

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health Care Finance**



**DHCF Transmittal No. 12-05**

**Officer of the Deputy Director**

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

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

**DATE: February 3, 2012**

**SUBJECT: Effective March 3, 2012: Revised Plan of Care Form for Medicaid  
Personal Care Aide and Home Health Skilled Services**

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In response to comments made at the Home Health Aides Provider Steering Committee meeting on December 6, 2011, the Department of Health Care Finance has added several new lines to the plan of care form sent to you in Transmittal 11-15 distributed on June 15, 2011. This new addition has been reviewed by the DC Department of Health's Regulation and Licensing Administration (HRLA) and meets the compliance requirements of the HRLA Survey.

The attached revised plan of care form will be effective on March 3, 2012. All other provisions of Transmittal 11-15 and Transmittal 11-20 apply to the use of this revised form.

Thank you in advance for your cooperation. If you have any questions, please contact Pamela L. Hodge, Management Analyst at 202-724-4282 or [pamela.hodge@dc.gov](mailto:pamela.hodge@dc.gov).

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



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.

Name of Home Health Agency \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signature of RN completing form: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Start of care date: \_\_\_/\_\_\_/\_\_\_

Plan of Care Certification Period: From: \_\_\_ To: \_\_\_ [ ] initial [ ] recertification

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):

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

Name of Medicaid Beneficiary: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_

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

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(14) FUNCTIONAL LIMITATIONS:

- Bathing
- Toileting
- Dressing
- Eating
- Getting in and out of bed
- Taking medication prescribed for self-administration
- Toilet independently
- Unstable gait
- Other (specify) \_\_\_\_\_

ACTIVITIES PERMITTED:

- Bedrest
- Complete bedrest
- BRP
- Up as tolerated
- Transfer bed/chair
- Crutches
- Cane
- Wheelchair
- Walker
- No restriction
  
- Transfer bed/chair
- Toilet with assistance
- Other (specify) \_\_\_\_\_

(15) Allergies:  Yes, please explain  No

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

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

Wound Care assessment: include the stages of tissue destruction, location, size, drainage and depth of the impaired skin integrity

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

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Name of Medicaid Beneficiary: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_

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

Yes, please explain       No, RN documents recommendations

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

(20) Nutritional Requirements:

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

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

(21) Safety Measures (Check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Use of assistant device when ambulating                | <input type="checkbox"/> Seizure precautions              |
| <input type="checkbox"/> Clear pathways of all obstructions (rugs, cords, etc.) | <input type="checkbox"/> Coumadin precautions             |
| <input type="checkbox"/> Support during transfer and lifting                    | <input type="checkbox"/> Client cannot be left unattended |
| <input type="checkbox"/> No smoking or open flames in vicinity of oxygen        | <input type="checkbox"/> Keep side rails up at all times  |
| <input type="checkbox"/> Keep hard candy on patient at all times                | <input type="checkbox"/> other (specify): _____           |
| <input type="checkbox"/> Wash hands before and after wound care procedure       |   |

(22) Mental Status (Choose all that apply):

- |                                      |                                    |                                    |                                       |
|--------------------------------------|------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Oriented    | <input type="checkbox"/> Comatose  | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Depressed    |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Agitated  | <input type="checkbox"/> Other: _____ |

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.  
Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> dietary regimen                                      | <input type="checkbox"/> medication regimen              | <input type="checkbox"/> wound care performance and management |
| <input type="checkbox"/> disease process                                      | <input type="checkbox"/> diabetic regimen                | <input type="checkbox"/> use of glucometer                     |
| <input type="checkbox"/> Insulin preparation and administration               | <input type="checkbox"/> coumadin/O2/seizure precautions |  |
| <input type="checkbox"/> Foley/suprapubic/condom catheter care and management | <input type="checkbox"/> NG G-Tube care and management   |  |

Patient will achieve maximum level of functioning in \_\_\_\_\_ weeks. Caregiver(s) will demonstrate competency in patient care in \_\_\_\_\_ weeks

(24) HHA/PCA Goals: \_\_\_\_\_

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

Name of Medicaid Beneficiary: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_

(25) Prognosis:                     Poor     Guarded     Fair     Good     Excellent

(26) Rehabilitation Potentials:     Poor     Guarded     Fair     Good     Excellent

(27) Discharge Plans:

Patient will be discharged to care of self/caregiver(s)/MD when:

- Patient needs skilled care and goals are met.
- Patient is referred to outpatient services
- Patient/family members are able to provide care.
- Other (specify) \_\_\_\_\_

Contact information for the RN completing form:

(28) Name of RN:

First Name	Middle Initial	Last Name
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Practitioner approving Plan of Care

(29) Name of Physician/Nurse Practitioner

First Name	Middle Initial	Last Name
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(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**

**For Division of Long-Term Care use only**

( ) Approved For \_\_\_\_\_

( ) Disapproved

Approval Period \_\_\_\_\_