Personal Care Services Request Form and Service Plan

I. Client and Provider Information

Client

Arkansas Total Care Member ID #	Service Plan Status ☐ Initial ☐ Revision ☐ Renewal	
Name (Last, First, Middle)		Date of Birth (MM/DD/YYYY)
County of Residence	Telephone Number(s)	Parent(s)/Guardian(s) Name(s)
Complete Mailing Address		

Client Resides: ☐ Alone ☐ With relatives ☐ Boarding home ☐ Group home
☐ Community-Based Residential Home ☐ Residential Care Facility (RCF)
☐ Other (describe): _____

PCP Name	Provider ID #/Taxonomy Code	Date of Last Exam

Personal Care Provider Name	Provider ID #	Mailing Address

II. Service Locations

Personal Care Service Location(s):

☐ Private residence ☐ Residential Care Facility ☐ School ☐ DDS facility ☐ Other (describe):
Service Location(s) Address(es):

III. Dates of Service

Start of Care Date(s)

Original (Required):	Per This Service Plan:	
Projected End Date of Service (if less than six months):	Current Assessment Date:	Assessing RN:
Attending Physician (if other than the PCP):	Attending Physician's Provider ID #/Taxonomy Code:	
Date of the Order or Referral for Assessment:	Referral Source (if other than attending physician):	

Client Name:	Arkansas Total Care Member ID #:

IV. Medical Diagnoses

ICD codes and descriptions. List in order of significance to the medical necessity for assistance.

ICD Code	Description

V. Mental Status

☐ Clear	☐ Somewhat confused	☐ Moderately confused	☐ Markedly confused
☐ Hyperactive	☐ Withdrawn	☐ Needs restraint	☐ Needs supervision for personal safety

Comments:

Special Administrative Section

Use this section when requesting prior authorization.

Procedure Codes Requested	Hours	Minutes	Frequency

VI. Physical Dependency Status

Bedridden	Ambulation	Continence Status
☐ Bedfast ☐ Requires turning in bed ☐ Bed to chair with help ☐ Bed to chair without help ☐ Must be lifted into chair	☐ Walks alone ☐ Walks with device ☐ Walks with help ☐ Wheelchair (self) ☐ Wheelchair (push) ☐ Motorized chair	☐ Catheter ☐ Colostomy ☐ Incontinent ☐ Bladder ☐ Bowels ☐ Training ☐ Cannot train ☐ Trained ☐ Needs training

Client Name:	Arkansas Total Care Member ID #:

Grooming Needs:	**No Help**	**Partial Help**	**Total Help**
Bathing: ☐ Tub ☐ Shower ☐ Bed	☐	☐	☐
Dressing	☐	☐	☐
Shaving	☐	☐	☐
Care of hair	☐	☐	☐

Eating	**Preparing Meals**
☐ Has the ability to eat without help ☐ Needs partial help to eat ☐ Needs help with eating ☐ Special diet ☐ Cannot cut food into bite-size pieces ☐ Cannot bring food from plate to mouth	☐ Has the ability to cook or prepare food without help ☐ Needs partial help with meal preparation ☐ Physically incapable of cooking or preparing meals

VII. Activities of Daily Living

Laundry	**Incidental Housekeeping**	**Shopping**
☐ Needs no help	☐ Needs no help	☐ Needs no help
☐ Needs partial help	☐ Needs partial help	☐ Needs partial help
☐ Physically incapable of performing task	☐ Physically incapable of performing task	☐ Physically incapable of performing task

Attach more pages as needed to describe the client's physical dependency needs. The assessing RN must date and initial all attachments.

VIII. Assessment Narrative

Narrative must detail level of assistance, cuing, or supervision required and frequency if applicable.

Client Name:	Arkansas Total Care Member ID #:

IX. Alternate Resources for Assistance

Make a list of people in the client's family who can help with their physical needs. If there are other family members or community resources that can also assist, write them down. You can find more details on how to do this in the Personal Care Provider Manual. If you need more space to write, you can add extra pages. Remember, requests without information about these other resources might not get approved.

X. Certification of Service Need and Duration

I certify that personal care services are required to:

Service Time

Maximum and minimum daily service-time estimates (in hours and minutes or hours and fractional hours for Personal Care Aide services) for the client are:

Daily Totals

Weekday #	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Maximum							
Minimum							

Weekly Totals

Maximum	
Minimum	

Additional comments regarding the duration, frequency, or scope of personal care services:

XI. Personal Care Service Plan

Attach additional pages as needed. The PCP or attending physician must sign or initial and date their attachments to the service plan. Please give detailed information.

Physician Authorization

I have examined this patient within the past 60 days. I confirm this assessment is accurate. I authorize the personal care assistance detailed in this service plan, including additions, deletions, and changes dated and initialed by myself. I am aware that all personal care must be medically necessary and that the Utilization Review Section of the Division of Medical Services may review this assessment and service plan.

Attending Physician - Signature

Date

Attending Physician - Print Name

Client Acceptance of Authorized Service Plan

I understand that I will receive only medically necessary assistance with my physical needs. I accept this personal care service plan.

Client or Client's Representative - Signature

Date