



PLAN OF CARE FORM*

(Optional)

REFER TO THE THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK FOR COMPLETE POLICY INFORMATION

RECIPIENT NAME: _____ MEDICAID ID #: _____

DATE OF BIRTH: _____ CHRONOLOGICAL AGE: _____

PROVIDER NAME: _____ PROVIDER ID #: _____

PLACE OF SERVICE: _____ MEDIPASS AUTHORIZATION #: _____
(If Required)

CURRENT PLAN OF CARE PERIOD: _____ To _____

CURRENT EVALUATION DATE: _____

PREVIOUS PLAN OF CARE PERIOD: _____ To _____

PREVIOUS EVALUATION DATE: _____

PLAN OF CARE TYPE : (Check One) PT _____ OT _____ SLP _____ RT _____

FREQUENCY: Weekly Visits: # _____ Visit Length: _____

DURATION: Months: # _____ Weeks: # _____

MEDICAL NECESSITY CRITERIA: Yes/No
Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. _____

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs. _____

Consistent with generally accepted professional medical standards as determined by the Medicaid program, not experimental or investigational. _____

Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide. _____

Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. _____

DESCRIPTION OF CONDITION, INCLUDING MOST SPECIFIC ICD-9 CODES:

PLAN OF CARE FORM

ALL TREATMENT SERVICES TO BE PROVIDED TO RECIPIENT:

THERAPY METHODS, e.g., stretching, strengthening, language therapy, developmental sequencing, etc.:

MONITORING CRITERIA, e.g., standardized tests, timed tests, observation, family or caregiver reporting, etc.:

CURRENT MEDICATIONS:

OTHER TREATMENTS THE RECIPIENT IS RECEIVING:

EQUIPMENT REQUIRED:

IS THE RECIPIENT ON A SPECIALIZED DIET? Yes _____ No _____

If yes, please specify:

METHODS OF DEMONSTRATING AND TEACHING THE FAMILY AND OTHER RELEVANT CAREGIVERS WHO ARE INVOLVED WITH THE RECIPIENT:

PLAN OF CARE FORM

HOW THE TREATMENT WILL BE COORDINATED WITH THE OTHER SERVICE NEEDS PRESCRIBED FOR THE RECIPIENT:

LONG-TERM GOALS:

- 1) _____
Progress: _____
- 2) _____
Progress: _____
- 3) _____
Progress: _____
- 4) _____
Progress: _____
- 5) _____
Progress: _____

SHORT-TERM GOALS:

- 1) _____
Progress: _____
- 2) _____
Progress: _____
- 3) _____
Progress: _____
- 4) _____
Progress: _____
- 5) _____
Progress: _____
- 6) _____
Progress: _____
- 7) _____
Progress: _____
- 8) _____
Progress: _____
- 9) _____
Progress: _____

PLAN OF CARE FORM

Other Information/Comments:

SIGNATURES

THERAPIST SIGNATURE:

Therapist Name (Please Print)	Therapist Signature	Date

By signing as the therapist, I hereby certify this plan of care was written based on evaluation results and the goals are reasonable and appropriate for this patient and that if this prescription is for a continuing plan, I have reviewed the patient's progress and adjusted the plan of care goals if necessary.

PHYSICIAN SIGNATURE:

PCP Name (Please Print)		Other Authorized Prescriber (Please Print)	
Signature	Date	Signature	Date

By signing as the PCP and/or other authorized provider, I hereby certify that I have reviewed each element of the therapy plan of care, that the goals are reasonable and appropriate for this patient, and that if this prescription is for a continuing plan, I have reviewed the patient's progress and adjusted the plan of care goals if necessary.

*Please note this form is not required by Florida Medicaid to prescribe therapy services. This form is provided as an optional convenience to therapy providers to assist in the process of writing a plan of care.