**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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|  |  |  |
|  |  |  |

 **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