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:		

Provider			
PCP Name:		Provider ID #/Taxonomy Code:	Date of Last Exam:
Personal Care Provider Name:	Provider ID #:	Mailing Address:	
Original Date of Service:	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's Provider ID #/Taxonomy Code:	
Date of the Order or Referral for Assessment:			

II. Medical Diagnoses

ICD codes and descriptions. List only active and relevant medical diagnosis diagnosed by a provider as relates to personal care.

ICD Code	Diagnosis

Member Name:	Arkansas Total Care Member ID:

III. Assessment and Service Plan

For any **Yes** answers, document a detailed description of the level of assistance required to complete the task along with any relevant health information. Requests may be delayed if we have to request additional information, or denied for medical necessity. Please refer to the ARTC.UM.19 clinical policy on ArkansasTotalCare.com for documentation requirements.

Mental Status and Cognition	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Has IDD: ☐ Yes ☐ No	Has cognitive impairment: ☐ Yes ☐ No
Lacks awareness of safety: ☐ Yes ☐ No	Other impairments (please specify):
Narrative:	

Eating	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance cutting meals: ☐ Yes ☐ No	Needs assistance carrying meals to table: ☐ Yes ☐ No
Receives tube feeding: ☐ Yes ☐ No	If receives tube feeding, also eats meals: ☐ Yes ☐ No
Needs physical assistance to consume meal: ☐ Yes ☐ No	Needs cuing to complete task: ☐ Yes ☐ No
Needs supervision for choking hazards: ☐ Yes ☐ No	Other impairments (please specify):
Narrative:	

Member Name:	Arkansas Total Care Member ID:

Bathing	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance turning on water, gathering supplies: ☐ Yes ☐ No	Needs assistance getting in or out of tub/shower: ☐ Yes ☐ No
Needs physical assistance to bathe lower body: ☐ Yes ☐ No	Needs physical assistance to bathe upper body: ☐ Yes ☐ No
Needs physical assistance shampooing hair: ☐ Yes ☐ No	Needs assistance drying body: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Unable to perform task without assistance: ☐ Yes ☐ No	
Narrative:	

Dressing	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance getting clothes from closet/drawers: ☐ Yes ☐ No	Needs assistance with zippers, buttons, or tying shoes: ☐ Yes ☐ No
Needs physical assistance to dress lower body: ☐ Yes ☐ No	Needs physical assistance to dress upper body: ☐ Yes ☐ No
Unable to perform task without assistance: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	
Narrative:	

Member Name:	Arkansas Total Care Member ID:

Toileting	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance getting on/off toilet, bedpan, or bedside commode: ☐ Yes ☐ No	Needs assistance with foley catheter or ostomy care: ☐ Yes ☐ No
Needs physical assistance to manage clothing during toileting: ☐ Yes ☐ No	Needs physical assistance to perform toileting or menstrual hygiene (including wiping self): ☐ Yes ☐ No
Unable to perform task without assistance: ☐ Yes ☐ No	Needs assistance to change diapers, briefs: ☐ Yes ☐ No
Needs cuing to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Incontinence: ☐ Yes ☐ No Incontinent of: ☐ Urine ☐ Bowel ☐ Both	Frequency: _____ times per ☐ week ☐ day Nocturnal enuresis only: ☐ Yes ☐ No
Narrative:	

Personal Hygiene/Grooming	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance combing, brushing, or styling hair: ☐ Yes ☐ No	Needs assistance with shaving (male or female): ☐ Yes ☐ No
Needs assistance brushing teeth: ☐ Yes ☐ No	Needs assistance applying lotions or makeup: ☐ Yes ☐ No
Unable to perform without assistance: ☐ Yes ☐ No	Needs assistance with nail care: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Narrative:	

Member Name:	Arkansas Total Care Member ID:

Mobility and Transfers	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance moving from sitting to standing: ☐ Yes ☐ No	Needs assistance moving from bed to wheelchair, chair to wheelchair: ☐ Yes ☐ No
Specify frequency of transfers required/day on average:	Unable to transfer without physical assistance: ☐ Yes ☐ No
Needs assistance from device: ☐ Yes ☐ No	Specify device(s) used:
Unable to use walker, cane, or crutches without supervision: ☐ Yes ☐ No	Assistive device(s) used: ☐ at all times ☐ as needed ☐ in community only
Unsteady gait: ☐ Yes ☐ No	Fall in last three months: ☐ Yes ☐ No
Environmental trip hazards: ☐ Yes ☐ No	Afraid of falling: ☐ Yes ☐ No
Has peripheral neuropathy, arthritis, chronic pain, or other condition that impacts ability to ambulate: ☐ Yes ☐ No	Uses assistive device(s) inappropriately: ☐ Yes ☐ No
Uses furniture to steady self: ☐ Yes ☐ No	Needs assistance applying a brace or device: ☐ Yes ☐ No
Has a visual impairment not correctable with prescription glasses or contacts: ☐ Yes ☐ No	Specify visual impairment:
Unable to propel wheelchair without assistance: ☐ Yes ☐ No	Requires equipment to transfer: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No

Narrative:

Member Name:	Arkansas Total Care Member ID:

Repositioning	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance changing position in a chair or wheelchair: ☐ Yes ☐ No	Needs assistance turning: ☐ Yes ☐ No
Unable to change position without assistance: ☐ Yes ☐ No	Specify average hours in chair/wheelchair/day: _____ Specify hours in bed/day:
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Narrative:	

Instrumental Activities of Daily Living

Please refer to ARTC.UM.19 clinical policy on ArkansasTotalCare.com for coverage limitations.

