**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 | | | |