Personal Care Services Plan of Care

For Use by Unlicensed Independent Personal Care Providers

SAVE AS

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: Orange

9. Street Address:

City: State: Zip Code:

10. Phone # (___)___ - ____

11. Medicaid Area Office: **7**

PROVIDER INFORMATION

12. Name: **AdelCare II, Inc.**

13. Provider Medicaid ID Number: **0 0 5 8 2 7 3 - 0 0**

14. Street Address: **3206 Conway Rd Ste 5**

City: **Orlando** State: **FL** Zip Code: **32812**

15. Phone # (**407**) **930**- **6577**

PATIENT MEDICAL AND SOCIAL INFORMATION

16. Diagnosis(es):

ICD 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*): _____

22. Safety Measures Required:

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

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

24. Mental/Neurological Status (*check all that apply):*
☐ Alert/oriented ☐ Agitated ☐ Disoriented
☐ Forgetful ☐ Depressed ☐ Lethargic
☐ Combative ☐ Seizures (how often): _____ ☐ 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 ☐ Toileting and Elimination
☐ Oral Hygiene ☐ Range of Motion and Positioning
☐ Oral Feedings and Fluid Intake ☐ Other _____

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

33. Discharge Plan:

N/A

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: _____ Date: __/__/____

ATTACH PRESCRIPTION

AHCA Form 5000-3506, Revised October 2014 (incorporated by reference in Rule 59G-4.130, F.A.C.)

PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

GENERAL INFORMATION

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

2. **Certification Request:** (check one)
Initial ☐ Re-certification ☐

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

(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.)

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

12. Home Health Services ordered: **Personal Care Services**

13. Frequency and duration:

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

To assist with activities of daily living.

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

AHCA Form 5000-3502, Revised February 2013 (incorporated by reference in Rule 59G-4.130, F.A.C.)