Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers

PATIENT INFORMATION

1. **ALLERGIES:**

2. **Certification Request:** (check one)
Initial ☐ Re-certification ☐
Certification Period: __/__/____ __/__/____
From To
(Re-certification required every 180 days)

3. Medicaid ID Number (10 digits) _ _ _ _ _ _ _ _ _ _

4. MediPass Authorization # (if applicable): _ _ _ _ _ _ _ - _ _

5. Last Name: First Name:

6. Gender: Male ☐ Female ☐

7. Date of Birth: __/__/____

8. County of Residence:

9. Street Address:
City: State: Zip Code:

10. Phone # (___)___ - ____

11. Medicaid Area Office: 04

PROVIDER INFORMATION

12. Name: Helping Hands of Flagler County

13. Provider Medicaid ID Number: 0018508-00

14. Street Address: 50 Cypress Point Pkwy Suite B-4
City: Palm Coast State: FL Zip Code: 32164

15. Phone # (386) 313 1239

PATIENT MEDICAL AND SOCIAL INFORMATION

16. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician)*:	Written Description:	Date of Diagnosis:
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____

17. Medications (Dose/Route/Frequency):

18. Durable Medical Equipment & Supplies Used by the Recipient:

19. Nutritional Requirements: _____

20. How Does the Patient Eat? (*check one*): Feeds Self ☐ Needs Assistance ☐ G-Tube ☐

21. Functional Limitations (*check all that apply*):

- ☐ Amputation *(describe)*: _____
- ☐ Limited use of arms, hands, or feet
- ☐ Hearing impaired
- ☐ Requires assistance to ambulate
- ☐ Shortness of breath/breathing difficulty (*explain*): _____
- ☐ Bowel/bladder incontinence (*frequency*): _____
- ☐ Paralysis
- ☐ Tires easily when moving about
- ☐ Speech difficulty
- ☐ Legally blind
- ☐ Other (*explain*): _____

Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers (continued)

22. Safety Measures Required:

23. Permitted Physical Activities *(check all that apply)*:
- ☐ Bed rest
- ☐ Up as tolerated
- ☐ Exercises prescribed
- ☐ Use of gait ball
- ☐ Assisted transfer from bed to chair
- ☐ Other (*specify*): _____

24. Mental/Neurological Status *(check all that apply)*:
- ☐ Alert/oriented
- ☐ Forgetful
- ☐ Combative
- ☐ Agitated
- ☐ Depressed
- ☐ Seizures (how often): _____
- ☐ Disoriented
- ☐ Lethargic
- ☐ Other (*specify*): _____

25. Parent/Guardian Work/School Hours and Days *(if applicable)*:

26. Parent/Guardian physical limitations in caring for child *(if applicable)*:

27. Number of other children in the home:

28. Age of other children in the home:

29. Special needs of other children in the home *(if applicable)*:

SERVICE INFORMATION

30. Specific Hours/Days of Service *(prescribed by the physician)*:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

31. Services Provided (*check all that apply)*:
- ☐ Bathing and Grooming
- ☐ Oral Hygiene
- ☐ Oral Feedings and Fluid Intake
- ☐ Toileting and Elimination
- ☐ Range of Motion and Positioning
- ☐ Other _____

32. Expected Health Outcome/Rehabilitation Potential (*check one*): Excellent ☐ Good ☐ Poor ☐ Unchanged ☐

33. Discharge Plan:

PHYSICIAN CERTIFICATION

I certify that personal care services are medically necessary for this individual, as furnished under this plan of care. This individual is under my care and I have examined him within the last 6 months.

Signature of Physician: ______________________ Date: __/__/____

Physician Name: _____ Date Seen By Physician __/__/____

SIGNATURES

I acknowledge that I have reviewed this plan of care and the information herein is accurate.

Signature of Recipient/Parent/Legal Guardian: Date: __/__/____

Legal Guardian Printed Name *(if applicable)*:

Signature of Personal Care Provider: Renee Williams Date: __/__/____

ATTACH PRESCRIPTION

MEDICAID PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

GENERAL INFORMATION

1. **TODAY'S DATE:** _ _ / _ _ / _ _ _ _

2. **Certification Request:** (check one)
   Initial   Re-certification
   (Re-certification required at least every 60 days for home health visits and at least every 180 days for private duty nursing and personal care services.)

