



**MEDICAID HOSPICE PLAN OF CARE FOR CURATIVE CARE
MEMBERS 20 YEARS AND YOUNGER**
State Form 54896 (2-12)

A. RECIPIENT INFORMATION

Name of recipient (<i>last, first, middle initial</i>)	
Social Security number of recipient	Medicaid number of recipient
Primary hospice diagnosis (ICD-9):	

B. HOSPICE PROVIDER INFORMATION

Name of hospice provider	Hospice provider number
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C. ASSESSMENT

Complete the following using the problem severity code listed at the bottom of the chart.

ASSESSMENT	PROBLEM SEVERITY CODE	ASSESSMENT	PROBLEM SEVERITY CODE
Altered Physical Comfort		Altered Urinary Elimination	
Altered Respiratory Status		Altered Bowel Elimination	
Altered Cardiovascular Status		Altered Sleep Pattern	
Altered Nutritional Status		Altered Grief / Spiritual (patient)	
Altered Skin Integrity		Altered Grief / Spiritual (family)	
Altered Mobility Status		Altered Oral Mucosa	
ACTIVITIES OF DAILY LIVING	PROBLEM SEVERITY CODE	ACTIVITIES OF DAILY LIVING	PROBLEM SEVERITY CODE
Eating / Feeding		Toileting	
Grooming / Hygiene		Continence	
Bathing		Transferring	
Dressing		Mobility	

PROBLEM SEVERITY CODE

0 = None; no problem present	3 = Moderate; able to function with support
1 = Problem; controlled at time of assessment	4 = Marked; able to function only with daily intervention
2 = Mild; function could be improved	5 = Severe; incapacitated by the problem

D. HOSPICE SERVICES

Document the proposed services for this benefit period (include frequency and expected outcome). (Services furnished by Hospice)

SERVICES REQUIRED	FREQUENCY	EXPECTED OUTLOOK	HOSPICE
Skilled Nursing			

D. HOSPICE SERVICES (continued)

SERVICES REQUIRED	FREQUENCY	EXPECTED OUTLOOK	HOSPICE
Inpatient Hospital			
Outpatient Hospital			
Physician Services			
Pharmacy			
Other Enhanced Services			

E. CURATIVE CARE SERVICES

Identify and delineate the curative care services and the manner in which the services and assessments are coordinated.

SERVICE	FREQUENCY	EXPECTED OUTLOOK	CURATIVE CARE

E. CURATIVE CARE SERVICES <i>(continued)</i>			
SERVICE	FREQUENCY	EXPECTED OUTLOOK	CURATIVE CARE

F. SIGNATURES		
<i>Sign and date the following. Signatures must represent the Medical Director as well as two (2) signatures from any of the other curative care disciplines listed above.</i>		
Signature	Title	Date (month, day, year)
Signature	Title	Date (month, day, year)
Signature	Title	Date (month, day, year)