Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers

PATIENT INFORMATION

1. **ALLERGIES:**

2. **Certification Request:** (check one)
Initial ☐ Re-certification ☐

Certification Period: __/__/____ __/__/____
From To
(Re-certification required every 180 days)

3. Medicaid ID Number (10 digits) _ _ _ _ _ _ _ _ _ _

4. MediPass Authorization # (if applicable): _ _ _ _ _ _ _ - _ _

5. Last Name: First Name:

6. Gender: Male ☐ Female ☐

7. Date of Birth: __/__/____

8. County of Residence:

9. Street Address:

City: State: Zip Code:

10. Phone # (___)___ - ____

11. Medicaid Area Office:

PROVIDER INFORMATION

12. Name:

13. Provider Medicaid ID Number: _ _ _ _ _ _ _ - _ _

14. Street Address:

City: State: Zip Code:

15. Phone # (___)___ - ____

PATIENT MEDICAL AND SOCIAL INFORMATION

16. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician)*:	Written Description:	Date of Diagnosis:
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____

17. Medications (Dose/Route/Frequency):

18. Durable Medical Equipment & Supplies Used by the Recipient:

19. Nutritional Requirements: _____

20. How Does the Patient Eat? (*check one*): Feeds Self ☐ Needs Assistance ☐ G-Tube ☐

21. Functional Limitations (*check all that apply):*

- ☐ Amputation *(describe):* _____
- ☐ Limited use of arms, hands, or feet
- ☐ Hearing impaired
- ☐ Requires assistance to ambulate
- ☐ Shortness of breath/breathing difficulty (*explain*): _____
- ☐ Bowel/bladder incontinence (*frequency*): _____
- ☐ Paralysis
- ☐ Tires easily when moving about
- ☐ Speech difficulty
- ☐ Legally blind
- ☐ Other (*explain*): _____

Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers (continued)

22. Safety Measures Required:

23. Permitted Physical Activities *(check all that apply):*
- ☐ Bed rest
- ☐ Up as tolerated
- ☐ Exercises prescribed
- ☐ Use of gait ball
- ☐ Assisted transfer from bed to chair
- ☐ Other (*specify*): _____

24. Mental/Neurological Status *(check all that apply):*
- ☐ Alert/oriented
- ☐ Forgetful
- ☐ Combative
- ☐ Agitated
- ☐ Depressed
- ☐ Seizures (how often): _____
- ☐ Disoriented
- ☐ Lethargic
- ☐ Other (*specify*): _____

25. Parent/Guardian Work/School Hours and Days *(if applicable)*:

26. Parent/Guardian physical limitations in caring for child *(if applicable)*:

27. Number of other children in the home:

28. Age of other children in the home:

29. Special needs of other children in the home *(if applicable)*:

SERVICE INFORMATION

30. Specific Hours/Days of Service *(prescribed by the physician)*:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

31. Services Provided (*check all that apply):*
- ☐ Bathing and Grooming
- ☐ Oral Hygiene
- ☐ Oral Feedings and Fluid Intake
- ☐ Toileting and Elimination
- ☐ Range of Motion and Positioning
- ☐ Other _____

32. Expected Health Outcome/Rehabilitation Potential (*check one*): Excellent ☐ Good ☐ Poor ☐ Unchanged ☐

33. Discharge Plan:

PHYSICIAN CERTIFICATION

I certify that personal care services are medically necessary for this individual, as furnished under this plan of care. This individual is under my care and I have examined him within the last 6 months.

Signature of Physician: Date: __/__/____

Physician Name: _____ Date Seen By Physician __/__/____

SIGNATURES

I acknowledge that I have reviewed this plan of care and the information herein is accurate.

Signature of Recipient/Parent/Legal Guardian: Date: __/__/____

Legal Guardian Printed Name *(if applicable)*:

Signature of Personal Care Provider: Date: __/__/____

ATTACH PRESCRIPTION