ADDING PSA SERVICES TO EXISTING HOME HEALTH AGENCY LICENSE

Dear Provider:

To add personal services to an existing home health agency license please provide the following items and/or documentation:

A letter on your agency's letterhead to include the following:

- The agency's license number. The number is located on agency's license.
- Your request to add personal services;
- The date the service is intended to be offered – the effective date.

Ensure you meet the requirements of IC 16-27-4-16 and provide the following:

- Copy of a basic attendant care provider job description as well as
- An updated training and evaluation policy that includes the following:
    1. A method of determining competency and provides a passing score for the attendants;
    2. Describe your determination of competency methods: i.e., how you evaluate, train, and retrain, if needed
- In addition, please submit page 2 of an Initial Home Health Agency application with Section E completed.

Once the above-mentioned documents are submitted and approved, the Department will update our database to reflect the changes and send a confirmation letter to the agency. A home health agency may not offer additional services until it has received approval form the Department.

Please submit your change request to:

4A – 07
Indiana State Department of Health
Division of Home and Community Based Care
2 North Meridian Street
Indianapolis IN 46204

SERVICE PLAN

(IC 16-27-4-10)

POLICY:

The Agency/Manager or the manager's designee will prepare a service plan for a client before providing personal services for the client. The service plan will include the service that is provided to the client such as Attendant Care, Homemaker Services and/or Companion Care.

The initial service plan or any permanent changes to the service plan must be in writing, dated, and signed by the individual who prepared it and by the client or client's representative.

The service plan must:

a. Be in writing, dated, and signed by the individual who prepared it as well as the client or client's representative;
b. List the types and schedule of services to be provided; and
c. List that the services to be provided to the client are subject to the client's right to temporarily suspend, permanently terminate, temporarily add, or permanently add the provision of any services.

PURPOSE:

To abide by state/federal guidelines and offer guidelines to ______________________________
__________________ staff, and community for the appropriate utilization of home services.

To assure continuity and consistency under the current plan.

To focus on the service, frequency and duration.

To provide updated, coordinated document that reflects the current home services.

PERSONAL CARE ASSISTANT SKILLS CHECK LIST

Name:____

NON-Medical Check skills only being demonstrated. Initial and date when each skill is evaluated. Mark met or not met. Initial, sign and dates at bottom of form.

DEMONSTRATION OF SKILLS

SKILL TESTED	DATE	MET	NOT MET	RE-TEST DATE	MET	NOT MET	COMMENTS
Mobility: Assistance with: • Ambulation Assist: Cane__________ Walker,________ or Crutches_____							
• ROM: Upper and Lower Active:__________ Passive:_________							
• Transfer: Assist Wheelchair_______ Or Bed-to-Chair_____							
• Positioning In a bed or________ In a chair__________							
Personal Care: Assistance with • Oral; Dentures______ Natural teeth,______ Or Gum Care_______							
• Bath at bedside – assist client							
• Bath Shower ________ Tub______ Or Sponge Bath___							

SKILL TESTED	DATE	MET	NOT MET	RE-TEST DATE	MET	NOT MET	COMMENTS
• Nail Care (except with Diabetes Patients) Fingers or Toes – Soak, File, or Trim							
• Hair: Shampoo Bed______ Sink;_______ or Bathtub/shower_____							
• Prevention of Skin Breakdown: Recognition of Pressure areas or Appropriate Massage Techniques							
Bodily Functions: Assistance with • Toileting; Bathroom;________ Bedpan;________ Urinal;_________ Bedside Commode___ Ex. Dwelling Catheter____ or Catheter_______							
• Fluid Balance: In-take or Out-Put Measurement							
Environmental Services • Linen Change:							
• **Universal Precautions,** as written by the Agency, are used and followed							
• Medication Reminder							
Other Individual Agency Requirements • Use of special equipment							

SKILL TESTED	DATE	MET	NOT MET	RE-TEST DATE	MET	NOT MET	COMMENTS

Evaluator(s) Signature and Date(s): ______________________________

Date: ___/___/____

Personal Care Attendant Signature and Date:

Date: ___/___/___

Service Plan (IC 16-27-4-10)

Client Name ____________________

Consultation Date __________ Mgr./Designee ____________________

Service Start Date __________

	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Directions
Personal Care Services (assistance with the following)								
Activity Level/Mobility								
Assistance with Transfer								
Bathing Assistance								
Hair Care Assistance								
Dressing/Grooming Assistance								
Medication Assistance								
Nail Care (no diabetics) Assist								
Oral Care Assistance								
Shaving Assist (blood thinners?)								
Toileting Assistance								
Homemaking Services								
Change Bed Linen								
Clean Bathroom								
Clean Kitchen								
Cooking *Special Diet:*								
Dust								
Laundry								
Clean Living Areas								
Vacuum/Sweep/Mop								
Companion Services								
Errands/Shopping								
Recreational Activities								
Transportation								
Other Services								
Transfer with hoyer lift								

By signing this *Service Plan* I acknowledge that I am directing *agency* to provide the above listed services to me and I that I have the right to temporarily suspend, permanently terminate, temporarily add, or permanently add the services.

____________________ __________

Client or Authorized Signature *Date*

____________________ __________

Representative Signature *Date*

Visit Record

Client Name ______________________ Employee ______________________ Week Ending ____________, 20____

(Per Service Plan)	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Notes
Date								
Time In								
Time Out								
Personal Care Services (assistance with the following)								
Activity Level/Mobility								
Assistance with Transfer								
Bathing Assistance								
Dressing/Grooming Assistance								
Hair Care Assistance (wash)(comb)								
Medication Reminders								
Nail Care (no diabetics) Assist								
Oral Care Assistance								
Shaving Assist								
Toileting Assistance								
Homemaking Services								
Change Bed Linen								
Clean Bathroom								
Clean Kitchen								
Cooking								
Dust								
Laundry								
Living Areas								
Vacuum/Sweep/Mop								
Companion Services								
Errands/Shopping								
Recreational Activities								
Transportation								
Other Services								
Transfer with hoyer lify								
Units								
Caregiver Signature								
Client Initials								

Mileage

Date	Location
Beg. Odometer	End. Odometer

By initialing above I agree that these services have been provided to me on that day. By signing below I agree that these services have been provided to me during the week as initialed above. (Signed the last daily visit of the week.)

Representative Signature/Title ______ _Date_ ______ _Client or Authorized Signature_ ______ _Date_ ______