

PERSONAL CARE

Plan of Care

Month

Year

Last Name	First Name	Middle Name	DOB	Service Level <input type="checkbox"/> 1 <input type="checkbox"/> 2
Plan of Care by: _____ RN Signature			Date _____	
			Plan Period (Month & Year):	

Date: Check correct day (Any change in schedule must be pre-approved and documented on back.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>	11 <input type="checkbox"/>	12 <input type="checkbox"/>	13 <input type="checkbox"/>	14 <input type="checkbox"/>	15 <input type="checkbox"/>	
	16 <input type="checkbox"/>	17 <input type="checkbox"/>	18 <input type="checkbox"/>	19 <input type="checkbox"/>	20 <input type="checkbox"/>	21 <input type="checkbox"/>	22 <input type="checkbox"/>	23 <input type="checkbox"/>	24 <input type="checkbox"/>	25 <input type="checkbox"/>	26 <input type="checkbox"/>	27 <input type="checkbox"/>	28 <input type="checkbox"/>	29 <input type="checkbox"/>	30 <input type="checkbox"/>	31 <input type="checkbox"/>
Day of Week:																
Time Arrived:																
Time Left:																
Total Hours:																
Member's Initials:																

Personal Care Tasks

Bath:																
Skin Care:																
Hair:																
Mouth Care:																
Dressing:																
Ambulation:																
Transfer:																
Toileting:																
Positioning: Turn Every ____ Hour(s) Up in Chair __ per day																
Prompt to take Medication																
Meals: <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Snacks__# Diet Special Directions:																
List Essential Errands:																
List Community Activities:																

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

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Travel documentation for Essential Errands and Community Activities if planned.

NOTE: Community Activities are not to exceed 20/hours per month.

Date	What was the destination and Purpose of the travel?	Was the member with you? Yes/No	How much time was spent?	Member Initials

Date:	1□	2□	3□	4□	5□	6□	7□	8□	9□	10□	11□	12□	13□	14□	15□	
Check correct day	16□	17□	18□	19□	20□	21□	22□	23□	24□	25□	26□	27□	28□	29□	30□	31□
Note Time assigned for each task:																
Making/Changing Bed																
Laundry:																
Dishwashing:																
Vacuum/Sweep:																
Mop:																
Dust:																
Straighten:																
Other:																
TOTAL TIME SPENT																

Total Environmental Tasks must not exceed 1/3 of the total plan of care.

<p>I have reviewed this worksheet and to the best of my knowledge and the reported information is complete and accurate.</p> <p>Date: _____ Begin Time: _____</p> <p>R.N. Printed Name: _____</p> <p>R.N. Signature: _____</p> <p>Comments _____</p>	<p>By signing, I certify that the reported information is complete and accurate. I understand Payment of the services certified on this form will be from Federal and State Funds, and that any false claims, statements, documents or concealment of material fact, may be prosecuted under Medicaid Fraud.</p> <p>Member/Legal Representative Signature _____ Date _____</p> <p>DCW Name: _____ Date: _____</p> <p>DCW Signature: _____ Date: _____</p>
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End Time: _____ Total Time: _____

Comments: _____