**School-Based Personal Care Service Plan of Care**

*To be completed by the ordering practitioner (NP, APRN or MD) of the child.*

**1. Student Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name |  | DOB |  |
| ID Number |  | Medicaid ID |  |
| Address |  | Phone Number |  |
| School |  |
| Parent/Guardian |  | Contact Number |  |

**2. Plan Information:**

The PCS services listed in this plan are authorized to begin on \_\_\_/\_\_\_/\_\_\_\_\_\_. This plan will be revaluated no more than 6 months from now on \_\_\_/\_\_\_/\_\_\_\_\_\_. If the plan is not revaluated at that time, the plan will come to an end 6 months from the authorization date.

**3. Medical History Supporting the Need for PCS Services:**

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Diagnosis |  | ICD-10 Code |  |
| Secondary Diagnosis |  | ICD-10 Code |  |

**Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Route |
|  |  |  |  |
|  |  |  |  |
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**Mental Status/Behavior:** Check Yes or No. If Yes, indicated frequency: 1 = seldom; 2 = frequent; 3 = always

|  |  |  |
| --- | --- | --- |
| Oriented □ Yes (1 2 3) □No | Depressed □ Yes (1 2 3) □No | Cooperative □ Yes (1 2 3) □No |
| Passive □ Yes (1 2 3) □No | Physically Abusive □ Yes (1 2 3) □No | Verbally Abusive □ Yes (1 2 3) □No |
| Verbal □ Yes (1 2 3) □No | Confused □ Yes (1 2 3) □No | Hostile □ Yes (1 2 3) □No |
| Forgetful □ Yes (1 2 3) □No | Injures others □ Yes (1 2 3) □No | Combative □ Yes (1 2 3) □No |
| Non-responsive □ Yes (1 2 3) □No | Injures self □ Yes (1 2 3) □No |  |

**Impairments:** Please rate the following. 1 = mild; 2 = moderate; 3 = severe. Leave blank if none.

|  |  |  |
| --- | --- | --- |
| Walking ( 1 2 3 ) | Chronic heart failure ( 1 2 3 ) | Vision Impairment ( 1 2 3 ) |
| Spasticity ( 1 2 3 ) | Speech Impairment ( 1 2 3 ) | Oral feeding ( 1 2 3 ) |
| Limb Weakness ( 1 2 3 ) | Seizure Disorder ( 1 2 3 ) | Bladder and bowel incontinence  ( 1 2 3 ) |
| Hypotonia ( 1 2 3 ) | Developmental Delay ( 1 2 3 ) |
| Chronic Resp Distress ( 1 2 3 ) | Hearing Impairment ( 1 2 3 ) | Intellectual Impairment ( 1 2 3 ) |

**Other Relevant Medical History**

**4. Services Authorized:**

|  |  |  |  |
| --- | --- | --- | --- |
| Service | Frequency | Total Requested Hours per Week | Special Instructions |
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**5. Practitioner’s Order:**

I certify/recertify that I am the attending practitioner for this patient and that the information provided is accurate and correct to the best of my knowledge. I authorize these school-based personal care services and will periodically review the plan. In my professional opinion, the services listed on this form are medically necessary and appropriate due to the child’s medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face-to-face evaluation must be held between beneficiary and practitioner.

|  |  |  |  |
| --- | --- | --- | --- |
| Partitioner Name |  | Practitioner NPI |  |
| Signature |  | Address |  |
| Date |  | Phone Number |  |

**6. Parental Consent:**

As the parent or legal guardian, I request these services be provided to my child at school. I understand this plan must be reviewed every 6 months and commit to assisting the school in ensuring it is updated as required. I understand these services may be provided by an individual who is unlicensed, but has undergone training in the specific needs of my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Parent Name Parent Signature Date