PERSONAL CARE

Plan of Care Month Year

Last Name	First Name	Middle Name	DOB	Service Level □ 1 □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□	2□	3□	4□	5□	6□	7□	8□	9□	10□	11□	12□	13□	14□	15□	
	16□	17□	18□	19□	20□	21□	22□	23□	24□	25□	26□	27□	28□	29□	30□	31□
Day of Week:																
Time Arrived:																
Time Left:																
Total Hours:																
Member's Initials:																

Personal Care Tasks

Bath : S P T																
Skin Care: S P T																
Hair: S P T																
Mouth Care: S P T																
Dressing: S P T																
Ambulation: S P T																
Transfer: S P T																
Toileting: S P T																
Positioning: Turn Every ____ Hour(s) Up in Chair ____ per day																
Prompt to take Medication ☐																
Meals: □B □L □D □Snacks ____ # Diet Special Directions:																
List Essential Errands:																
List Community Activities:																

SPECIALIZED TREATMENTS (DCW will be trained specifically on this care delivery): _____

PERSONAL CARE

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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: Check correct day	1□	2□	3□	4□	5□	6□	7□	8□	9□	10□	11□	12□	13□	14□	15□	
	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:																
Dust,Vacuum/Sweep, Mop, Straighten																
Other:																
TOTAL TIME SPENT																

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

I have reviewed this worksheet and to the best of my knowledge and belief the reported information is complete and accurate.

Date: _____

R.N. Printed Name: _____

R.N. Signature: _____

Comments:

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

_____Date:_____

Member/Legal Representative Signature

DCW Name: _____Date: _____

DCW Signature: _____ Date: _____

Comments: