**SCHOOL BASED PERSONAL CARE MEDICAID LOG SHEET Page \_\_\_ of \_\_\_**

Total Number of Allowable Units (28 - 15 minute units per instructional day). Personal Care must be identified as a service on Plan of Care.

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|  |  |  |  |  | Medicaid Number | Last Name | First Name | County | School | Procedure Code |
|  |  |  |  |  | T1019 SE |
| WVEIS # | Diagnosis Code(s) | Date of Birth | Date of Service | Provider Name (Printed) |
|  |  |  |  |  |
| **1. Grooming** | **6. Brushing Teeth** | **11. Assistance with Medication** | **16. Meal Preparation** | **21. Making/Changing Bed** |
| **2. Bathing** | **7. Hand Washing** | **12. \*Range of Motion** | **17. Feeding** | **22. Dishwashing** |
| **3. Toileting** | **8. Repositioning/Transfer** | **13. \*Vitals** | **18. Special Dietary Needs** | **23. Supervision/Non-Educational** |
| **4. Dressing** | **9. Walking** | **14. Catheterization** | **19. Housecleaning** | **24. Redirection** |
| **5. Laundry (Employee)** | **10. @Medical Equipment** | **15. Communication** | **20. Laundry/Ironing Student** | **25. Positive Behavior Support** |

**@(Adaptive) \* (Per Physician Orders)**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **List Number of Activity** | **Start Time** | **End Time** | **List Number of Activity** | **Start Time** | **End Time** | **List Number of Activity** | **Start Time** | **End Time** |
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| **TOTAL MINUTES PER COLUMN** |  | **TOTAL MINUTES PER COLUMN** |  | **TOTAL MINUTES PER COLUMN** |  |

**Carryover Minutes from Previous Instructional Day TOTAL MINUTES: TOTAL UNITS: Carryover for next instructional day:**

 No carryover if maximum units reached for the day.

PROVIDER SIGNATURE/CREDENTIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_