Meal Preparation	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance with meal preparation: ☐ Yes ☐ No	Needs assistance preparing tube feeding: ☐ Yes ☐ No
Is unable to reheat meal: ☐ Yes ☐ No	Receives Meals on Wheels or other assistance with meals: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Narrative:	

Member Name:	Arkansas Total Care Member ID:

Housekeeping: Must be for areas used only by the member, not common areas.	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance with sweeping or mopping: ☐ Yes ☐ No	Needs assistance with cleaning bathrooms after use: ☐ Yes ☐ No
Needs assistance with cleaning sleeping area: ☐ Yes ☐ No	Needs assistance with changing linens or straightening bed: ☐ Yes ☐ No
Needs assistance with cleaning immediate living area or kitchen after use: ☐ Yes ☐ No	Needs assistance taking out trash: ☐ Yes ☐ No
Needs assistance straightening/picking up living area: ☐ Yes ☐ No	Unable to perform all housekeeping tasks without assistance: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No

Narrative:

Laundry: Must be for items used only by the member.	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance with carrying laundry to/from laundry area: ☐ Yes ☐ No	Needs assistance loading washer: ☐ Yes ☐ No
Needs assistance removing items from washer or dryer: ☐ Yes ☐ No	Needs assistance loading dryer: ☐ Yes ☐ No
Needs assistance folding clothing: ☐ Yes ☐ No	Needs assistance putting clothing away: ☐ Yes ☐ No
Unable to perform all laundry tasks: ☐ Yes ☐ No	Has laundry needs greater than an average person: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No

Narrative:

Member Name:	Arkansas Total Care Member ID:

Shopping, Errands, and Transportation	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance with carrying light items: ☐ Yes ☐ No	Needs assistance carrying heavy items: ☐ Yes ☐ No
Needs assistance making list: ☐ Yes ☐ No	Needs assistance/cuing to pay for items: ☐ Yes ☐ No
Has a condition that prevents them from driving: ☐ Yes ☐ No NOTE must specify in narrative	Is unable to utilize transportation benefit to attend MD appointments: ☐ Yes ☐ No NOTE must specify why
Unable to perform all shopping tasks: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No
Needs cuing throughout to perform task: ☐ Yes ☐ No	

Narrative:

Medication Administration	
Task:	Min/Mod/Max assistance:
Time (minutes per week):	Frequency per week:
Needs assistance with opening bottles: ☐ Yes ☐ No	Needs assistance with handing medication to member: ☐ Yes ☐ No
Needs assistance drawing medication into syringe: ☐ Yes ☐ No	Assistance is required beyond reminding to take medications: ☐ Yes ☐ No
Unable to perform all tasks related to taking medications: ☐ Yes ☐ No	Needs frequency assistance _____ per day
Needs cuing throughout to perform task: ☐ Yes ☐ No	Needs supervision for safety: ☐ Yes ☐ No

Narrative:

Member Name:	Arkansas Total Care Member ID:

IV. Alternate Resources for Assistance

The narrative must detail resource availability for all **Yes** answers.

Lives with spouse: ☐ Yes ☐ No	Lives with parent, foster parent, legal guardian if under the age of 18: ☐ Yes ☐ No
Receives Waiver services: ☐ Yes ☐ No	Receives Meals on Wheels: ☐ Yes ☐ No
Lives with other family members/friends: ☐ Yes ☐ No	Attends day treatment program: ☐ Yes ☐ No
Attends school: ☐ Yes ☐ No	Has assistance from other community resources: ☐ Yes ☐ No
Working hours of parents/spouse: _____ hours per ☐ Week ☐ Day	Number of children in home if a minor:

Narrative:

V. Certification of Service Need and Duration

I certify that the daily service time estimate hours are required for the client and that the services are not being performed by a personal care aide that meets the Arkansas definition of family.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Maximum							
Minimum							

Total Weekly Hours:

RN Signature From Agency:	Date:

Printed Name:

Member Name:	Arkansas Total Care Member ID:

Physician Authorization

Note: After January 1, 2024, if the request is to increase service time, physician authorization is required on the first authorization for each provider.

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.

Physician Signature:	Date:
Printed Name of Physician:	

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.

Signature of Client Or Client Representative:	Date: