

DATA SHEET AND PRESCRIPTION FOR PERSONAL CARE RECIPIENTS IN ALTERNATIVE RESIDENTIAL SETTINGS

- Initial
 Review

_____ CMH Agency

Name Agency Case Number Move In Date

Date of Birth Sex SSN # FIA Medicaid Case Number Medicaid Recipient ID number

Diagnosis (Current DSM) Type of Guardianship County of Residence

Facility Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Medicaid Provider ID Number Global Assessment of Functioning End Date Reason

Parent/Legal Guardian Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Treatment/Training (PPB) Objective (Check One)

- (Re)habilitation Maintenance Psycho-Soc Adjustment Crisis Resolution

Type of Facility

License Type

- | | | | | | |
|---------------------------------|---|-------|---|-------|---|
| <input type="checkbox"/> MI | <input type="checkbox"/> Semi-independent | CHILD | <input type="checkbox"/> Foster Family Home | ADULT | <input type="checkbox"/> Foster Care Family Home |
| <input type="checkbox"/> DD | <input type="checkbox"/> General Foster Care | | <input type="checkbox"/> Foster Family Group Home | | <input type="checkbox"/> Foster Care Small Group |
| <input type="checkbox"/> AIS/MR | <input type="checkbox"/> Level I Specialized Home | | <input type="checkbox"/> CCI (FIA Rates) | | <input type="checkbox"/> Foster Care Medium Group |
| | <input type="checkbox"/> Level II Specialized Home | | <input type="checkbox"/> CCI (DCH Rates) | | <input type="checkbox"/> Foster Care Large Group |
| | <input type="checkbox"/> Level III Specialized Home | | | | <input type="checkbox"/> Congregate Facility |

PERSONAL CARE SERVICES

For recipients in non-specialized (general) and specialized residential settings, indicate below the area(s) in which individual personal care services will be delivered, and the intensity of those services.

	Provide/Assist	Guide/Direct	N/A
Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I recommend personal care services as indicated.

This person does not require continuous nursing care as defined in DCH/FIA Agreement of 1984. I recommend personal care services as indicated.

1. _____
Case Manager Date

2. _____
Qualified Case Manager/Physician Date

3. _____
Case Manager Supervisor/Nurse Date