PERSONAL CARE ASSESSMENT AND SERVICE PLAN

I. CLIENT AND PROVIDER INFORMATION

Client Name *(Last/First/Middle)* _____ **Date of Birth** *(MM/DD/YYYY)* _____

County of Residence _____ **Telephone Number(s)** _____ **Parent(s)/Guardian(s) Name(s)** _____

Complete Mailing Address _____

PERSONAL CARE PROVIDER INFORMATION:

District Name _____ **Provider ID Number** _____

District Mailing Address _____ **Service Location Address(es)** _____

II. DATES OF SERVICE

Start of Care Date _____ **End Date** _____ **Units per Month Requested** _____

III. MEDICAL DIAGNOSES

ICD code and descriptions. List in the order of significance to the medical necessity for assistance with the client's physical dependency needs.

ICD Code	Description

IV. PHYSICAL DEPENDENCY STATUS

Bedridden

___ Bedfast
___ Requires turning in bed
___ Bed to chair with help
___ Bed to chair without help
___ Must be lifted into chair

Ambulation

___ Walks alone
___ Walks with device
___ Walks with help
___ Wheelchair (self)
___ Wheelchair (push)
___ Motorized chair

Continence Status

___ Catheter
___ Bladder
___ Colostomy
___ Incontinent
___ Bowels

Training

___ Cannot Train
___ Trained
___ Needs Training

Grooming	Client Needs:	No Help	Partial Help	Total Help
Bathing	___ Tub ___ Shower ___ Bed			
Dressing				
Care of Hair				

Eating

____ Has physical ability to eat without help.
____ Needs partial help to eat.
____ Needs help with eating:
  ____ Special diet.
  ____ Cannot cut food into bite-size pieces.
  ____ Cannot bring food from plate to mouth.

Preparing Meals

____ Has ability to cook or prepare food without help.
____ Needs partial help with meal preparation.
____ Physically incapable of cooking or preparing meals.

V. Assessment Narrative

VI. Personal Care Service Plan

Daily Minutes Requested _____ Daily Units _____ *(15 Minutes = 1 Unit)*
Weekly Minutes Requested _____ Weekly Units _____
Monthly Minutes Requested _____ Monthly Units _____

Task	Minutes/Day Needed	Details (if needed)

_____
Registered Nurse's Signature, Credentials and Date

VII. Client Freedom of Choice/Acceptance of Plan

I hereby select the listed school district as my child's personal care provider. To help assure a complete and accurate assessment of my physical dependence needs and an individualized service plan to address those needs, I hereby authorize the release of any medical information by or to the attending physician and/or PCP. I understand that I will receive only medically necessary assistance with my physical dependency needs. I accept this personal care service plan.

_____ _____
Signature – *Client or Client's Representative* **Date**

_____ _____
Witness Signature Witness Signature
(Two witnesses required if signed by mark)