POC TASK LIST for WEEKLY LONG TERM–PERSONAL CARE SERVICES / ELDERLY and DISABLED ADULT WAIVER–COMPANION SERVICES

SUPPORT COORDINATION OR SINGLE POINT OF ENTRY AGENCY NAME & TELEPHONE #: _____

PARTICIPANT NAME: _____ MEDICAID ID #: _____

DATE DEVELOPED: _____ DATE APRROVED BY REGIONAL OFFICE: _____

Day of Week:	Sunday				Monday				Tuesday				Wednesday				Thursday				Friday				Saturday			
1ST Expected Arrival Time/Day →																												
1ST Anticipated Departure Time/Day →																												
2ND Expected Arrival Time/Day →																												
2ND Anticipated Departure Time/Day →																												
	LT-PCS	CS-1	CS-2	CS-3	LT-PCS	CS-1	CS-2	CS-3	LT-PCS	CS-1	CS-2	CS-3	LT-PCS	CS-1	CS-2	CS-3	LT-PCS	CS-1	CS-2	CS-3	LT-PCS	CS-1	CS-2	CS-3	LT-PCS	CS-1	CS-2	CS-3
Daily Total # of LT-PCS & CS Hours →																												
Daily Total # of LT-PCS & CS Units →																												
Weekly SHARe Allocations →	LT-PCS: Hrs X 4 = Units EDA-CS for 1: Hrs X 4 = Units EDA-CS for 2: Hrs X 4 = Units EDA-CS for 3: Hrs X 4 = Units																											
Tasks To be Completed↓ Indicate Task/Service Type To Be Completed Each Day W/Check Mark →	LTPCS	CS1	CS2	CS3	LTPCS	CS1	CS2	CS3	LTPCS	CS1	CS2	CS3	LTPCS	CS1	CS2	CS3	LTPCS	CS1	CS2	CS3	LTPCS	CS1	CS2	CS3	LTPCS	CS1	CS2	CS3
Eating																												
Bathing																												
Dressing																												
Grooming																												
Transferring																												
Ambulation																												
Toileting																												
Light Housekeeping																												
Food Preparation & Storage																												
Grocery Shopping																												
Laundry																												
Medication Reminders																												
Assist To Sched Med Appts																												
Assist To Arrange Med Trans																												
Accompany To Med Appts																												
Supv/Assist W/Health Tasks																												
Supv/Assist W/Comm Tasks																												
Supv/Assist For Safety																												

POC PROVIDER AGREEMENT for
WEEKLY LONG TERM–PERSONAL CARE SERVICES / ELDERLY and DISABLED ADULT WAIVER–COMPANION SERVICES / ADULT DAY HEALTH CARE SERVICES

SUPPORT COORDINATION OR SINGLE POINT OF ENTRY AGENCY NAME & TELEPHONE #: _____
PARTICIPANT NAME: _____ **MEDICAID ID #:** _____ **DATE DEVELOPED:** _____

This Participant Schedule is subject to change depending on the participant's preferences and fluctuations in his/her personal schedule. Therefore the anticipated schedule on the approved POC Task List and/or POC and Individualized Service Plan shall not be used for audit or monitoring purposes. Weekly allocations are to be used flexibly, in accordance with the participant's preferences and personal schedule within the week that begins on Sunday @ 12:00 a.m., and ends on the following Sunday @ 12: 00 a.m. Allocations are to be used within the prescribed week only. Unused portions of a weekly allocation cannot be saved or borrowed from one week for use in another week. Total hours used within the week may not exceed the prior authorized weekly allocation. Total number of days of ADHC attendance may not exceed the prior authorized weekly allocation.

X_____ X_____
☐Participants or ☐Personal Representative's Signature and Date — Support Coordinator's or Assessor's Printed Name and Signature and Date

☐We agree to provide services/supports in accordance with the approved POC Task List and/or POC and Individualized Service Plan. Completion of the provider number(s) section(s) below denotes type(s) of service to be provided.
*If you (Provider) do not agree to provide services/supports in accordance with the approved POC Task List and/or POC and Individualized Service Plan, you must submit written documentation that supports your inability to meet the individual's health and welfare needs, or to support that all previous efforts to provide services/supports have failed, and that there is no option but to refuse service provision.
☐ If not agreeing to provide services to this participant, I (Provider) have attached requested information.

X_____ _____ _____ _____
Provider Agency Printed Name and Numbers — LT-PCS Provider # — EDA-CS Provider # — ADHC Provider #

X_____ _____ _____ _____
2nd Provider Agency Printed Name and Numbers (if applicable) — LT-PCS Provider # — EDA-CS Provider # — ADHC Provider #

X_____
Pre-Approval Provider Agency Representative Printed Name and Title and Signature and Date

X_____
2nd Pre-Approval Provider Agency Representative Printed Name and Title and Signature and Date (if applicable)

X_____
OAAS Regional Office Representative Approval Signature and Date

X_____
Post-Approval Provider Agency Representative Printed Name and Title and Signature and Date

X_____
2nd Post-Approval Provider Agency Representative Printed Name and Title and Signature and Date (if applicable)