Transitional Plan - Personal Care Worksheet

Individual Name: _____ Date: _____

This worksheet is used to determine the maximum amount of Choices for Care Personal Care Services.

Step 1: Circle the column that corresponds directly with the clinical assessment.							**Step 2:** *Time Requested **by Waiver**	**Step 3:** # days/week **Waiver**	**Step 4:** Total mins/week **Waiver**	**Step 5:** Other Services *(use key)*
A. ADL's, Meal Prep & Meds	**0/8**	**1**	**2**	**3**	**4** **<6 x/day**	**6+ x/day**				
Toilet Use	0	5	10	20	40	60		x		
Eating	0	5	15	30	45	NA				
Bed Mobility	0	5	5	10	20	30				
Transferring	0	5	10	15	25	45 (Hoyer)				
Bathing	0	10	20	30	45	NA				
Dressing	0	5	10	20	30	NA				
Mobility	0	5	15	20	30	45		x		
Personal Hygiene	0	5	10	15	20	NA		x		
Adaptive Devices	0	5	5	10	15	NA		x		
Meal Prep	0	45	60	NA			*			
Medication Manage.	0	5	15	NA				x		

B. *Additional Incontinence Assist	**ILA Health Assess** *(ILA pg 17, #3 & #6)*				*Time Requested	# days/week	*Total mins/week	Other Services
	1-3x/wk	**4-6x/wk**	**1-3x/day**	**4+x/day**				
*Urinary	10	10	20	40	*			
*Bowel	10	10	20	40	*			
C. Instrumental Activities of Daily Living (IADL's): Phone Use, Money Management, Household Maintenance, Housekeeping, Laundry, Shopping, Transportation, Care of Adaptive Equipment.				330		**per week**		

Step 6: Calculations	
Total min/wk:	
Divide by 60 min:	*/* **60**
Maximum hrs per week (Round to nearest .25 hr)	*hrs/wk*
	X 2
Maximum hrs every 2 wks	

***NOTES:**

*Adjust time for other services such as LNA, Adult Day, family.
*When attending Adult Day, reduce time for at least meal prep.
*Additional help with incontinence should only be requested when time for other activities is not sufficient to meet the overall need.

KEY for Step 5

LNA = Licensed Nurses Aid = _____days/wk
AD = Adult Day Services = _____days/wk
ASP = Attendant Services Program = _____ days/wk
F = Family/Friend =_____ days /wk
HDM = Home Delivered Meals =_____ days/wk
O = Other = _____ days/wk

DAIL 10/05