**SCHOOL BASED PERSONAL CARE MEDICAID LOG SHEET (Page 1 of 2)**

Total Number of Allowable Units (28 - 15 minute units per instructional day)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medicaid Number** | **Last Name** | **First Name** | **County** | **School** | **Procedure Code** |
|  |  |  |  |  | T1019 SE |
| **WVEIS #** | **Diagnosis Code** | **Date of Birth** | **Month/Year** | **Provider Name (Printed)** |
|  |  |  |  |  |  |

# Personal Care must be identified on the Service Plan

**DATE OF SERVICE:**

|  |  |  |
| --- | --- | --- |
| **CATEGORY/ACTIVITY** | **START/END TIMES FOR EACH ACTIVITY**For each time an activity is provided list the start and end time. If more than six in one activity use an additional form | **MINUTES** |
| Self Help Skills | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time |  |
| A. Grooming |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Bathing |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Toileting |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D. Dressing |  |  |  |  |  |  |  |  |  |  |  |  |  |
| E. Laundry (Employee Doing) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| F. Brushing Teeth |  |  |  |  |  |  |  |  |  |  |  |  |  |
| G. Hand Washing |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Non-Tech Physical Assistance | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time |  |
| A. Repositioning/Transfer |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Walking |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Medical Equipment (Adaptive) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D. Assistance with Medication |  |  |  |  |  |  |  |  |  |  |  |  |  |
| E. Range of Motion (ROM) (Per Phys. Order) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| F. Vitals(Per Phys. Order) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| G. Catheterization |  |  |  |  |  |  |  |  |  |  |  |  |  |
| H. Communication |  |  |  |  |  |  |  |  |  |  |  |  |  |

SCHOOL BASED PERSONAL CARE MEDICAID LOG SHEET (Page 2 of 2)

Student Name:

# DATE OF SERVICE:

|  |  |  |
| --- | --- | --- |
| **CATEGORY/ACTIVITY** | **START/END TIMES FOR EACH ACTIVITY**For each time an activity is provided list the start and end time. If more than six in one activity use an additional form | **MINUTES** |
| Nutritional Support | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time |  |
| A. Meal Preparation |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Feeding |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Special Dietary Needs |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Environmental | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time |  |
| A. Housecleaning |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Laundry/Ironing (Supervision) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Making/Changing Bed |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D. Dishwashing |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Behavior Modifications | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time | Start Time | End Time |  |
| A. Supervision of Non-Educational Time |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Redirection |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Positive Behavior Supports |  |  |  |  |  |  |  |  |  |  |  |  |  |

CARRYOVER MINUTES FROM PREVIOUS INSTRUCTIONAL DAY

|  |  |  |  |
| --- | --- | --- | --- |
| TOTAL DAILY MINUTES | DIVIDE BY 15 = | TOTAL DAILY UNITS | Carryover minutes for next instructional day |

PROVIDER SIGNATURE/CREDENTIAL: DATE: