PERSONAL CARE SERVICES PROGRAM
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-Month/Year):	

If multiple shifts are required throughout the day, each shift requires a POC explaining services to be completed to ensure no duplication of services occurs.

Date: Check correct day (Any change in schedule must be pre-approved & 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, Lotion, Hair, Mouth Care, Nails, Shaving: S P T																
Dressing: S P T																
Walking: P T S=unbillable																
Wheeling: S P T																
Transfer: S P T																
Toileting: S P T																
Positioning: Turn Every ____ Hour(s). Up in chair____/day																
Prompt to take Medication:																
Feeding: S P T																
Meals: □B □L □D S P T □Snacks___# Diet Special Directions:																
Incontinent Laundry:																
Specialized Treatments: i.e. ROM, care of med equip																

PERSONAL CARE SERVICES PROGRAM

PLAN OF CARE

List Specific Essential Errands:																
List Specific Community Activities:																

Travel documentation for all Essential Errands and Community Activities Planned or approved by the RN with documentation

NOTE: Community Activities are not to exceed 20/hours per month.

Date	What was the destination and Purpose of the travel? i.e. Walmart Chas. Groceries	Was the member with you? Yes/No	Total of drive time and time spend for essential errands and/or comm. Activity. 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:_____

_____Date:_____

Before signing, I will review this form for accuracy and report any discrepancies to the agency providing me with care. I further understand the PC Program is funded by State and Federal monies and misuse can result in prosecution.

_____Date:_____

Member/Legal Representative Signature

DCW Name: _____

DCW Signature: _____Date:_____

comments:_____

_____