APPENDIX J
MEDICAID INSTRUCTIONS FOR THE PERSONAL CARE SERVICES PLAN OF CARE

ITEM 1 - ALLERGIES

Enter any known medicine or other allergies that the recipient has. If unknown, enter "NKA"

ITEM 2 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the eight-digit month, day and year, (i.e., MMDDYYYY).

FROM DATE

- The first day this POC covers includes this day.
- On the initial certification, the "FROM" date will be the same as start of care date.

TO DATE

- This is the end of the certification. The "TO" date is the last day of the plan of care.
- The "TO" date can include up to, but never exceed, 180 calendar days.
- On subsequent re-certifications the next sequential "FROM" date will be the day after the "TO" date on the previous plan of care.

ITEM 3 – MEDICAID ID NUMBER

Enter the recipient's ten digit Medicaid identification number.

ITEM 4 – MEDIPASS AUTHORIZATION NUMBER

If the recipient is enrolled in the MediPass program, enter the primary care physician's MediPass authorization number. This can be obtained by contacting the recipient's MediPass primary care physician.

ITEM 5 – PATIENT'S NAME

Enter the recipient's last name and first name as shown on the recipient's Medicaid eligibility file.

ITEM 6 – GENDER

Check the appropriate box.

ITEM 7 – DATE OF BIRTH

Enter the recipient's date of birth in the eight-digit format, (i.e., MMDDYYYY).

ITEM 8 – COUNTY OF RESIDENCE

Enter the county in which the recipient resides.

ITEM 9 – PATIENT'S ADDRESS

Enter the recipient's address (street address, city, state, and zip code) where care is being provided.

Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers (continued)

***Medicaid Instructions for Personal Care Services Plan of Care**,* continued

ITEM 10 – PHONE NUMBER

Enter the recipient's home telephone number.

ITEM 11 – MEDICAID AREA OFFICE

Enter the recipient's local Medicaid area office.

ITEM 12 – PROVIDER NAME

Enter your name.

ITEM 13 – PROVIDER MEDICAID ID NUMBER

Enter your Medicaid provider ID number.

ITEM 14 – PROVIDER ADDRESS

Enter your address.

ITEM 15 – TELEPHONE NUMBER

Enter your telephone number.

ITEM 16 – DIAGNOSIS(ES)

Enter a valid ICD-9 code which best describes the recipient's primary reason for needing personal care services on the first line. The code is the full ICD-9-CM diagnosis code including all digits.

Enter all other pertinent diagnoses relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset or exacerbation in eight-digit format (MMDDYY) for each diagnosis. The diagnosis date does <u>not</u> refer to dates of the certification period on the plan of care.

The diagnoses should come from the recipient's primary care physician and be documented on the written physician's order.

ITEM 17 – MEDICATIONS

Enter ALL of the recipient's medications including over-the-counter drugs.

Enter dosage (*mg, one, two, etc*), frequency (*how often*) and route of administration (*oral, rectal, etc.*).

ITEM 18 – DURABLE MEDICAL EQUIPMENT AND SUPPLIES

List supplies and equipment needed for care. For example, gloves, wheel chair, commode, incontinence supplies (briefs), walker, cane, etc.

ITEM 19 – NUTRITIONAL REQUIREMENTS

Enter the physician's orders for the diet including any therapeutic diets or specific dietary requirements and restrictions (i.e., normal, soft, liquid).

ITEM 20 – HOW DOES THE PATIENT EAT

Check the appropriate box.

ITEM 21 – FUNCTIONAL LIMITATIONS

Check current limitations as assessed by the physician. If "Other" is checked, provide detail below other or in an addendum to the POC.

ITEM 22 – SAFETY MEASURES

Enter the physician's instructions for safety measures or those identified by your assessment of the recipient (i.e., keeping path ways clean and free of clutter, assisting with walking, etc.).

ITEM 23 –PERMITTED PHYSICAL ACTIVITIES

Check all activities allowed by the recipient's physician. If "Other" is checked, a detailed explanation is required.

ITEM 24 – MENTAL STATUS

Check the most appropriate box that describes the recipient's mental status. If "Other" is checked, specify.

ITEM 25 – PARENT/GUARDIAN WORK AND SCHOOL SCHEDULE

If applicable, enter the parent or legal guardian's work and school schedule (include the hours and days).

ITEM 26 – PARENT/GUARDIAN PHYSICAL INFORMATION

If applicable, enter any medical or physical limitations that the parent or legal guardian has that would prevent him from participating in the child's care to the fullest extent possible.

ITEM 27 – NUMBER OF OTHER CHILDREN IN THE HOME

Enter the number of children who live in the same place of residence as the residence.

If recipient lives in a group home for children with special needs, enter "N/A".

ITEM 28 – AGE OF OTHER CHILDREN IN THE HOME

Enter the age of the each of the children living in the home (from Item 27).

If recipient lives in a group home for children with special needs, enter "N/A".

Medicaid Instructions for Personal Care Services Plan of Care, continued

ITEM 29 – SPECIAL NEEDS OF OTHER CHILDREN IN THE HOME

If applicable, enter the special needs of any other children who live in the same home with the recipient.

If recipient lives in a group home for children with special needs, enter that here.

ITEM 30 – SPECIFIC HOURS PER DAY AND DAYS OF WEEK SERVICE WILL BE PROVIDED

Enter the specific hours per day and days per week that you will be providing medically necessary personal care services, as prescribed by the recipient's physician.

ITEM 31 – SERVICES PROVIDED

Check all activities of living/self care tasks that you will be assisting the recipient to accomplish. If "Other" is checked, a detailed explanation is required.

ITEM 32 – EXPECTED HEALTH OUTCOME/ REHABILITATION POTENTIAL

Check the most appropriate box that describes the recipient's expected health outcome and the ability for the recipient to achieve goals (i.e., re-learn or acquire the ability to perform some or all of his self care tasks).

ITEM 33 –DISCHARGE PLAN

Address discharge plans (if applicable).

PHYSICIAN CERTIFICATION

Enter the name of the attending physician that prescribed the services. The plan of care must be signed and dated by the attending physician prior to submission of a prior authorization request. If a rubber stamp signature is used, it must be initialed by the physician.

Faxed signatures are acceptable; however, the physician must retain the plan with his original signature in the recipient's medical record. The provider is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his patients in his absence,(i.e., partnership agreement).

SIGNATURES

The plan of care must be signed and dated by the recipient's parent or legal guardian. A recipient 18 years of age or older who is capable of signing the plan of care may do so, instead of the parent or legal guardian.

Enter the parent or legal guardian's printed name (if applicable).

The plan of care must also be signed by the provider rendering care.

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

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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