2017-18 Aurora Public Schools 28J

The Consortium
Improving student health together

Personal Care Services

Required fields are noted with an asterisk (*)

***Student Last Name: ______________________ *First Name: ______________________ *Student ID#: ______________**

***Date of Birth: ______________________ *School: ______________________ * ICD-10 Code: ______________**

***Indicate the personal care services as clearly defined in the IEP/IFSP. If stated *as needed*, check the appropriate box. If stated in *duration and frequency terms*, complete the maximum time per service, and the maximum number of services PER DAY.**

	As Needed	*OR*	**Maximum time per service*	**Maximum number of services*
1___ Physical assistance with eating	☐		*__________ mins.*	*_______ times/day*
2 ___ Personal hygiene/diapering/toileting	☐		*__________ mins.*	*_______ times/day*
3 ___ Assistance with mobility/positioning	☐		*__________ mins.*	*_______ times/day*
4 ___ Safety monitoring/dangerous behavior	☐		*__________ mins.*	*_______ times/day*
5 ___ Other assistance (not delegated nursing services): ______________________	☐		*__________ mins.*	*_______ times/day*

**Total Time for services may not exceed length of school day______*

☐ *Check if it is medically necessary for more than one staff member to perform services at the same time. Providers should enter time and initials on separate lines.*

****Enter corresponding service # from above*** ** Personal Care Services are delivered individually, unless noted as "G" for Group services is Circled.*

	*Service #			*Service #			*Service #			*Service #			*Service #		
***Date MM/DD/YYYY**	*Actual Minutes		*Provider Initials	*Actual Minutes		*Provider Initials	*Actual Minutes		*Provider Initials	*Actual Minutes		*Provider Initials	*Actual Minutes		*Provider Initials
		G			G			G			G			G	
		G			G			G			G			G	
		G			G			G			G			G	
		G			G			G			G			G	
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		G			G			G			G			G	

I certify that the information provided on this form is true and accurate and that the services were provided in accordance with federal and state laws applicable to Medicaid.

***Printed Name**	***Signature**	***Initials**	***Date**	***Job Title**
______________________	______________	________	________	______________________
______________________	______________	________	________	______________________
______________________	______________	________	________	______________________

☐ Medicaid eligibility verified. **Send form to Medicaid Dept. ESC 3(Phone: 303-365-7813 x28528 Fax: 303-326-1813 or scan logs & email to: Laura Ahlf ldahlf@aps.k12.co.us)**

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Enter corresponding service # from above (previous page) *Personal Care Services are delivered individually, unless noted as "G" for Group services is Circled*

*Student's Name ______________________________ ID # ____________________

	Service:			Service:			Service:			Service:			Service:		
Date MM/DD/YYYY	Actual Minutes		Provider Initials	Actual Minutes		Provider Initials	Actual Minutes		Provider Initials	Actual Minutes		Provider Initials	Actual Minutes		Provider Initials
		G			G			G			G			G	
		G			G			G			G			G	
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		G			G			G			G			G	

I certify that the information provided on this form is true and accurate and that the services were provided in accordance with federal and state laws applicable to Medicaid. Required fields are noted with an asterisk (*)

*Printed Name	*Signature	*Initials	*Date End of Month	*Job Title
______________	______________	________	__________	______________
______________	______________	________	__________	______________
______________	______________	________	__________	______________

APS 28J 2017-18 School Year