# Personal Care

## *Specialized Family Care Plan of Care* Month Year

| Last Name | First Name | Middle Name | DOB | Service Level: □ 1 □ 2<br>Hours Per Month: |
|---|---|---|---|---|
| **Plan of Care by**: _____ _____<br>**RN Signature** **Date** | | | | **Plan Period (Month & Year):** |

| **Date: Check correct day**<br>(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: | | | | | | | | | | | | | | | | |
| Direct Care Periods of Time:<br>P1:<br>P2:<br>P3: | | | | | | | | | | | | | | | | |
| Total hours: | | | | | | | | | | | | | | | | |

**Personal Care Tasks**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bath: | | | | | | | | | | | | | | | |
| Skin Care: | | | | | | | | | | | | | | | |
| Hair: | | | | | | | | | | | | | | | |
| Nails: | | | | | | | | | | | | | | | |
| Mouth Care: | | | | | | | | | | | | | | | |
| Dressing: | | | | | | | | | | | | | | | |
| Ambulation: | | | | | | | | | | | | | | | |
| Transfer: | | | | | | | | | | | | | | | |
| Toileting: | | | | | | | | | | | | | | | |
| Positioning: Turn Every __ Hour(s)<br>Up in Chair _____ per day | | | | | | | | | | | | | | | |
| Prompt to take Medication: | | | | | | | | | | | | | | | |
| Meals: □ B □ L □ D □ Snacks___#<br>Diet:_____<br>Special Directions:_____ | | | | | | | | | | | | | | | |
| **List Essential Errands:** | | | | | | | | | | | | | | | |

**SPECIALIZED TREATMENTS (PA/HM will be trained specifically on this care delivery): _____**
**_____**
**_____**

***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 |
|---|---|---|---|---|
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|---|---|
| I have reviewed this worksheet and to the best of my knowledge and the reported information is complete and accurate.<br><br>Date: _____ Begin time: _____<br><br>R.N. Printed Name: _____<br><br>R.N. Signature: _____<br>Comments: _____<br>_____<br>_____<br>End Time: Total Time: | By signing, I certify that the reported information is true, complete and accurate and that I have completed this work myself. 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 concealment of material fact, may be prosecuted under Medicaid Fraud.<br><br>.<br><br>SFC Provider Printed Name: _____ Date: _____<br><br>SFC Provider Signature: _____ Date:_____ |

Comments: _____