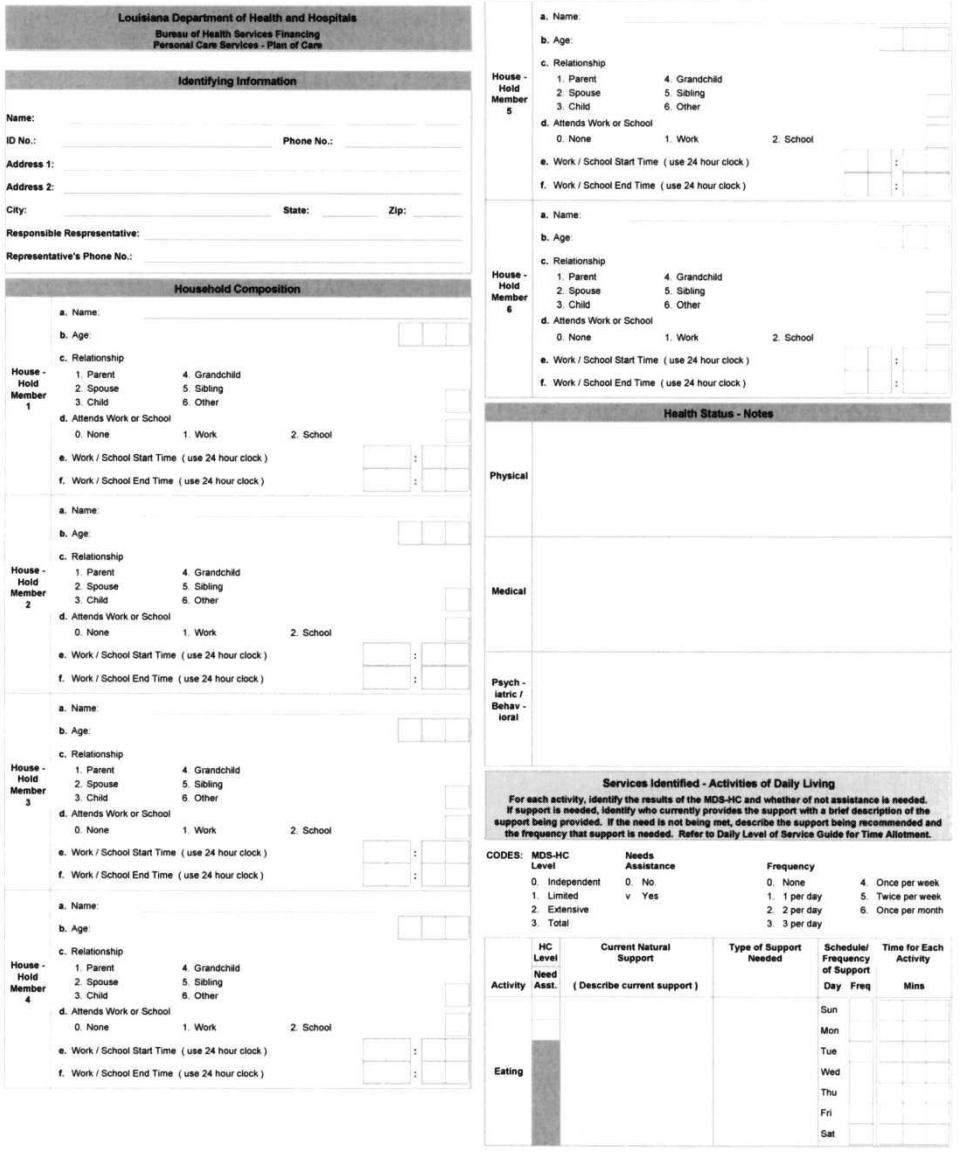

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
Personal Care Services - Plan of Care

Identifying Information

Name:
ID No.: Phone No.:
Address 1:
Address 2:
City: State: Zip:
Responsible Respresentative:
Representative's Phone No.:

Household Composition

House - Hold Member 1
House - Hold Member 2
House - Hold Member 3
House - Hold Member 4
House - Hold Member 5
House - Hold Member 6

a. Name:
b. Age:
c. Relationship
1. Parent 4. Grandchild
2. Spouse 5. Sibling
3. Child 6. Other
d. Attends Work or School
0. None 1. Work 2. School
e. Work / School Start Time (use 24 hour clock)
f. Work / School End Time (use 24 hour clock)

Health Status - Notes

Physical
Medical
Psych - iatric / Behav - ioral

Services Identified - Activities of Daily Living

For each activity, identify the results of the MDS-HC and whether of not assistance is needed. If support is needed, identify who currently provides the support with a brief description of the support being provided. If the need is not being met, describe the support being recommended and the frequency that support is needed. Refer to Daily Level of Service Guide for Time Allotment.

