

## **Personal Care Services (age 21 and older)**

*Refer to the Miscellaneous Chapter of this manual for those under age 21*

**Definition:** Personal Care Services are defined as assistance, either hands-on (actually performing a personal care task for a person) or cueing so that the person performs the task by him/herself, in the performance of Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs). ADLs include eating, bathing, dressing, toileting, transferring, personal hygiene, and maintaining continence. IADLs capture more complex life activities and include light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist of delivery of payment to a designated recipient on behalf of the client. Personal Care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Authorizations to providers will be made at two different payment levels. The higher level will be called Personal Care II and will be used, based on assessed need, when the majority of care is related to activities of daily living (e.g. hands-on care to include bathing, dressing, toileting, etc.). This service may also include monitoring temperature, checking pulse rate, observing respiratory rate, and checking blood pressure. The lower level, Personal Care I, will be authorized when, based on assessed need, all of the care is for instrumental activities of daily living (e.g. hands off tasks such as laundry, meal preparation, shopping, etc.). PC I services do not include hands-on care. Both services allow the provider to accompany the individual on visits in the community when the visits are related to the needs of the individual, specified in the plan of care, and related to needs for food, personal hygiene, household supplies, pharmacy or durable medical equipment. You have the responsibility to identify the necessity of the trip, document the plan of care, authorize this component of the service, and monitor the provision of the services.

The unit of service is 15 minutes, provided by one Personal Care Aide (PCA).

Please see:     Scope of Services for Personal Care 1 (PC I) Services  
                  Scope of Services for Personal Care 2 (PC II) Services

**Note:** Service options available via the CS Waiver when a person is assessed to need assistance with IADLs or ADLs are **Personal Care Services** or **In-Home Supports Services**.

**Note:** **In-Home Supports services are services where the participant/family can supervise the care provided by a personal care aide. Refer to the “In-Home Supports” section of Chapter 10 in this manual for further information to provide to participants/families.**

**Providers:** Personal Care Services are provided by an agency contracted with the Department of Health and Human Services. The recipient/family should be given a listing of available providers from which to choose. **The offering of this provider choice must be documented.**

**Arranging for the Services:** In order to determine the amount of Personal Care Services needed, you must complete the **Personal Care Needs Assessment (Community Supports Form PC-34)**. The need for the service must be clearly outlined in the recipient’s plan to include the amount, frequency, duration and provider type of services. Personal Care Services (I or II) are approved at the local level.

Budget requests for Personal Care Services (I or II) will be entered on the Waiver Tracking system using the following codes: PC I – S29 or PC II – S10. The Waiver Tracking System will not allow a request of personal care units beyond the CS Waiver cap.

**Authorizing Services:** Once the service is approved, an authorization (**Community Supports Form PC-3**) is completed and forwarded to the chosen personal care agency. On the **Community Supports Form PC-3**, you must indicate either Personal Care Services I (PC I) or Personal Care Services II (PC II) and include the personal care activities that are requested. These activities must correspond to the assessment (see notes on the assessment).

Upon receipt of the **Community Supports Form PC-3**, the personal care agency is authorized to provide the services. This authorization remains in effect until a new/revised **Community Supports PC-3** is sent or until services are terminated (see Chapter 8).

**Monitoring the Services:** You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service (refer to Chapter 9 "Monitorship of Community Supports Waiver Services"). Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following schedule should be followed when monitoring Personal Care Services (I and II).

- Must complete on-site monitorship during the first month while the service is being provided unless a Supervisor makes an exception. An exception is defined in the following circumstances:
  - the service is **only provided** in the early morning hours (prior to 7:00 a.m.)
  - the service is **only provided** in late evening hours (after 9:00 p.m.)
  - The exception and approval by the Supervisor must be documented. **NO** other exceptions will be allowed.
- At least once during the second month of service
- At least quarterly thereafter
- Start over with each new provider
- Yearly on-site monitorship required.

In addition, review the daily logs completed by the person care provider (Note: Daily logs can be requested from personal care providers as often as needed for monitoring purposes and must be requested for all on-site visits). Monitorship of the individual's health status should always be completed as a part of Personal Care monitorship.

Some items to consider during monitorship include:

- Is the individual receiving Personal Care services as authorized?
- Does the PCA show up on time and stay the scheduled amount of time?
- If the PCA does not show up for a scheduled visit, who is providing back-up services?
- What kinds of tasks is the PCA performing for the individual? Does the service need to continue at the level that it has been authorized?
- Has the individual's health status changed since your last monitorship? If so, is the current level of Personal Care appropriate?
- Is the individual satisfied with the provider of services? Does the provider show the individual courtesy and respect when providing the individual's care?
- Who is providing supervision of the PCA? How often is on-site supervision taking place?

