL SUPPORT</b>			
<i>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.</i>			
<i>Task</i>	<i>Frequency</i>		<i>Support Needed</i>
Wandering	<input type="checkbox"/> N/A <input type="checkbox"/> Daily <input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly <input type="checkbox"/> Occasionally	School/Work: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Extensive Home: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Extensive Public/Social: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Extensive
Verbally Abusive	<input type="checkbox"/> N/A <input type="checkbox"/> Daily <input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly <input type="checkbox"/> Occasionally	School/Work: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Extensive Home: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Extensive Public/Social: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Extensive

**BEHAVIORAL SUPPORT CONT'D**

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

**ADDITIONAL SUPPORTS**

Medical Support    If the member CANNOT self-administer medications:

**DMAS-7 - Medical Needs Assessment and Personal Care Services Referral**

	a) Can he/she be trained to self-administer medications? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> Not necessary <span style="float: right;">If yes, approx. #/month:</span>	
	Does the member require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> New Need/Order <input type="checkbox"/> Owns and functional <input type="checkbox"/> Repair/Replace 2) Device: Condition: <input type="checkbox"/> New Need/Order <input type="checkbox"/> Owns and functional <input type="checkbox"/> Repair/Replace 3) Device: Condition: <input type="checkbox"/> New Need/Order <input type="checkbox"/> Owns and functional <input type="checkbox"/> Repair/Replace	

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.
<b>Provider Signature (no stamps) and credentials (MD/DO, NP or PA only):</b>	
_____	NPI #: Date:
<i>"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."</i>	

**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-7 - Medical Needs Assessment and Personal Care Services Referral**

- *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.					