**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.

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| --- | --- | --- |
| **ICD Code** |  | **Description** |
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|  |  |  |
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**Bedridden Ambulation Continence Status**

**IV. Physical Dependency Status**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Bedfast | | | |  | | Walks alone | | | | |  |  | Catheter | |  |  | | | | |  | | | Colostomy | | |
|  | Requires turning in bed | | | |  | | Walks with device | | | | |  |  |  | |  | Incontinent | | | | |  | |  | | | |
|  | Bed to chair with help | | | |  | | Walks with help | | | | |  |  | Bladder | |  |  | | | | |  | | Bowels | | | |
|  | Bed to chair without help | | | |  | | Wheelchair (self) | | | | |  |  |  | |  | **Training** | | | | | |  | |  | | |
|  | Must be lifted into chair | | | |  | | Wheelchair (push) | | | | |  |  |  | |  | Cannot Train | | | | | |  | |  | | |
|  |  | | | |  | | Motorized chair | | | | |  |  |  | |  | Trained | | | | | |  | |  | | |
|  |  | | | |  | |  | | | | |  |  |  | |  | Needs Training | | | | | |  | |  | | |
|  | |  |  |  | | | | |  | |  | | | |  | | | |  | |  | | | | |  |  | |
| **Grooming** | |  |  | Client Needs: | | | | |  | |  | | | | No Help | | | |  | | Partial Help | | | | |  | Total Help | |
| Bathing | |  | Tub |  | | Shower | |  | | Bed | | | | |  | | |  | |  | | | | | |  |  | |
| Dressing | |  |  |  | |  | | |  | |  | | | |  | | |  | |  | | | | | |  |  | |
| Care of Hair | |  |  |  | |  | | |  | |  | | | |  | | |  | |  | | | | | |  |  | |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Eating** | |  | **Preparing Meals** | |
|  | Has physical ability to eat without help. | |  | Has ability to cook or prepare food without help. | |
|  | Needs partial help to eat. | |  | Needs partial help with meal preparation. | |
|  | Needs help with eating: | |  | Physically incapable of cooking or preparing meals. | |
|  |  | Special diet. | | |  |
|  |  | Cannot cut food into bite-size pieces. | | |  |
|  |  | Cannot bring food from plate to mouth. | | | |

**V. Assessment Narrative**

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| **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)

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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)*

**VII. Client Freedom of Choice/Acceptance of Plan**

Registered Nurse’s Signature, Credentials and Date