**Reduction, Suspension, or Termination of Services:** If services need to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian. Include the details regarding the change(s) in service and the Reconsideration and Appeal Information. You must wait ten (10) calendar days before proceeding with the reduction, suspension or termination of the service. See **Chapter 8** for specific details and procedures regarding written notification and the appeals process.



**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
PERSONAL CARE/ATTENDANT CARE ASSESSMENT FOR ADULTS**

WAIVER PARTICIPANT'S NAME: \_\_\_\_\_ DOB/AGE: \_\_\_\_\_ / \_\_\_\_\_

Service(s) Requested  PC 1  PC 2  Attendant Care

I. PLEASE LIST ALL MEDICAL CONDITIONS AND WHEN EACH CONDITION FIRST OCCURRED. USE AN EXTRA SHEET OF PAPER IF YOU NEED MORE SPACE.

DIAGNOSIS/MEDICAL CONDITION	DATE FIRST OCCURRED
1.	
2.	
3.	
4.	

II. LIST ALL PERSONS INCLUDING PAID SERVICE PROVIDERS (E.G., NURSES, RESPITE CARE, ETC) WHO ARE NOW HELPING CARE FOR THE ADULT. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

PERSON/RELATIONSHIP	TIMES EACH DAY & DAYS EACH WEEK WHEN HELPING

III. PROVIDE A TWO WEEK SCHEDULE THAT SHOWS HOW/WHEN SERVICES/SUPPORTS (INCLUDING NATURAL SUPPORTS) ARE PROVIDED. INCLUDE THE ANTICIPATED SCHEDULE FOR PERSONAL CARE. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

**ASSISTANCE NEEDED**

**ASSISTANCE REQUIRED**

**FREQUENCY, TIME REQUIRED,  
TIMES PER WEEK**

**A. PERSONAL CARE**

BATH: BED  SHOWER/TUB  PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

SHAVING: PARTIAL  TOTAL  \_\_\_ X DAILY, 15 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

ORAL HYGIENE: PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

SKIN CARE: PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

DRESSING AND GROOMING: PARTIAL  TOTAL  \_\_\_ X DAILY, 15 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

INCONTINENCE CARE: PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

TOILETING: PARTIAL  TOTAL  \_\_\_ X DAILY, 15 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

RE-POSITIONING/TURING IN BED: PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

MONITORING MEDICATION: PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

(E.G., INFORMING THAT IT IS TIME TO TAKE MEDICATION AS PRESCRIBED OR AS INDICATED ON THE LABEL OR HANDING A MEDICATION CONTAINER – THE AIDE IS NOT RESPONSIBLE FOR GIVING MEDICATIONS).

**MEDICAL MONITORING OF CONDITION - SPECIFY:**

(E.G., MONITOR TEMPERATURE, CHECK PULSE RATE, OBSERVE RESPIRATORY RATE OR CHECK BLOOD PRESSURE).

\_\_\_\_\_ PARTIAL  TOTAL  FREQUENCY, TIME REQUIRED \_\_\_\_\_, \_\_\_X WEEKLY

\_\_\_\_\_ PARTIAL  TOTAL  FREQUENCY, TIME REQUIRED \_\_\_\_\_, \_\_\_X WEEKLY

EXERCISE: PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

**TRANSFERS:**

MANUAL  PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

HOYER  PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

SLIDING BOARD  PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

LIFT SYSTEM  PARTIAL  TOTAL  \_\_\_ X DAILY, 10 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

OTHER: \_\_\_\_\_ PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

**OTHER PERSONAL CARE NEEDS:**

\_\_\_\_\_ PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

\_\_\_\_\_ PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

**ASSISTANCE/TIME NEEDED FOR PERSONAL CARE (TOTAL SECTION A):** \_\_\_\_\_

**B. MEAL AND DINING**

PREPARATION AND SET-UP: PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

DINING/FEEDING: PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

CLEAN UP: PARTIAL  TOTAL  \_\_\_ X DAILY, 30 MIN  OTHER \_\_\_, \_\_\_X WEEKLY

**ASSISTANCE/TIME NEEDED FOR MEALS/DINING (TOTAL SECTION B):** \_\_\_\_\_

**C. GENERAL/HOUSEHOLD**

FLOOR CLEANING PARTICIPANT’S ROOM/AREA: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 15 MIN  OTHER \_\_\_

DUSTING PARTICIPANT’S ROOM/AREA: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 15 MIN  OTHER \_\_\_

STRAIGHTENING PARTICIPANT’S ROOM/AREA: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 30 MIN  OTHER \_\_\_

CHANGING BED LINENS: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 15 MIN  OTHER \_\_\_

PARTICIPANT'S LAUNDRY: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 90 MIN  OTHER \_\_\_

SHOPPING: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 60 MIN  OTHER \_\_\_

