Personal Care Assessment and Service Plan

I. Client and Provider Information

Client	Medicaid ID #	Service Plan Status
	1234567801	Initial ✓ Revision ☐ Renewal ☐

Name (Last/First/Middle)	Date Of Birth (MM/DD/YYYY)
Doe, Johnny	01/01/1997

County of Residence	Telephone Number(s)	Parent(s) / Guardian(s) Name(s)
Logan	501-555-1212	**Judy & John Doe**

Complete Mailing Address
PO Box 1212, Somewhere, AR 72181

Client Resides: ✓ Alone ☐ With Relatives ☐ Boarding Home ☐ Group Home
☐ Community-Based Residential Home ☐ Residential Care Facility (RCF)
☐ Other (Describe):_____

PCP	Name	Provider ID Number/Taxonomy Code	Date Of Last Exam
	Dr. PCP	**123456701**	8/15/17

Personal Care Provider	Name School District Here
Provider ID Number 123456732	**Mailing Address** PO Box 1212, Somewhere, AR 72181

II. Service Locations

Personal Care Service Location(s): ☐ Private Residence ☐ Residential Care Facility
✓ School ☐ DDS Facility ☐ Other (describe):_____

Service Location(s) Address(es): School address where service is being provided_____

III. Dates of Service

Start of Care Date(s)

Original 8/15/17
(Required):Date the PCP signs this

Per this
Service Plan: 8/15/17-6/5/18_____
Date PCP signs this thru
end of school date

Projected End Date of Service (If less than 6 months): Leave blank_____

Current Assessment Date:8/10/17_____ **Assessing RN: Dana Bennett, RN**_____

Attending Physician (if other than the PCP): only used if another doctor is signing instead of PCP _____

Attending Physician's Provider ID Number/Taxonomy Code: _____

Date of the Order or Referral for Assessment: Leave blank_____

Referral Source (If other than attending physician): Leave blank_____

Client's Name: **Doe, Johnny** _____ **Medicaid ID #:** 1234567801_____

IV. Client Freedom of Choice

I hereby select the agency named in Section I of this document as my personal care provider. To help assure a complete and accurate assessment of my physical dependency needs and an individualized service plan to address those needs, I hereby authorize the release of any medical information by or to the attending physician and/or the PCP named above.

Parent's signature

Signature:_____ **Date:**_____

Client or Client's Representative

Nurse can sign as witness _____ _____

Witness Signature *(Two witnesses required if signed by mark)* *Witness Signature*

V. Medical Diagnoses

ICD codes and descriptions. List in the order of significance to the medical necessity for assistance with the client's physical dependency needs.

ICD Code	Description
343.9	Cerebral Palsy
345.1	Seizure Disorder

VI. Mental Status

- ☑ Clear
- ☐ Somewhat confused
- ☐ Moderately confused
- ☐ Markedly confused
- ☐ Hyperactive
- ☐ Withdrawn
- ☐ Needs restraint
- ☐ Needs supervision for personal safety

Comments: Becomes frustrated when she is unable to express her needs._____

Special Administrative Section

Use this section when requesting prior authorization.

Procedure Codes Requested	Hours	Minutes	Frequency
T1019-U4 _____	1	30	5X Week

Client's Name: Doe, Johnny Medicaid ID #: 1234567801

VII. Physical Dependency Status

Bedridden	Ambulation	Continence Status
☐ Bedfast	☐ Walks alone	☐ Catheter ☐ Colostomy
☐ Requires turning in bed	✓ Walks with device	✓ Incontinent
✓ Bed to chair with help	☐ Walks with help	✓ Bladder ☐ Bowels
☐ Bed to chair without help	☐ Wheelchair (self)	Training
☐ Must be lifted into chair	✓ Wheelchair (push)	☐ Cannot Train
	☐ Motorized chair	☐ Trained
		✓ Needs Training

Grooming	Client Needs:	No Help	Partial Help	Total Help
Bathing:	✓ Tub ☐ Shower ☐ Bed	☐	✓	☐
Dressing		☐	✓	☐
Shaving N/A		☐	☐	☐
Care of hair		☐	☐	✓

Eating

- ☐ Has physical ability to eat without help.
- ☐ Needs partial help to eat.
- ✓ Needs help with eating:
  - ☐ Special diet.
  - ✓ Cannot cut food into bite-size pieces.
  - ☐ Cannot bring food from plate to mouth.

Preparing Meals

- ☐ Has physical ability to cook or prepare food without help.
- ☐ Needs partial help with meal preparation.
- ✓ Physically incapable of cooking or preparing meals.

