REQUEST FOR SUPERVISION HOURS IN PERSONAL CARE

Participant Name: _____ Medicaid ID: _____

Primary Provider: _____ Provider Number: _____

I. PARTICIPANT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY NEED FOR SUPERVISION

A. **Cognitive Status:** Describe the participant's cognitive status and the impact it has on his/her behavior. If the participant is confused at different times of the day, please explain. State whether the participant can/cannot be left alone. If the participant can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the participant have appropriate judgement/decision making abilities? *(Be as detailed as possible. It is important that the RN/SF make a correct appraisal of the cognitive status of the participant. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.)*

B. **Physical Incapacity:** Describe the degree of physical incapacity and how it justifies a need for supervision.

1. Incontinence:
   Bowel: _____ Frequency of Changes: _____
   Bladder: _____ Frequency of Changes: _____
2. Can the participant change position/shift/transfer without assistance?
3. Skin Breakdown (*Note areas affected/recently documented problems within the last year, including dates*):
4. Potential for skin breakdown (*Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.*):
5. Falls [*Describe any falls that have occurred during the past 3 months, including dates and times of fall(s), and the scenario of the fall(s). Interactions and side effects of medications that may have contributed to the fall(s) must be included. Document what interventions, if any, have been put in place to prevent future falls*:

C. The participant can call (via telephone) for assistance: ☐ Yes ☐ No

If No, explain: _____

_____

6. Unstable Medical Condition(s) [*List the participant's current medical diagnoses and needs in relation to any unstable medical condition(s).*]

7. Seizures (*Note the frequency and severity within the past 3 months.*):

8. Mobility (Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.):

9. For participants age 12 and under, please describe support needs that are a barrier to participation in traditional child care arrangements.

II. CURRENT SUPPORT SYSTEM

A Primary Caregiver Information

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Name: _____ Home Phone: _____

Does the primary caregiver live with the participant? ☐ **Yes** ☐ **No**

If no, the caregiver's address: _____

_____

If yes, does the primary caregiver work out of the home? ☐ **Yes** ☐ **No**

If yes, employer's name: _____ Employer's Phone #: _____

Work Hours: _____

Leave Home: _____ Returns Home: _____

*Note: A schedule may be requested.

B. List the names of all adults (age 18 and older) living in the home. Provide the days and times in which they are away from the home and unable to provide supervision.

C. List the Support System / Backup System for the primary caregiver when the Personal Care Aide is absent from the home. Include the name and times the support system is available to assist. *(The provider must be able to contact the participant's support system in case of an emergency.)(Please list the names, phone number, and schedules of all active support systems for the primary caregiver when the Personal Care Aide is absent from the home.)*

D The amount of time in the Plan of Care for ADL care and Home Maintenance requirements:

E The amount of additional support time required that can not be provided by participant's support system.

# of Hours:	Between the time of:	and

F. For school age participants. Please list the times the participant is out of the home for school including time spent in travel:

School hours: _____

G. Does the participant participate in any adjunct therapies, i.e.: ABA, PT, OT, ST. Provide a schedule and frequency of the service:

Provide any additional information not addressed above to further demonstrate the need for supervision.

_____
Agency / Screening Team

_____ _____
RN Supervisor/Service Facilitator or PAS Team Member Date

Instructions

If a participant is requesting supervision, the provider must fill this form out completely and submit it to the DMAS SA contractor or MCO for authorization. The DMAS SA contractor or MCO must approve the request before DMAS will reimburse for this service.