ESCORT: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 60 MIN  OTHER \_\_\_

TRANSPORTATION: PARTIAL  TOTAL  \_\_\_ X WEEKLY, 60 MIN  OTHER \_\_\_

**ASSISTANCE/TIME NEEDED GENERAL/HOUSEHOLD (TOTAL SECTION C):** \_\_\_\_\_

**D. Other Needs**

Shopping Assistance\*: Errands \_\_\_ x Weekly, 60 Min  Other \_\_\_\_\_

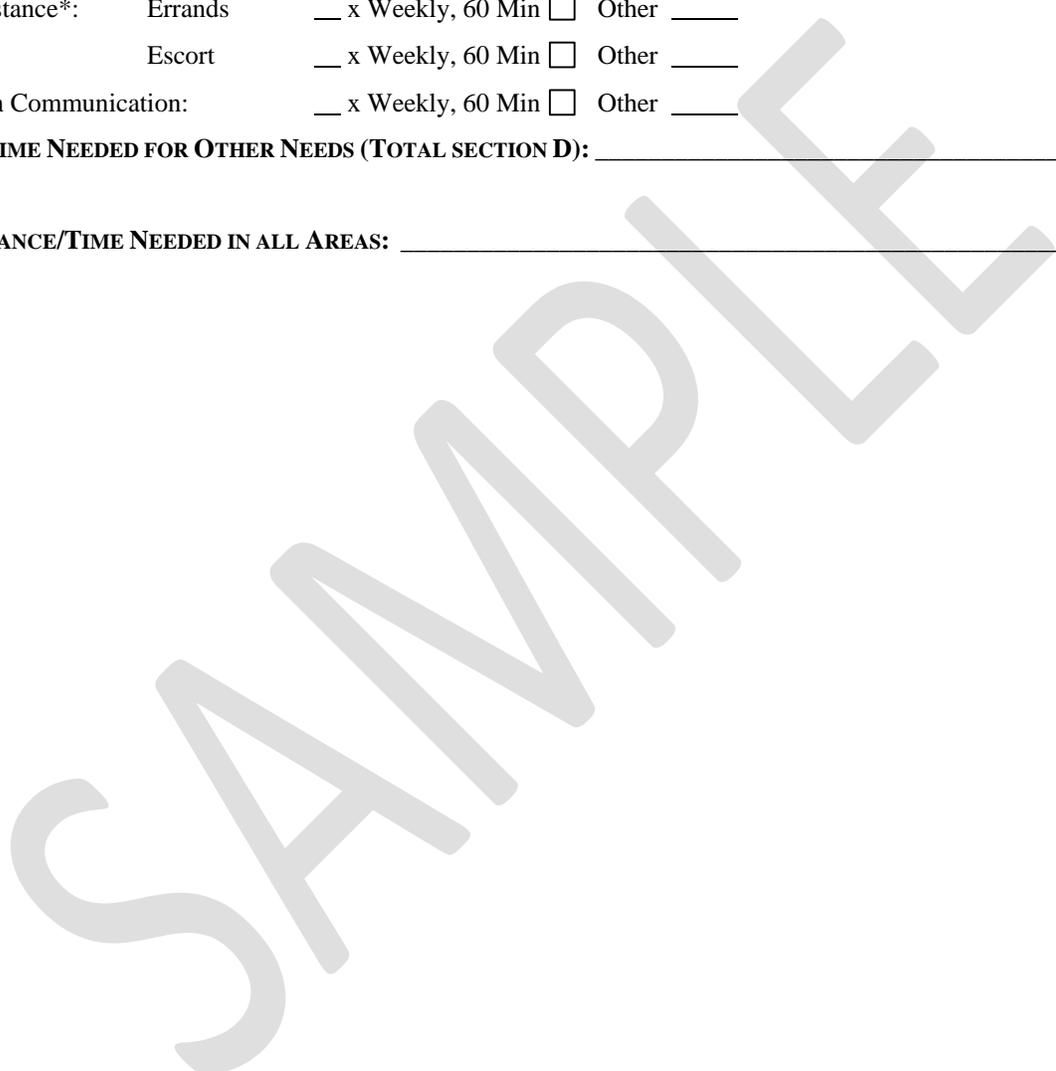
Escort \_\_\_ x Weekly, 60 Min  Other \_\_\_\_\_

Assistance with Communication: \_\_\_ x Weekly, 60 Min  Other \_\_\_\_\_

**ASSISTANCE/TIME NEEDED FOR OTHER NEEDS (TOTAL SECTION D):** \_\_\_\_\_

**TOTAL ASSISTANCE/TIME NEEDED IN ALL AREAS:** \_\_\_\_\_

**NOTES:**



\_\_\_\_\_  
SIGNATURE OF PERSON COMPLETING/TITLE

\_\_\_\_\_  
DATE