Instructions For Completion
INCOMPLETE or INCORRECT Care Plans will be returned and may result in a delay of the prior authorization for Personal Care Services.

Assessment Information

1. A new or updated *Care Plan* must be completed with each annual re-assessment visit.
2. Print legibly.
3. Prior to submitting this *Care Plan* valid Idaho Medicaid must be in place for the child.
4. Complete all sections. Please indicate what the Instructions are for each area of need.
5. Attach a copy of the most current behavioral Care Plan and/or the Qualified Intellectual Disabilities Professional (QIDP) plan for participants with behavioral challenges.
6. Review this *Care Plan* with the parent/guardian and have them sign the acknowledgement section.
7. A current H&P and the Primary Care Provider Statement of Need signed by the child's physician must be included in the documentation submitted to Medicaid. Please include EPSDT paperwork if more than 16 hours of PCS requested.

Return the current Plan of Care to:

Division of Medicaid
Bureau of Long Term Care
(Regional address)

☐ Initial Assessment ☐ Re-determination

Date ________________

Agency Name ______________________________

Agency Phone (___) ______________________________

PCS Frequency

Days per week _________ Hours per Day __________

(Refer to the Week-At-A-Glance for Individual Task Time)

Diagnoses: ______________________________

____

Referral Information

Participant

Name ______________________________

Medicaid ID #________________DOB ___/___/___

Address ______________________________

City ____________ State _____ Zip __________

Parent/Guardian

Name ______________________________

Physical Address ______________________________

City ____________ State _____ Zip __________

Daytime Phone (___) ______________________________

Mailing Address (if different)

____

PCS Family Alternate Care Home Provider

Name ______________________________

Address ______________________________

Phone ______________________________

Functional Status/Limitations

Dependence

☐ Total ☐ Partial

Mobility

☐ Immobile ☐ Partially Immobile

Deficits

☐ Cognitive ☐ Memory

Impairments *(Check all that apply)*

☐ Vision ____________________
☐ Hearing ____________________
☐ Speech ____________________

Medical Information

Primary Physician ____________________ Phone No ____________________
QIDP ____________________ Phone No ____________________
Developmental Center ____________________ Phone No ____________________
Pharmacy ____________________ Phone No ____________________

Activities of Daily Living (ADL)

1. Bathing

Method

☐ Bed ☐ Tub ☐ Independent ☐ Partial Assist
☐ Shower ☐ Stool ☐ Supervise/Cue ☐ Total Assist
☐ Other Equipment

Frequency ____________________

Instructions: ____________________

____

____

____

QIDP Program Attached - Yes ____ No ____

2. Grooming (Personal Hygiene)

Hair Care

☐ Independent ☐ Partial Assist
☐ Supervise/Cue ☐ Total Assist

Shaving/Make-up

☐ Independent ☐ Partial Assist
☐ Supervise/Cue ☐ Total Assist

Oral Care

☐ Independent ☐ Partial Assist
☐ Supervise/Cue ☐ Total Assist

Fingernail/Toenail Care

☐ Independent ☐ Partial Assist
☐ Supervise/Cue ☐ Total Assist

Handwashing

☐ Independent ☐ Partial Assist
☐ Supervise/Cue ☐ Total Assist

Instructions: ____

____

____

____

____

QIDP Program Attached - Yes ____ No ____

3. Dressing & Undressing-Upper Body

☐ Independent ☐ Partial Assist ☐ Braces ☐ Splints
☐ Supervise/Cue ☐ Total Assist ☐ Other assistive devices ____________

____

Instructions: ____

____

____

____

QIDP Program Attached - Yes ____ No ____

4. Dressing & Undressing-Lower Body

☐ Independent ☐ Partial Assist ☐ Braces ☐ Splints
☐ Supervise/Cue ☐ Total Assist ☐ Other assistive devices ____________

____

Instructions: ____

____

____

____

____

QIDP Program Attached - Yes ____ No ____

5-6. Toilet Use-Bladder ☐ CONTINENT ☐ INCONTINENT ☐ OCCASIONALLY INCONTINENT

ELIMINATION METHOD

☐ Toilet ☐ Bedpan ☐ Independent ☐ Partial Assist
☐ Commode ☐ Diaper ☐ Supervise/Cue ☐ Total Assist
☐ Indwelling Catheter
☐ Intermittent Catheter

Frequency ______________________________

Instructions: ____

____

____

____

QIDP Program Attached - Yes ____ No ____

7. Toilet Use – Bowel ☐ CONTINENT ☐ INCONTINENT ☐ OCCASIONALLY INCONTINENT

BOWEL PROGRAM ______________________________

ELIMINATION METHOD

☐ Toilet ☐ Bedpan ☐ Independent ☐ Partial Assist
☐ Commode ☐ Diaper ☐ Supervise/Cue ☐ Total Assist
☐ Ostomy Frequency ______________________________

