State Plan Personal Care Program
Care Plan

Member Information

Instructions

Member last name _____ First name _____ Middle initial _____ County _____ Case number _____

Client identification number _____ Provider agency _____ Date of visit _____

Plan of Care

Long term goal:

List the **strengths** that will help the member achieve the long term goal:

+ • _____
- • _____
- • _____

List the **challenges** that are keeping the member from reaching the long term goal:

+ • _____
- • _____
- • _____

Supervision and Monitoring

Objective

_____'s care will be supervised and monitored for quality of care throughout the one-year service plan period.

Action Steps

A Medicaid agency licensed nurse or Oklahoma Department of Human Services (DHS) nurse (for individual providers) will make a supervisory home visit at least one time every six months. The agency visit is documented on Form 02AG044E, Progress Note, and a copy is forwarded to the DHS nurse.

Expected Outcomes

_____receives assistance with care and needs, while also participating in the plan of care as able. Services are provided according to the plan of care as evidenced by observation and documentation from the provider agency and verbal reports from_____.

Other _____

Member last name	First name	Middle initial	County	Case number

Personal Hygiene

Not applicable ☐

Objective

_____will receive assistance with personal hygiene throughout the one-year service plan period.

Action Steps

The personal care assistant (PCA) will assist_____with the indicated personal care tasks for a total of_____unit(s)_____time(s) per week:

- ☐ Bath assistance
- ☐ Skin care
- ☐ Grooming
- ☐ Shaving assistance
- ☐ Oral hygiene
- ☐ Shampooing
- ☐ Brushing/combing hair
- ☐ Rolling hair
- ☐ Drying hair
- ☐ Oiling scalp
- ☐ Dressing
- ☐ Safety supervision
- ☐ Transfer or standby assistance
- ☐ Do not leave unattended during bathing
- ☐ Making bed
- ☐ Linen change (when housekeeping is not included on plan of care and member is receiving a bed bath)

+ ☐ Other _____

\- ☐ Other _____

Expected Outcomes

_____has adequate personal hygiene/ personal care as evidenced by observation and documentation from the provider agency and verbal reports from_____.

Other _____

Member last name	First name	Middle initial	County	Case number

Nutrition

Not applicable ☐

Objective

_____ will receive assistance with nutrition throughout the one-year service plan period.

Action Steps

The PCA will assist _____ with the indicated meal preparation tasks for a total of _____ unit(s) _____ time(s) per week:

- ☐ AM
- ☐ Noon
- ☐ PM
- ☐ Advanced AM
- ☐ Advanced Noon
- ☐ Advanced PM
- ☐ Extra for weekends
- ☐ Store foods appropriately
- ☐ Clean kitchen and area
- ☐ Clean stove
- ☐ Clean refrigerator (including removing spoiled items)

\+ ☐ Other _____

\- ☐ Other _____

Expected Outcomes

_____ has adequate nutrition as evidenced by observation, absence of unintended weight loss, and documentation from the provider agency and verbal reports from _____.

Other _____

Housekeeping

Not applicable ☐

Objective

_____ will receive assistance with housekeeping throughout the one-year service plan period.

Action Steps

The PCA will assist _____ with the indicated housekeeping tasks for a total of _____ unit(s) _____ time(s) per week:

- ☐ Sweep floors
- ☐ Mop floors
- ☐ Clean and tidy living room
- ☐ Vacuum floors
- ☐ Dust mop floors
- ☐ Clean and tidy bedroom
- ☐ Dust
- ☐ Remove trash
- ☐ Thoroughly clean bathroom
- ☐ Change linens

\+ ☐ Other _____

\- ☐ Other _____

Expected Outcomes

_____'s home environment is clean and tidy as evidenced by observation, and documentation from the provider agency and verbal reports from _____.

Other _____

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

Laundry

Not applicable ☐

Objective

_____ will receive assistance with laundry throughout the one-year service plan period.

☐ In home ☐ Laundromat ☐ Apartment facility

Action Steps

The PCA will assist_____with the indicated laundry tasks (includes wash, dry, fold, and put away) for a total of_____unit(s) _____ time(s) per week:

\+ ☐ Other _____

\- ☐ Other _____

Expected Outcomes

_____ has clean laundry available as evidenced by observation and documentation from the provider agency and verbal reports from_____.

Other: _____

Shopping/Errands

Not applicable ☐

Objective

_____ will receive assistance with shopping/errands throughout the one-year service plan period.

Action Steps

The PCA will assist_____with the indicated shopping/errand tasks for a total of _____ unit(s)_____time(s) per week:

☐ Groceries ☐ Medications ☐ Mail ☐ Medical supplies

\+ ☐ Other _____

\- ☐ Other _____

Expected Outcomes

_____ has adequate groceries and supplies as evidenced by observation and documentation from the provider agency and verbal reports from_____.

Other _____

Member last name	First name	Middle initial	County	Case number

Special Tasks

Not applicable ☐

Objective

_____will receive assistance with designated special tasks throughout the one-year service plan period.

Action Steps

The PCA will assist_____with the following special tasks for a total of_____unit(s) _____time(s) per week:

- ☐ Reading mail
- ☐ Nail care
- ☐ Foot care
- ☐ Spoon feeding
- ☐ Reminder to take medicine
- ☐ Toileting
- ☐ Cleaning bedside commode/urinal
- \+ ☐ Other _____
- \- ☐ Other _____

Expected Outcomes

_____has adequate assistance with special tasks as evidenced by observation and documentation from the provider agency and verbal reports from_____.

Other _____

Signatures

Member or legal representative signature _____ Date _____

When the member signs with a mark, two witnesses are required.

Witness Signature _____ Date _____ Witness Signature _____ Date _____

Signature of nurse completing form _____ Date _____