GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DHCF Transmittal No. 11- 20

Officer of the Director

TO: **Home Health Agencies Enrolled in the District of Columbia Medicaid Program**

FROM: **Linda Elam, PhD, MPH**
Deputy Director, Medicaid

DATE: **July 6, 2011**

SUBJECT: **Effective Monday August 15, 2011: Revised Plan of Care Form for Medicaid Personal Care Aide and Home Health Skilled Services**

In response to comments made at the Department of Health Care Finance's meeting with you on June 28, 2011, we have added a new line to the plan of care form sent to you in Transmittal 11-15, to identify the home health agency of the Registered Nurse completing the form. The revised form is attached.

This revised plan of care form will be effective on August 15, 2011. All other provisions of Transmittal 11-15 apply to the use of this revised form.

Thank you in advance for your cooperation. Please contact Ericka Bryson-Walker, Project Manager at 202-442-9054 or ericka.walker@dc.gov if you have any questions.

Attachment:
Revised Plan of Care Form for Medicaid Personal Care Aide and Home Health Skilled Services

899 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5988 Fax (202) 442-4790

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Plan of Care Certification Period: From: _____ To: _____

This Plan of Care is for (check): [ ] Home Health Visits [ ] Home Health Hours [ ] Personal Care Aide Hours

(1) Name of Beneficiary:_____
First Name Middle Initial Last Name

(2) Permanent Address:_____

(3) Phone (_____) _____ – _____ (4) Date of Birth _____ / _____ / _____ (5) Sex _____

(6) SS# _____-_____-_____ (7) Medicare # _____ (8) Medicaid # _____

(9) Contact information for Next of Kin/Responsible Party (Indicate N/A, if applicable):

_____
First Name Middle Initial Last Name

(10) Permanent Address _____

(11) Phone (_____) _____ – _____

(12) Describe the home environment and the patient's support system (family and community resources):

_____

_____

_____

_____

_____

_____

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

_____

_____

_____

_____

Name of Medicaid Beneficiary:_____

Medicaid ID:_____

(14) FUNCTIONAL LIMITATIONS:

[ ] Bathing
[ ] Toileting
[ ] Dressing
[ ] Eating
[ ] Getting in and out of bed
[ ] Taking medication prescribed for self-administration
[ ] Other (specify) _____

ACTIVITIES PERMITTED:

[ ] Bedrest
[ ] Complete bedrest
[ ] BRP
[ ] Up as tolerated
[ ] Transfer bed/chair
[ ] Toilet independently
[ ] Transfer bed/chair
[ ] Toilet with assistance
[ ] Other (specify) _____

[ ] Crutches
[ ] Cane
[ ] Wheelchair
[ ] Walker
[ ] No restriction

(15) Allergies: ❑ Yes, please explain ❑ No

_____

(16) Medication(s) (dose, route, and frequency):

_____

_____

_____

_____

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

_____

_____

_____

_____

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

_____

_____

_____

_____

(19) Does the patient have a 24-hour management plan? (i.e., a plan for care when home health services/personal care aide services are not in the home)

❑Yes, please explain ❑No, RN documents recommendations

_____

_____

_____

Name of Medicaid Beneficiary:_____

Medicaid ID:_____

(20) Nutritional Requirements:

❑Yes, a specific diet is required. Explain below ❑No. Indicate 'None' below

_____

_____

_____

_____

(21) Date service(s) to begin: _____

Contact information for the RN completing form:

(22) Name of RN:_____
First Name Middle Initial Last Name

(23) Name of Home Health Agency_____

(24) Address _____

(25) Phone (_____) _____ – _____ (26) Fax (_____) _____ - _____

(27) Signature of RN completing form: _____ (28) Date: ___/___ /_____

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner:

_____
First Name Middle Initial Last Name

(30)Address_____

(31) Phone (_____) _____ – _____ (32) Fax (_____) _____ - _____

(33) Physician/Nurse Practitioner Signature: _____ (34) Date:____/_____/____

The practitioner must sign the form within 30 days of its development