**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13(2), Wis. Admin. Code

F-11136 (10/2008)

**FORWARDHEALTH**

**PERSONAL CARE ADDENDUM**

**Instructions:** Print or type clearly. Refer to the Personal Care Addendum Completion Instructions, F-11136A, for information on completing this form.

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| **SECTION I — PROVIDER INFORMATION** |
| 1. Name — Provider      | 2. Provider Number      |
| **SECTION II — MEMBER INFORMATION** |
| 3. Name — Member      | 4. Member Identification Number      |
| **SECTION III — GENERAL ASSESSMENT** |
| 5. Skilled Visits Required by Member (Check all that apply.) [ ]  Registered Nurse [ ]  Physical Therapist[ ]  Licensed Practical Nurse [ ]  Occupational Therapist[ ]  Home Health Aide [ ]  Speech-Language Pathologist |
| 6. Communication Capability (Check one.) [ ]  Communicates needs verbally.[ ]  Communicates verbally with difficulty, but can be understood.[ ]  Communicates with sign language, symbol board, written messages, gestures, or interpreter.[ ]  Communicates inappropriate content, makes garbled sounds.[ ]  Does not communicate needs.[ ]  Child with age-appropriate communication. |
| 7. Hearing Aid Usage Does the member wear a hearing aid? [ ]  Yes [ ]  No If yes, what is the member’s ability to hear with the hearing aid, if customarily worn? (Check one, if applicable.)[ ]  No hearing impairment.[ ]  Hearing difficulty at level of conversation.[ ]  Hears and understands only very loud sounds (e.g., person speaking to member must yell to be heard.)[ ]  No useful hearing; unable to interpret audible sounds.[ ]  Not determined. |
| 8. Vision Correction Does the member wear corrective lenses? [ ]  Yes [ ]  No If yes, what is the member’s ability to see with corrective lenses, if customarily worn? (Check one, if applicable.)[ ]  Has no impairment of vision.[ ]  Has difficulty seeing at level of print, but may be able to read large or thick print.[ ]  Has difficulty seeing obstacles in environment.[ ]  Has no useful vision.[ ]  Not determined. |

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| **SECTION III — GENERAL ASSESSMENT (Continued)** |
| 9. Orientation (Check one.) [ ]  Oriented[ ]  Minor forgetfulness of the following (Check all that apply.) [ ]  Time [ ]  Medications [ ]  Place [ ]  Meals [ ]  Person[ ]  Partial or intermittent periods of disorientation in the following (Check all that apply.) [ ]  a.m. [ ]  Consistently [ ]  p.m. [ ]  Inconsistently [ ]  Two Hours or Less[ ]  Totally disoriented — does not know time, place, or identity[ ]  Comatose [ ]  Not determined |
| 10. Medications |
| Medication Name | Dosage / Frequency | Route | Start Date | End Date |
|       |       |       |       |       |
|       |       |       |       |       |
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|       |       |       |       |       |
| 11. Supporting Rationale for Requested Increase of Units      |

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| **SECTION IV — SOCIAL INFORMATION** |
| 12. Social / Economic / Cultural Factors      |
| 13. Scheduled Activities Outside Residence Does the member attend regularly scheduled activities outside his or her residence? [ ]  Yes [ ]  No If yes, specify in the following table the times of day for each activity. |
| Scheduled Activity | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| School |       |       |       |       |       |       |       |
| Work |       |       |       |       |       |       |       |
| Day Program |       |       |       |       |       |       |       |
| Other (Specify)      |       |       |       |       |       |       |       |
| Other (Specify)      |       |       |       |       |       |       |       |
| **SECTION V — HISTORY OF CONDITION** |
| 14. Condition / Past and Present Problems Affecting Personal Care      |

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| **SECTION VI — STAFFING SCHEDULE** |
| 15. Staffing Schedule of Each Agency or Provider Providing Services Specify the times of day each provider provides services. |
| Level of Care | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Skilled Nursing Services |       |       |       |       |       |       |       |
| Home Health Aide Services |       |       |       |       |       |       |       |
| Personal Care Worker Services |       |       |       |       |       |       |       |
| Case Sharing (Specify agency[ies])      |       |       |       |       |       |       |       |
| Other (Specify, e.g., Home and Community-Based Waiver Services Worker)      |       |       |       |       |       |       |       |
| 16. Other Information      |
| **SECTION VII — SIGNATURE** |
| 17. **SIGNATURE —** Authorized Nurse Completing Form      | 18. Date Signed       |