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

☐ Initial ☐ MPS
☐ Review ☐ Non-MPS

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

☐ MI
☐ DD
☐ AIS/MR
☐ Semi-independent
☐ General Foster Care
☐ Level I Specialized Home
☐ Level II Specialized Home
☐ Level III Specialized Home

License Type

CHILD
☐ Foster Family Home
☐ Foster Family Group Home
☐ CCI (FIA Rates)
☐ CCI (DCH Rates)

ADULT
☐ Foster Care Family Home
☐ Foster Care Small Group
☐ Foster Care Medium Group
☐ Foster Care Large Group
☐ 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	☐	☐	☐
Toileting	☐	☐	☐
Bathing	☐	☐	☐
Grooming	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Ambulation/Mobility	☐	☐	☐
Taking Medication	☐	☐	☐

I recommend personal care services as indicated.

1. _____
Case Manager Date

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

2. _____
Qualified Case Manager/Physician Date

3. _____
Case Manager Supervisor/Nurse Date

Distribution: (1) Consumer's Record (2) Provider Copy