VIII. Activities of Daily Living

Laundry	Incidental Housekeeping	Shopping
☐ Needs no help.	☐ Needs no help.	☐ Needs no help.
☐ Needs partial help.	☐ Needs partial help.	☐ Needs partial help.
✓ Physically incapable of performing task.	✓ Physically incapable of performing task.	✓ Physically incapable of performing task.

Attach additional pages as needed to describe the client's physical dependency needs. The assessing Registered Nurse must date and initial all attachments.

IX. Assessment Narrative

This is a 10 year old female with cerebral palsy and a seizure disorder. She can ambulate using a walker on level surfaces or must be pushed in a wheelchair. She is incontinent at times and must be taken to the bathroom every 2 hours. She requires assistance with undressing and re-dressing and clean up during toileting routine. She is on a regular diet. She requires assistance with her lunch tray and must have food cut into bite-sized pieces. She has a history of choking and must be observed closely while eating. She is permanently disabled.

X. Alternate Resources for Assistance

List alternate resources for assistance with the client's physical dependency needs, beginning with other members of the client's household. Repeat as appropriate for other family and community resources, in accordance with instructions found in the Personal Care provider manual. Attach additional pages as necessary to give a full account.

She is in a classroom with nine other special needs children. There is one teacher. The teacher is unable to leave the other children in the classroom every two hours to take her to the bathroom; there is one aide in the room.

Client's Name: Doe, Johnny **Medicaid ID #: 1234567801**

XI. Certification of Service Need and Duration

I certify that personal care services are required to: Provide for the child's activities of daily living while in school.

Service Time

Maximum and minimum *daily aggregate* service-time estimates (in hours and minutes or hours and fractional hours for Personal Care Aide services for the client are:

Daily Totals

Weekday #	1	2	3	4	5	6	7
Maximum	1.5	1.5	1.5	1.5	1.5		
Minimum	1.5	1.5	1.5	1.5	1.5		

Weekly Totals

Maximum 7.5 Minimum 7.5

Additional comments regarding the duration, frequency or scope of personal care services:
This is the minimum amount of time needed to provide the required personal care assistance.

RN signs
Registered Nurse's Signature and Date

XII. Personal Care Service Plan

Attach additional pages as necessary. The PCP or attending physician must sign or initial and date his or her attachments to the service plan. Please give detailed information.

Meal Prep-5min/day 5 x week (lunch)
Meal Assist-20 min/day 5 x week (cut food into bite-sized pieces)
Bathing-10min/day 5 x week (sponge bath)
Hygiene-5min/day 5 x week (brush teeth after eating)
Toileting-40min/day 5 x week (assist to bathroom, undress/redress)
Mobility-10min/day 5 x week (transfers)

Client's Name: Doe, Johnny Medicaid ID #:1234567801

XIII. Personal Care Service Plan (Continued)

Physician Authorization

I have examined this patient within the past 60 days. I have reviewed the assessment and I confirm its accuracy. I authorize the personal care assistance detailed in this service plan, including additions and modifications dated and initialed by myself and excluding deletions dated and initialed by myself. I am aware that all personal care must be medically necessary and that the Utilization Review Section of the Division of Medical Services may review this assessment and service plan.

This is start of care date

PCP signs here
Signature of Attending Physician

Date

Client Acceptance of Authorized Service Plan

I understand that I will receive only medically necessary assistance with my physical dependency needs. I accept this personal care service plan.

Parent's signature
Signature of Client or Client's Representative

Date

To prior authorize services for recipients under age 21, send completed pages 1 through 6 to:

Arkansas Foundation for Medical Care (AFMC)
ATTN: Jarrod E. McClain, RN, CPHM
Director, Clinical Review
P.O. Box 180001
Fort Smith, AR 72918-0001
PH (479) 573-7780 FAX (479) 573-7781
jmcclain@afmc.org

For extension of benefits for recipients of age 21 or over, send completed pages 1 through 7 to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

Client's Name: Doe, Johnny _____ Medicaid ID #: 12345678901 _____

Providers requesting prior authorization of services for clients under the age of 21 *do not* use this page.

Providers requesting extensions of benefits for clients aged 21 and over must complete only the first item—"Additional Service-Time Increments Requested" and dates of service. The remainder of the page is your notification of approval or denial, to be forwarded to you upon the disposition of the benefit extension request.

Additional Service-Time Increments Requested	Begin Date of Service	End Date of Service

XIV. Provider Notification

Notification of Approval

Procedure Code	Service-Time Increments	Begin Date	End Date	Control Number

Signature of UR Nurse:_____ Date:_____

Signature of DMS Medical Director:_____ Date:_____

Notification of Denial

Signature of UR Nurse:_____ Date:_____

Signature of DMS Medical Director:_____ Date:_____