



**INSTRUCTIONS FOR COMPLETION**

*INCOMPLETE or INCORRECT Care Plans will be returned and may result in a delay of the prior authorization for PCA services.*

1. A new or updated *Care Plan* must be completed with each 6-month re-assessment visit.
2. Print legibly.
3. Prior to submitting this *Care Plan* valid Vermont Medicaid must be in place for the child.
4. A Medicaid provider or a Vermont Department of Health employee of the Children with Special Health Needs (CSHN) program or Family, Infant & Toddler Project (FITP) must complete this *Care Plan*.
5. Complete all sections. For each area of need, indicate what the goals are for subsequent *Care Plans* or updates. If goals are unattainable, re-evaluate and present new more reasonable and attainable goals.
6. Attach a copy of the most current behavioral *Care Plan* to the Assessment/Application form for clients with primarily behavioral challenges.
7. Review this *Care Plan* with the parent/guardian.
8. Both the clinician/care manager and the parent/guardian must sign the acknowledgement section.
9. Provide the second copy of this *Care Plan* to the recipient. Provide the third copy of this *Care Plan* to the Agency.
10. Return the original of this *Care Plan* to:

Children's Personal Care Services  
 Division of Disability & Aging Services  
 Department of DAIL  
 103 South Main Street  
 Waterbury, VT 05671  
 Fax: 802-241-4224

**CLIENT INFORMATION**

Client Name \_\_\_\_\_  
 Medicaid ID # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Last Updated \_\_\_\_/\_\_\_\_/\_\_\_\_

**PCA FREQUENCY**  
 Days per Week \_\_\_\_\_ Hours per Day \_\_\_\_\_  
 Diagnosis \_\_\_\_\_

**SAFETY/INFECTION PRECAUTIONS**

*(Check all that apply)*  
 Mask  Goggles  
 Gown  Apron  
 Not Applicable

**FUNCTIONAL STATUS/LIMITATIONS**

**DEPENDENCE**  
 Totally  Partially

**MOBILITY**  
 Immobile  Partially Immobile

**IMPAIRMENTS** *(Check all that apply)*  
 Vision  
 Hearing  
 Speech

**DEFICITS**  
 Knowledge  Memory

**BATHING**

**METHOD**  
 Bed  Tub  
 Shower  Stool  
 Other Equipment

Frequency \_\_\_\_\_  
 Supervise  Partially Assist  
 Totally Assist  Independent

**GOAL(s)** \_\_\_\_\_



**GROOMING**

**SHAMPOO**

- Supervise  Partially Assist
- Totally Assist  Independent

**BRUSH/COMB**

- Supervise  Partially Assist
- Totally Assist  Independent

**MOUTH CARE**

- Supervise  Partially Assist
- Totally Assist  Independent

**BRUSH TEETH**

- Supervise  Partially Assist
- Totally Assist  Independent

**GOAL(s)** \_\_\_\_\_

**DRESSING: LOWER BODY**

- Supervise  Partially Assist
- Totally Assist  Independent

**GOAL(s)** \_\_\_\_\_

**DRESSING: UPPER BODY**

- Supervise  Partially Assist
- Totally Assist  Independent

**GOAL(s)** \_\_\_\_\_

**BOWEL  INCONTINENT  CONTINENT**

**BOWEL PROGRAM**

**ELIMINATION METHOD**

- Toilet  Bedpan
- Commode  Diaper
- Ostomy

Frequency \_\_\_\_\_

- Supervise  Partially Assist
- Totally Assist  Independent

**GOAL(s)** \_\_\_\_\_

**BLADDER  INCONTINENT  CONTINENT**

**ELIMINATION METHOD**

- Toilet  Bedpan
- Commode  Diaper
- Foley Bag  Cath Care
- I&O Cath

Frequency \_\_\_\_\_

- Supervise  Partially Assist
- Totally Assist  Independent

**GOAL(s)** \_\_\_\_\_

**MOBILITY**

**WHEELCHAIR TRANSFERS**

- Supervise  Partially Assist
- Totally Assist  Independent

**BEDBOUND/POSITION CHANGES**

- Supervise  Partially Assist
- Totally Assist  Independent

**EQUIPMENT**

- Gait Belt  Hoyer Lift
- Transfer Board  Crutches
- Cane  Walker
- Wheelchair  Braces
- Other \_\_\_\_\_

**UP IN CHAIR**

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

**UPPER EXTREMITIES PT EXERCISES**

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

- Supervise  Partially Assist
- Totally Assist  Independent

**LOWER EXTREMITIES PT EXERCISES**

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

- Supervise  Partially Assist
- Totally Assist  Independent

**THERAPEUTIC PLAY ACTIVITIES**

\_\_\_\_\_

**CHEST PT**

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

**OTHER SPECIAL CARE/CONSIDERATIONS**

\_\_\_\_\_

**GOAL(s)** \_\_\_\_\_

**NUTRITION**

**TYPE OF DIET**

- Breakfast  Lunch
- Supper  Snack

**INTAKE METHOD**

- Total Feed  G-Tube Only
- I&O Records  Encourage Fluids
- Fluid restrictions

Frequency \_\_\_\_\_

- Supervise  Partially Assist
- Totally Assist  Independent

Weight \_\_\_\_\_ Frequency \_\_\_\_\_

Record/Schedule \_\_\_\_\_

**GOAL(s)** \_\_\_\_\_



**MEDICATIONS & OTHER DELEGATED MEDICAL CARE**

**ORAL MEDICATIONS**

Medication #1 \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

- Supervise/Remind Only
- Administer Pre-poured
- Independent
- Other \_\_\_\_\_

Medication #2 \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

- Supervise/Remind Only
- Administer Pre-poured
- Independent
- Other \_\_\_\_\_

Medication #3 \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

- Supervise/Remind Only
- Administer Pre-poured
- Independent
- Other \_\_\_\_\_

Medication #4 \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

- Supervise/Remind Only
- Administer Pre-poured
- Independent
- Other \_\_\_\_\_

Medication #5 \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

- Supervise/Remind Only
- Administer Pre-poured
- Independent
- Other \_\_\_\_\_

**DRESSING CHANGES (Clean Technique Only)**

Delegated By \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Protocol \_\_\_\_\_

**GOAL(s)** \_\_\_\_\_

**OTHER**

Delegated By \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Protocol \_\_\_\_\_

**GOAL(s)** \_\_\_\_\_

**HOMEMAKING TASKS/LIFE SKILLS**

**LINEN CHANGE** Frequency \_\_\_\_\_

**LAUNDRY** Frequency \_\_\_\_\_

**ASSIST WITH MEAL PREP**

- Breakfast
- Lunch
- Dinner
- Snack

**GOAL(s)** \_\_\_\_\_

**TRANSPORTATION/TRAVEL**

- Routine
- On Demand

Frequency \_\_\_\_\_

**REASON FOR** \_\_\_\_\_

**OTHER BASIC LIVING SKILLS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CLINICIAN/CASE MANAGER ACKNOWLEDGEMENT**

*This Care Plan has been reviewed with the client and/or primary care person.*

\_\_\_\_\_

Clinician/Case Manager Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

**PARENT/GUARDIAN ACKNOWLEDGEMENT**

*I acknowledge this Care Plan was performed with input from me and is a Care Plan to follow in delivering care to my child.*

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date