3. Date of last physician's office visit: _ _ / _ _ / _ _ _ _

PATIENT INFORMATION

4. Medicaid ID Number (10 digits) _ _ _ _ _ _ _

5. MediPass Authorization # (if applicable): _ _ _ _ _ _ _ - _ _

6. Last Name: ________________ First Name: __________

7. Gender: Male   Female

8. Date of Birth: _ _ / _ _ / _ _ _ _

9. Phone #(_ _ _) _ _ _ - _ _ _ _

10. Street Address: ___________________________________
    City: _________________________ State: _____ Zip Code: __________

PATIENT MEDICAL AND SOCIAL INFORMATION

11. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician):*	Written Description:	Date of Diagnosis:
_ _ _ . _ _		__/__/___
_ _ _ . _ _		__/__/___
_ _ _ . _ _		__/__/___

12. Home Health Services ordered:

13. Frequency and duration:

14. Reason services must be provided (must be medically necessary):

15. Skill level required (i.e. RN, LPN, or Aide): _____

ORDERING PHYSICIAN INFORMATION

16. Name: ___________________________

17. Phone # (____) ___ - _____

18. Street Address: _________________________
    City: _________________ State:___ Zip Code: _____

19. Provider Medicaid ID Number: _ _ _ _ _ _ _ - _ _
    OR
    Provider NPI Number: _ _ _ _ _ _ _ _ _ _
    OR
    Provider Medical License Number: _ _ _ _ _ _ _

PHYSICIAN'S SIGNATURE: ***I certify that home health services are medically necessary for this individual, as furnished in this written prescription for services. This individual is under my care and I have examined him within 30 days prior to the initiation of services or within the last 6 months for continuation of services.***

Signature: ______________________________________ ***Date:*** __/__/____

AHCA-Med Serv Form 5000-3525, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)

PHYSICIAN VISIT DOCUMENTATION FORM

This form must be completed by the Physician ordering home health services.

Date: ______________________________

Medicaid Recipient's Name: ______________________________

Physician's Name: ______________________________

Physician's Address: ______________________________

____

Physician's Telephone Number: (________) ______________________________

Diagnosis(es): ______________________________

Date of the recipient's last examination or consultation in your office: ________________

Please describe the patient's ongoing need for home health services:

____

____

____

____

____

____

I hereby certify that I have examined the above named recipient on ______________ and have ordered home health services to treat the recipient's acute or chronic medical condition as described above.

Signature of Physician: ______________________________

National Provider Identifier: ____________________

Pursuant to 409.905 (4) (c), Florida Statutes: In order for Medicaid to reimburse for home health services, the physician ordering the services must have examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

After completion of this form, please send directly to the recipient's home health agency.

PARENT OR LEGAL GUARDIAN STATEMENT OF WORK SCHEDULE

Recipient's Name:____

Parent/Legal Guardian's Name:__________________________________

Statement of Work Schedule

Name of Employer: ____

Address: ____

____

Work Schedule:
(Include work hours for each day)

Monday: ____________________

Tuesday: ____________________

Wednesday: ____________________

Thursday: ____________________

Friday: ____________________

Saturday: ____________________

Sunday: ____________________

My signature below certifies that I am self-employed and that the schedule above is true and accurate. I understand that any person who makes, presents, or submits documentation that is false or fraudulent is subject to a reduction or termination of Medicaid services.

Parent/Legal Guardian Signature:________________________

Date:______________________________

Telephone Number:(__________)______________________

For use by the Provider:

Recipient's Name: ____________________ Recipient Medicaid ID: ____________

AHCA-Med Serv Form 5000-3504, December 2011

PARENT OR LEGAL GUARDIAN WORK SCHEDULE

This form must be completed by a Supervisor at the place of employment.

Parent/Legal Guardian's Name: ______________________

Name of Employer: ______________________

Address: ______________________

____

Work Schedule:
(Include work hours for each day)

Monday: ______________

Tuesday: ______________

Wednesday: ______________

Thursday: ______________

Friday: ______________

Saturday: ______________

Sunday: ______________

If employee works a variable work schedule, please indicate the average number of hours per week, this employee works: ______________

Any person who makes, presents or submits a document that is false or fraudulent is subject to a reduction or termination of Medicaid services.

Supervisor Name: ______________

Title: ______________

Telephone Number: (______) ______________

Signature: ______________

Date: ______________

For use by the Provider:

Recipient's Name: ______________ Recipient Medicaid ID: ______________

AHCA-Med Serv Form 5000-3503, December 2011

PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS

This form must be completed by the Parent or Legal Guardian's Physician.

Date: ______________________

Patient Name: ____

Physician Name: ____

Physician Address: ____

____

Physician Telephone Number: (______) ______________________________

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

____

____

____

____

____

____

____

If limitation/disability is temporary, please document the expected timeframe for resolution.

____

Signature of Physician: ___________________________

National Provider Identifier: ________________

____

Signature of Parent/Legal Guardian: ____
(By my signature, I am allowing release of this information to be used for the purpose of determining authorization for my child.)

For use by the Provider:

Recipient's Name: _________________________ Recipient Medicaid ID: ______________