State Plan Personal Care Progress Note

Member last name | First name | Middle name | County | Case number

Provider agency | Date of visit | Client identification number

Health Information

Reason for visit:

- ☐ Initial visit
- ☐ Annual service plan visit
- ☐ Problem or complaint
- ☐ Six-month visit
- ☐ Request for change in unit(s)
- ☐ Other: _____

Health history:

Health conditions:

☐ Unchanged ☐ Improved ☐ Deteriorated

Comments and service plan implications:

Mental status:

☐ Oriented ☐ Confused ☐ Forgetful ☐ Anxious ☐ Lethargic

☐ Depressed ☐ Comatose ☐ Other: _____

Comments and service plan implications:

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Medication concerns: ☐ Yes ☐ No

Comments, required when Yes, and service plan implications:

List any medication **changes** since the Uniform Comprehensive Assessment Tool (UCAT) assessment or last home visit:

+	Medication Name	Dosage	Frequency	Physician	Date filled	New medication	Discontinued medication
-						☐	☐
-						☐	☐
-						☐	☐
-						☐	☐
-						☐	☐
-						☐	☐

Medical utilization:

+	Physician visit	Contact number	Date of last visit
-			
-			
-			
-			
-			
-			

Has the member been treated in the emergency room or hospital since the UCAT assessment or last home visit? ☐ Yes ☐ No

+	Name of hospital/ emergency room	Date	Length of stay	Reason for treatment/ admission
-				
-				
-				

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Nutrition

Has the member experienced a significant weight change in the last six months? ☐ Yes ☐ No

Current weight: _____ Current height: _____ ☐ Gain ☐ Loss Number of pounds: _____

Gain or loss attributed to: _____

Current diet:

Nutritional supplement used: ☐ Yes ☐ No

Name, quantity, and frequency of supplement: _____

Home delivered meals: ☐ Yes ☐ No

Provider name, and frequency : _____

Comments and service plan implications:

Skin Condition

Condition of skin: _____ Peripheral edema: _____

☐ Bruise ☐ Cuts ☐ Decubitus/lesions ☐ Rash ☐ Incision ☐ Other: _____

Location of site:

Comments and service plan implications:

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Functional Assessment

Member is independent with mobility ☐ Yes ☐ No

Member requires assistance with mobility ☐ Yes ☐ No

Type of assistance required:

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Bedfast

☐ Other: _____

Changes in activities of daily living (ADLs) or independent activities of daily living (IADLs) functions since the last UCAT assessment or last home visit:

ADLs: ☐ Unchanged ☐ Changed

IADLs: ☐ Unchanged ☐ Changed

Comments, required when ADLs or IADLs have changed:

Are there any safety issues? ☐ Yes ☐ No

Comments , required when Yes:

Subjective Evaluation of Health

Rating of own health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

(Ask member) What makes you feel this way?

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Informal and Formal Support

Informal support: ☐ Adequate ☐ Inadequate

Primary Caregiver _____

(Ask member) What does your primary caregiver do to assist you and how often?

Formal support:

☐ Home health ☐ Hospice ☐ Veteran's Affairs aide ☐ Indian Health ☐ Adult day health
☐ Developmental Disability Services (DDS) ☐ Counseling ☐ Other: _____

(Ask member) What do your formal caregivers do to assist you and how often?

Personal Care Services

Skip to follow-up section when this is the initial home visit

(Ask Member) I have a few questions about the personal care attendant (PCA) that is providing services in your home.

- Do you currently have a PCA providing services? ☐ Yes ☐ No
  If no, indicate reason: _____
- How long have you been without services? _____
- Can you tell me the name of your PCA? ☐ Yes ☐ No
  Name of PCA: _____
- Is the PCA related to you? ☐ Yes ☐ No
  If yes, relationship: _____
- Does your PCA arrive on time? ☐ Yes ☐ No
- Does your PCA stay the allotted time? ☐ Yes ☐ No
- How many hours a week does your PCA assist you? _____
- When your PCA is unable to make the regular visit, does the agency send another PCA? ☐ Yes ☐ No

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Comment, required when No is marked:

What activities does your PCA assist you with? What days does the PCA provide assistance?

Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Member comments
Personal Care	☐	☐	☐	☐	☐	☐	☐	
Meal preparation	☐	☐	☐	☐	☐	☐	☐	
Housekeeping	☐	☐	☐	☐	☐	☐	☐	
Laundry	☐	☐	☐	☐	☐	☐	☐	
Shopping and errands	☐	☐	☐	☐	☐	☐	☐	
Special tasks	☐	☐	☐	☐	☐	☐	☐	

Assessor Recommendation:

☐ No change in unit(s) needed
☐ Reassignment of unit(s)
☐ Service plan change needed: ☐ Decrease in unit(s) ☐ Increase in unit(s)

Note: when a change is needed, the following documentation is required with this form:

- *Form 02AG030E, Planning Schedule and Service Plan*
- *Form 02AG029E, State Plan Personal Care Plan*
- *Form 02AG032E, Personal Care Provider Communication with justification for the change*

Is a copy of the care plan and planning schedule/service plan currently available in the home? ☐ Yes ☐ No

Follow Up

Date of next planned skilled nurse visit: _____

Signatures

_____ Signature of nurse completing form

_____ Date

_____ Co-signature, when required

_____ Date