CODES: MDS-HC Level: 0. Independent 1. Limited 2. Extensive 3. Total
Needs Assistance: 0. No v. Yes
Frequency: 0. None 1. 1 per day 2. 2 per day 3. 3 per day 4. Once per week 5. Twice per week 6. Once per month

Activity	HC Level / Need Asst.	Current Natural Support (Describe current support)	Type of Support Needed	Schedule/ Frequency of Support Day	Freq	Time for Each Activity Mins
Eating				Sun		
				Mon		
				Tue		
				Wed		
				Thu		
				Fri		
				Sat		

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				Day		
Bathing				Sun Mon Tue Wed Thu Fri Sat		
Dressing				Sun Mon Tue Wed Thu Fri Sat		
Grooming				Sun Mon Tue Wed Thu Fri Sat		
Trans-ferring				Sun Mon Tue Wed Thu Fri Sat		
Ambu-lation				Sun Mon Tue Wed Thu Fri Sat		
Toileting				Sun Mon Tue Wed Thu Fri Sat		
					Hrs	Mins
Total Weekly Hours Recommended for ADLs						

Services Identified - Instrumental Activities of Daily Living

For each activity, identify the results of the MDS-HC and whether of not assistance is needed. If support is needed, identify who currently provides the support with a brief description of the support being provided. If the need is not being met, describe the support being recommended and the frequency that support is needed. Refer to Daily Level of Service Guide for Time Allotment.

CODES:

MDS-HC Level	Needs Assistance	Frequency	
0. No Difficulty	0. No.	0. None	4. Once per week
1. Some Difficulty	1. Yes	1. 1 per day	5. Twice per week
2. Difficult		2. 2 per day	6. Once per month
		3. 3 per day	

Activity	HC Level / Need Asst.	Current Natural Support (Describe current support)	Type of Support Needed	Schedule/ Frequency of Support: Day	Freq	Time for Each Activity: Mins
Light House-keeping				Sun Mon Tue Wed Thu Fri Sat		
Food Prepar-ation and Storage				Sun Mon Tue Wed Thu Fri Sat		
Grocery Shopping				Sun Mon Tue Wed Thu Fri Sat		
Laundry				Sun Mon Tue Wed Thu Fri Sat		
Medi-cation Remind-ers						
Accom-panying to Medical Appoint-ments						
Assist-ance Arrang-ing Medical Trans-portation						

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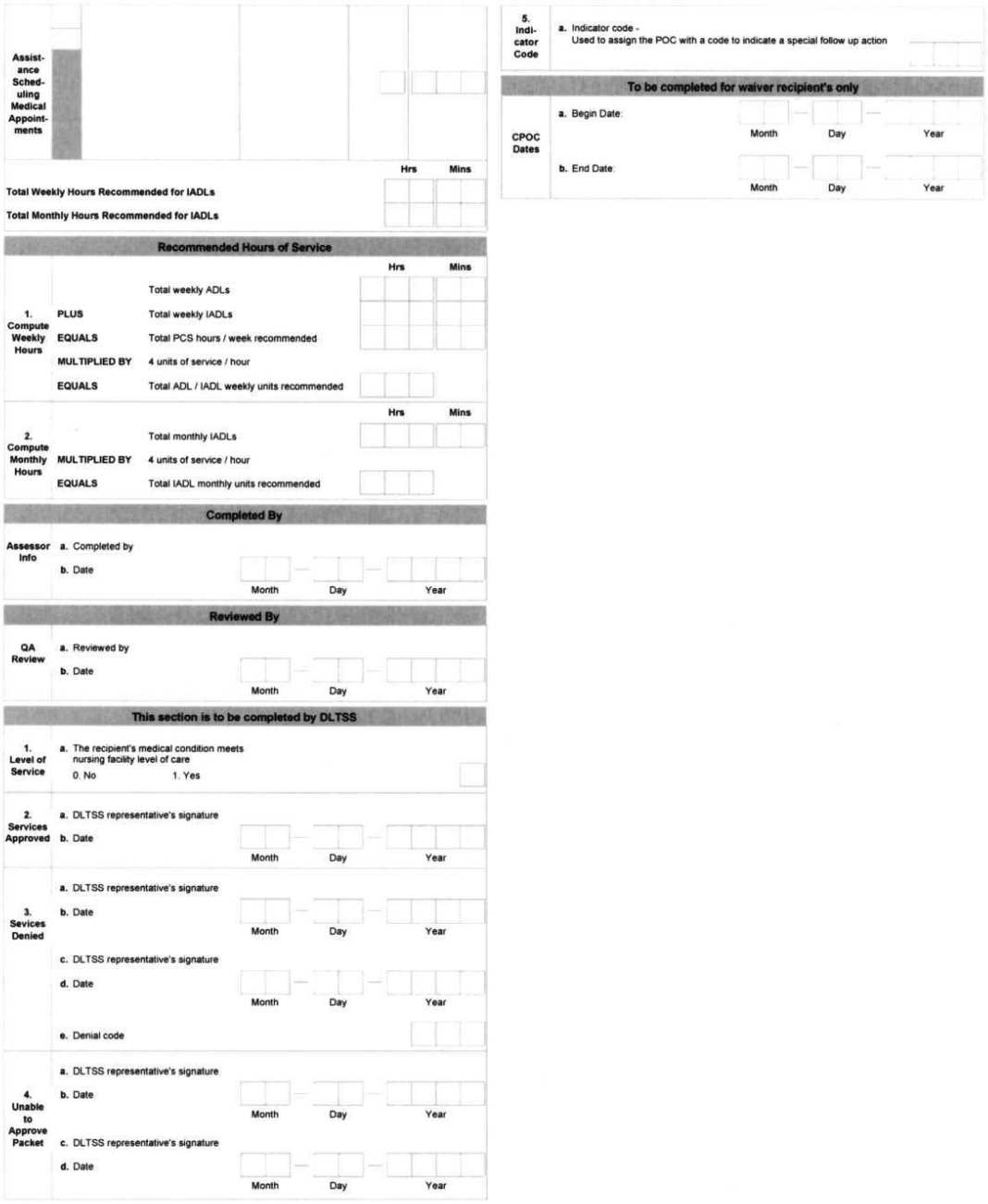

Assistance Scheduling Medical Appointments

Total Weekly Hours Recommended for IADLs — Hrs Mins

Total Monthly Hours Recommended for IADLs — Hrs Mins

Recommended Hours of Service

1. Compute Weekly Hours

		Hrs	Mins
	Total weekly ADLs		
PLUS	Total weekly IADLs		
EQUALS	Total PCS hours / week recommended		
MULTIPLIED BY	4 units of service / hour		
EQUALS	Total ADL / IADL weekly units recommended		

2. Compute Monthly Hours

		Hrs	Mins
	Total monthly IADLs		
MULTIPLIED BY	4 units of service / hour		
EQUALS	Total IADL monthly units recommended		

Completed By

Assessor Info
a. Completed by
b. Date — Month Day Year

Reviewed By

QA Review
a. Reviewed by
b. Date — Month Day Year

This section is to be completed by DLTSS

1. Level of Service
a. The recipient's medical condition meets nursing facility level of care
0. No 1. Yes

2. Services Approved
a. DLTSS representative's signature
b. Date — Month Day Year

3. Sevices Denied
a. DLTSS representative's signature
b. Date — Month Day Year
c. DLTSS representative's signature
d. Date — Month Day Year
e. Denial code

4. Unable to Approve Packet
a. DLTSS representative's signature
b. Date — Month Day Year
c. DLTSS representative's signature
d. Date — Month Day Year

5. Indicator Code
a. Indicator code -
Used to assign the POC with a code to indicate a special follow up action

To be completed for waiver recipient's only

CPOC Dates
a. Begin Date: — Month Day Year
b. End Date: — Month Day Year

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