

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX C – LT-PCS PLAN OF CARE FORM

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 Representative: _____
 Representative's Phone No.: _____

Household Composition

House - Hold Member 1

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) _____ : _____

House - Hold Member 2

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) _____ : _____

House - Hold Member 3

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) _____ : _____

House - Hold Member 4

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) _____ : _____

House - Hold Member 5

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) _____ : _____

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 - latric / Behav - ioral

Services Identified - Activities of Daily Living

For each activity, identify the results of the MDS-HC and whether or 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.

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

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

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Assistance Scheduling Medical Appointments			Hrs	Mins
	Total Weekly Hours Recommended for IADLs			
Total Monthly Hours Recommended for IADLs				
Recommended Hours of Service				
1. Compute Weekly Hours	PLUS	Total weekly ADLs	Hrs	Mins
	EQUALS	Total weekly IADLs		
	MULTIPLIED BY	Total PCS hours / week recommended		
	EQUALS	4 units of service / hour		
2. Compute Monthly Hours	MULTIPLIED BY	Total ADL / IADL weekly units recommended		
	EQUALS	Total monthly IADLs	Hrs	Mins
	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. Services 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