Instructions: ____

____

____

____

QIDP Program Attached - Yes ____ No ____

8. Adaptive Devices

☐ Braces ☐ Prosthesis
☐ Splints

Frequency applied and removed ______________________________

Instructions: ____

____

____

____

9-10. Mobility/Transferring

Wheelchair Transfers

- ☐ Independent
- ☐ Partial Assist
- ☐ Supervise/Cue
- ☐ Total Assist

Equipment

- ☐ Gait Belt
- ☐ Hoyer Lift
- ☐ Transfer Board
- ☐ Crutches
- ☐ Cane
- ☐ Walker
- ☐ Manual Wheelchair
- ☐ Braces
- ☐ Electric Wheelchair

Bedbound /Position Changes

- ☐ Independent
- ☐ Partial Assist
- ☐ Supervise/Cue
- ☐ Total Assist

Services

- ☐ Physical Therapy
- ☐ Occupational Therapy

Instructions for therapies: ____________________________

____

____

____

Other Special Care/Considerations:____________________________

____

Instructions: ____________________________

____

____

____

QMRP Program Attached - Yes ____ No ____

11. Eating/Feeding

Intake Method

- ☐ Oral
- ☐ G-tube only
- ☐ Oral and G-tube

Type of Diet ____________________________

- ☐ Breakfast
- ☐ Supper
- ☐ Lunch
- ☐ Snack

Frequency ____________________________

- ☐ Independent
- ☐ Partial Assist
- ☐ Supervise/Cue
- ☐ Total Assist

Instructions:____________________________

____

____

____

QIDP Program Attached - Yes ____ No ____

12. Medications & Other Delegated Medical Care

Route

☐ Oral ☐ G-tube ☐ Rectal ☐ Topical

☐ Independent
☐ Supervise/Remind Only
☐ Physical Assist

Instructions: ____

____

____

Dressing Changes

Delegated by ______________________________ Date ___/___/___

Protocol ____

____

____

____

Other Specialized Treatments: ____

____

____

Delegated by ______________________________Date ___/___/___

Protocol ____

____

____

____

Instrumental Activities of Daily Living (IADLS)

Medically Related Household Tasks Required for Participant Only

Linen Change Frequency ____________________ QIDP Program Attached - Yes ____ No ___
Laundry Frequency ____________________
Housekeeping Frequency ____________________
Meal Preparation Frequency ____________________
Essential Shopping Frequency ____________________

Instructions: ____

____
____

Behavioral Management

Describe mental status/behavior problems which the PCS provider must address and methods to be used: _____
____
____
____
____
____
____
____

Provider Instructions: ____
____
____
____
____
____
____

QIDP Program Attached - Yes ____ No ____

Behavioral Plan Attached - Yes ____ No ____
(i.e. IBI, PSR, etc.)

Supervision

Can the participant be left alone at any time? Yes _____ No _____
Provider Instructions: ____
____
____
____

Parent/Guardian Acknowledgement

I acknowledge this Care Plan was performed with input from me and is a Care Plan to follow in delivering care to my child.

____ ___/___/___
Parent/Guardian Signature Date

Agency Nurse Acknowledgement

I acknowledge this Care Plan was performed by me and is a Care Plan to follow in delivering care to this child.
____ ___/___/___
Agency Nurse Date

Week-At-A Glance

Participant ____ Date: ______________

Instructions: R.N. to use for calculating hours and scheduling tasks. Attendant will review daily for tasks to be completed.

PROVIDER TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT
Bathing							
Shaving/Shampoo							
Skin/Nail Care							
Oral/Denture Care							
Dressing/Undressing							
Bladder/Bowel Program							
Peri/Menses/Incontinence Care							
Catheter/Ostomy Care							
Adaptive Devices							
Transferring							
Mobility/Ambulation							
Eating/Feeding							
Assistance with Medications							
Preparing Light Meals							
Light Housekeeping							
Wash Dishes/Clean-up/Trash							
Surfaces/Cupboards/Appliances							
Linen Change/Bed Making							
Laundry							
Shopping – Medical Supplies							
Medical Escort							
Supervision							
Individual Training Program							
1.							
2.							
3.							
4.							
5.							
Other							
1.							
2.							
Total Hours							

Plan of Care

PART II

Name:	Medicaid ID#:	DOB:
Address:		

PCS Care Plan Request

Personal Care Services requested (hours/day, days/week): ______________________________
The personal care attendant will assist with the following activities: Hygiene/Dressing ☐
Toileting ☐ Mobility ☐ Meal Preparation/Feeding ☐ Household Tasks ☐ Medications ☐
Other (specify): ____

Supervising Nurse Signature: ____________________________________Date: ____________

Client Responsibilities

I have reviewed this care plan. I have disclosed to the nurse and personal care attendant all pertinent facts about my medical needs and problems, and acknowledge full responsibility for failure to do so.

My rights to make medical treatment decisions have been explained to me.

Acceptance of Waiver Services: (only for persons requesting more than sixteen (16) hours of personal care services per week). I choose to receive personal care services rather than to accept placement in a facility. I understand that I may, at any time, choose facility admission.

Signature of participant/responsible party: ___________________________ Date: ___________

Physician Order for PCS

I agree that personal care services are medically necessary for this person.
Additional instructions/comments: ____
____
____

Physician signature: ____ Date: _______________