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Instructions For Completion INCOMPLETE or INCORRECT Care Plans may result in recoupment of funds.				
	Assessment	Information		
<u>1.</u>	A new or updated <i>Care Plan</i> must be completed annually.	☐ Initial Assessment ☐ Re-determination Date		
<u>2.</u>	Print legibly.			
3. 4. 5.	Prior to submitting this Care Plan valid Idaho Medicaid must be in place for the child. Complete all sections. Please indicate what the Instructions are for each area of need. Attach a copy of the most QIDP plan for student with skill based training program. Review this Care Plan with the parent/guardian and have them sign the acknowledgement section.	District/School Name District/School Phone () PCS Frequency Days per week Hours per Day (Refer to the Week-At-A-Glance for Individual Task Time) Diagnoses: Referral Information Participant Name Medicaid ID #DOB//		
		Address City State Zip Parent/Guardian Name Physical Address City State Zip Daytime Phone ()		

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Functional Status/Lir	mitations	VEISIUIT I — 0/2012
Dependence		Impairments (Check all that apply)
☐ Total	☐ Partial	☐ Vision
Mobility		Hearing
☐ Immobile	Partially Immobile	Speech
Deficits		
☐ Cognitive	☐ Memory	
Medical Information		
Primary Physician _		Phone No
Q.I.D.P		Phone No
Activities of Daily Li	ving (ADL)	
1. Grooming (Persor	nal Hygiene)	
Hair Care Independent Supervise/Co		Oral Care Independent Partial Assist Supervise/Cue Total Assist
Hand washing Independent Supervise/Co		
Instructions:		
QIDP Plan is Part of	the IEP Attached - Yes	_ No

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2. Dressing & Undressing-Upper Body				
☐ Independent ☐ Partial Assist ☐ Braces ☐ Splints ☐ Supervise/Cue ☐ Total Assist ☐ Other assistive devices				
Instructions:				
QIDP Plan is Part of IEP Attached - Yes No				
3. Dressing & Undressing-Lower Body				
☐ Independent ☐ Partial Assist ☐ Braces ☐ Splints ☐ Supervise/Cue ☐ Total Assist ☐ Other assistive devices				
Instructions:				
QIDP Plan is Part of IEP Attached - Yes No				
4-5. Toilet Use-Bladder CONTINENT INCONTINENT OCCASIONALLY INCONTINENT				
ELIMINATION METHOD				
☐ Toilet ☐ Independent ☐ Partial Assist				
☐ Commode☐ Supervise/Cue☐ Indwelling Catheter				
☐ Intermittent Catheter				
Diaper				
☐ Menses Care				
Frequency				
Instructions:				
QIDP Plan is Part of IEP Attached - Yes No				

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6. Toilet Use - Bowel	☐ CONTINENT ☐ INCONTINEN	T OCCASIONALLY INCO	NTINENT	
BOWEL PROGRAM				
ELIMINATION METHOD Toilet Diaper Ostomy	Frequency	☐ Independent ☐ Supervise/Cue	☐ Partial Assist ☐ Total Assist	
Instructions:				
QIDP Plan is Part of IEP A	ttached - Yes No			
7. Adaptive Devices				
Braces Prosthesis Splints Frequency applied and removed Instructions:				
8-9. Mobility/Transferring				
Wheelchair Transfers Independent Supervise/Cue	☐ Partial Assist ☐ Total Assist	Bedbound /Positio Independent Supervise/Co	Partial Assist	
Equipment Gait Belt Transfer Board Cane Manual Wheelcha				

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Services	
☐ Physical Therapy	Instructions for therapies:
Occupational Therapy	
Other Special Care/Considerations:	
Instructions:	
QIDP Plan is Part of IEP Attached - Yes 1	
10. Eating/Feeding	
Intake Method	Type of Diet
☐ Oral☐ G-tube only☐ Oral and G-tube	☐ Breakfast ☐ Supper ☐ Lunch ☐ Snack
Frequency	
☐ Independent☐ Partial Assist☐ Supervise/Cue☐ Total Assist	
Instructions:	
QIDP Plan is Part of IEP Attached - Yes 1	No
11. Medications & Other Delegated Medical Care	
Route Oral G-tube Rectal	ГорісаІ
☐ Independent☐ Supervise/Remind Only☐ Physical Assist	

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Instructions:	V EISIOIT I — 0/2012
Dressing Changes	
Delegated by	Date / /
Delegated by	
Protocol	
Other Specialized Treatments:	
Other Specialized Treatments:	
Delegated by	Date//
Drotocol	
Protocol	
Parent/Guardian Acknowledgement	
I acknowledge this Care Plan was performed with input from me a	and is a Care Plan to follow in delivering care to
my child.	
Pare	ent/Guardian Signature Date
Nivera A almanula de amant	
Nurse Acknowledgement	
I acknowledge this Care Plan was performed by me and is a Care Plan t	to follow in delivering care to this child.
	1 1
	Desistand Number Dete
	Registered Nurse Date

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Week-At-A Glance

Participant _		Date:
Instructions:	R.N. to use for scheduling tasks.	Attendant will review daily for tasks to be completed.

PROVIDER TASKS	MON	TUES	WED	THUR	FRI
Skin Care					
Oral Care					
Dressing/Undressing					
Bladder/Bowel Program					
Peri/Menses/Incontinence Care					
Catheter/Ostomy Care					
Adaptive Devices					
Transferring					
Mobility/Ambulation					
Eating/Feeding					
Assistance with Medications					
Individual Education Program					
1.					
2.					
3.					
4.					
5.					
Other					
1.					
2.					
Total Hours					

Participant Name: MID#:	Page 7 of 7
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