# Personal Care Additional Documentation Attachment

Applicant/Member Name: _____
Medicaid Number: _____

**Date: _____**

**Agency Name: _____**

**Agency RN Name: _____**

**Provide specific, detailed and accurate information when assessing the applicant/member for Personal Care Services.**

| |
|---|
| **Decubitus:** |
| **Vacating:** |
| **Eating:** |
| **Bathing:** |

# Personal Care Additional Documentation Attachment

Applicant/Member Name: _____

Medicaid Number: _____

| |
|---|
| **Dressing:** |
| **Grooming:** |
| **Continence: Bowel/Bladder:** |
| **Orientation:** |
| **Transferring:** |

# Personal Care Additional Documentation Attachment

Applicant/Member Name: _____

Medicaid Number: _____

| |
|---|
| **Walking:** |
| **Wheeling:** |
| **Vision:** |
| **Hearing:** |
| **Communication:** |

# Personal Care Additional Documentation Attachment

Applicant/Member Name: _____

Medicaid Number: _____

| **Professional & Technical Care Needs:** |
| --- |
| **Medication Administration:** |