

# Aged and Disabled Waiver Program Plan of Care

Month

Year

Last Name	First Name	Middle Name	DOB	Service Level: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>
Plan of Care by: _____			Plan Period (Month & Year):	
RN Signature			Date	

Date: circle correct day <small>(Any change in schedule must be pre-approved and documented on back.)</small>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Day of week:																
Time Arrived:																
Time left:																
Total hours:																
Member's initials:																

DESCRIPTION OF SERVICES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Bath:																
Skin Care:																
Hair:																
Nails:																
Mouth Care:																
Dressing:																
Ambulation:																
Transfer:																
Toileting:																
Positioning: Turn Every Hr(s) Up in Chair																
Bed making:																
Special Directions:																
Assist with Medication:																
Meals: B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Snacks <input type="checkbox"/>																
Diet:																
Special Directions:																
Laundry:																
Vacuum/Sweep:																
Mop:																
Dust:																
Straighten:																

Member Name \_\_\_\_\_ Date \_\_\_\_\_

Date: circle correct day <small>(Any change in schedule must be pre-approved and documented below.)</small>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Transportation (any limitations and special directions)																
Essential Errands: Describe																
Community Activities: (not to exceed 30 hours/month) Describe																
Other:																

**SPECIALIZED TREATMENTS (PA/HM will be trained specifically on this care delivery)**


Date	Total Miles	Total Travel Time	Destination/Purpose of Travel	Essential Errands Time Spent	Community Activities Time Spent	Was member with you?		Member Initials
						Yes	No	

I have reviewed this worksheet and to the best of my knowledge the reported information is complete and accurate.  
 Date: \_\_\_\_\_ Begin time: \_\_\_\_\_  
 R.N. Printed Name: \_\_\_\_\_  
 R.N. Signature: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 End time: \_\_\_\_\_ Total Time: \_\_\_\_\_

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents or concealment of material fact, may be prosecuted under Medicaid Fraud.  
 Member/ \_\_\_\_\_ Date: \_\_\_\_\_  
 Legal Representative  
 Personal Assistant/  
 Homemaker Printed Name \_\_\_\_\_  
 Personal Assistant/  
 Homemaker \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_