

Personal Care Worksheet

CFC 806 11/2/08

Individual Name: _____ Date: _____

This worksheet is used to determine the maximum amount of Choices for Care Personal Care Services.

Step 1: Circle the column that corresponds directly with the ILA "Self-Performance" score for each activity listed.							Step 2: *Time Requested by Waiver	Step 3: # days/week Waiver	Step 4: Total mins/week Waiver	Step 5: Other Services (use key)
A. ADL's, Meal Prep & Meds	0/8	1	2	3	4					
					<6 x/day	6+ x/day				
Dressing	0	5	10	20	30	NA		x		
Bathing	0	10	20	30	45	NA		x		
Personal Hygiene.	0	5	10	15	20	NA		x		
Bed Mobility	0	5	5	10	20	30		x		
Toilet Use	0	5	10	20	40	60		x		
Adaptive Devices	0	5	5	10	15	NA		x		
Transferring	0	5	10	15	25	45 (Hoyer)		x		
Mobility	0	5	15	20	30	45		x		
Eating	0	5	15	30	45	NA				
Meal Prep	0	45	60	NA			*			
Medication Manage.	0	5	15	NA				x		
B. Additional Incontinence Assist	ILA Health Assess (ILA pg 17, #3 & #6)				Time Requested	# days/week	Total mins/week	Other Services		
	1-3x/wk	4-6x/wk	1-3x/day	4+x/day						
Urinary	10	10	20	40						
Bowel	10	10	20	40						
C. Instrumental Activities of Daily Living (IADL's): Phone Use, Money Management, Household Maintenance, Housekeeping, Laundry, Shopping, Transportation, Care of Adaptive Equipment.					270		per week			
					Step 6: Calculations					
					<i>Total min/wk:</i>					
					<i>Divide by 60 min:</i>			/ 60		
					Maximum hrs per week (Round to nearest .25 hr)			hrs/wk		
								X 2		
					Maximum hrs every 2 wks					

***NOTES:**

- A variance must be requested for any time requested exceeding the maximum (see reverse).
- Adjust time for other services such as LNA, Adult Day, family.
- When attending Adult Day, reduce time for at least meal prep and other duplication of assistance.
- Additional help with incontinence should only be requested when time for other activities is not sufficient to
- meet the overall need.

KEY for Step 5

LNA = Licensed Nurses Aid = _____ days/wk	F = Family/Friend = _____ days /wk
AD = Adult Day Services = _____ days/wk	HDM = Home Delivered Meals = _____ days/wk
ASP = Attendant Services Program = _____ days/wk	O = Other = _____ days/wk

Copy to PCA employer (CD/SD/HHA), DAIL, Case Manager

Personal Care & Adult Day: The volume of Personal Care and Adult Day services may be utilized within a two-week period of time.

Service Plan Changes: Approved Service Plan changes will start no earlier than the date the Service Plan is received at the DAIL regional office (except consumer/surrogate services).

Consumer or surrogate directed services changes will always start the next full pay period after the Service Plan is received at the DAIL regional office. (Same as ISO payroll schedule)

2008/2009 – Payroll Schedule (1 st Sunday of each two-week cycle)							
Sep-21	Nov-02	Dec-14	Jan-25	March-08	April-19	May-31	July-12
Oct-05	Nov-16	Dec-28	Feb-08	March-22	May-03	June-14	July-26
Oct-19	Nov-30	Jan-11	Feb-22	April-05	May-17	June-28	Aug -09

Reassessments: Annual reassessments will start on the date after the previous Service Plan ends. If a reassessment start date is to begin prior to the previous Service Plan end date, it must follow the start dates for Service Plan changes above.

Retroactive Change Requests: Retroactive Service Plan increases will be approved ONLY under certain circumstances when a precipitating event necessitates an IMMEDIATE start of services that exceeds the Service Plan allocation. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing home placement. For example: primary caregiver is hospitalized or the individual has a medical event that requires immediate increase in services. Retroactive Service Plan changes will not be approved to cover administrative errors or non-emergent requests for increases. ***All requests for retroactive coverage must accompany a Service Plan change, a written request for a specific start date and description of the precipitating event.***

If the total bi-weekly hours of Personal Care Services are not sufficient to meet the individual's personal care needs, the Case Manager may request a variance to exceed the maximum times. The request must be submitted in writing to the Department of Disabilities, Aging and Independent Living, Local Long-Term Care Clinical Coordinator.

Variance Requests shall be submitted in writing and shall include:

1. A description of the individual's specific unmet need(s);
2. An explanation of why the unmet need(s) cannot be met; and
3. A description of the actual/immediate risk posed to the individual's health, safety or welfare.

To obtain a variance from the maximum of 4.5 hours per week for IADLs, the applicant or participant must show that the granting of a variance will have the result of directly ameliorating a harmful condition and that the variance is necessary to protect the health, safety or welfare of the individual. The harmful condition must be documented and the documentation presented at the time of the variance request.

In making a decision, the Department of Disabilities, Aging and Independent Living (DAIL) may require the case manager to submit further information and documentation. DAIL may require an in-home visit by DAIL staff. DAIL will review the request and forward a decision to the Choices for Care participant.

Variance requests may be written in the space provided below. Attach additional pages if necessary.
