Prescribed Pediatric Extended Care Center (PPECC) Plan of Care Instructions

Use the guidelines below in filling out the PPECC Plan of Care (POC) form. Additional pages may be attached, as needed.	
Section A: Client Information	
Client's name*	Last name, first name, middle initial
Date of birth*	Date of birth given by month, day, and year
Date last seen by ordering physician	Client must be seen by the ordering physician within 30 days of the initial start of care, and at least once each year
Medicaid number*	Nine-digit number from client's current Medicaid identification card
Section B: Rendering PPECC Provider Information	
Name*	Name of PPECC provider
Hours of operation	Provide the PPECC's hours of operation for client services, including time zone. For example, 7 a.m. – 7 p.m., Central
Fax	Number that the provider can be reached by fax
Telephone	Area code and telephone number of provider
Street Address*	Provider mailing address (street, city, state, and ZIP + 4 Code)
PPECC provider license number	The PPECC provider's license number
Benefit Code*	Provider's benefit code
Tax ID	Provider's Tax Identification Number (TIN)
NPI*	National Provider Identifier number (10-digit)
Taxonomy*	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the PPECC
Date of PPECC nursing assessment	Indicate the date that the PPECC assessment and intake was completed
Registered Nurse's (RN) name	The name of the RN who completed the nursing assessment in Section B must be the RN who completes and signs the PPECC Plan of Care in Section F
Telephone	Provide the RN's telephone number
Title and credentials of RN	List the title and credentials of the RN completing and signing the PPECC Plan of Care
Section C: Private Duty Nursing (PDN) Provider Information (If known, PPECC to complete this section if client receives PDN services)	
Name	Name of PDN provider
Fax	Number that the provider can be reached by fax
Telephone	Area code and telephone number of PDN provider
Address	Provider mailing address (street, city, state, and ZIP Code)
Tax ID	PDN provider's TIN
NPI	PDN provider's National Provider Identifier number (10-digit)
Section D: Requesting Physician Information	
Name*	Name of physician requesting PPECC services. The physician's name on the PPECC Plan of Care must match the physician's name on the CCP Prior Authorization Request Form
Telephone	Area code and telephone number of requesting physician
NPI*	National Provider Identifier number (10-digit) of requesting physician
Section E: Plan of Care Information	
Status (initial / new client, revision, or recertification) and effective dates*	Indicate with a check mark if POC is for an initial request/new client, revision, or recertification request. Indicate from and to dates of authorization period for ordered PPECC services (up to 90 days for initial authorization, and 180 days for recertification). For a recertification request, the authorization "from" date should reflect the start date of the extension period. Revision end dates are always the end of the existing authorization period (initial or recertification).

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Section E: Plan of Care Information (cont.)	
Services client receives from other agencies, and if applicable, from the client's school	List other community or state agency services client receives, including in school and in the home. Examples: School Health and Related Services, Early Childhood Intervention, Medically Dependent Children's Program, etc.
Client Schedule	Include client's scheduled days and hours of attendance, including the exact time of day
Diagnoses, including any known allergies	Diagnosis related to ordered PPECC services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered.
Functional limitations/ permitted activities	Include on revised request, only if pertinent
Nutritional requirements	Provide details of the client's nutritional requirements, including the type, method of administration and frequency. Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable.) May also include nutritional counseling for client or client's responsible adult.
Mental status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, clinical condition, nursing observations pertinent to the plan of care, the proposed plan of treatment, and instructions for discharge.
Client stable to receive PPECC transportation services	Indicate with a check mark yes or no if the client is stable to receive PPECC transportation services. If yes, indicate with a check mark the provider type, RN/LVN or direct care staff, that must accompany the client on the PPECC transport vehicle.
Client and/or responsible adult training needs	Describe training needs of client's responsible adult or the client.
Responsible adult name and phone number	Document the name of the client's responsible adult and phone number.
Emergency contact name and phone number	Document an alternative emergency contact name and phone number in the event that the client's responsible adult cannot be reached.
Wound description and ordered care	Describe any wounds, including location and size, and care for those wounds.
Nursing services requested	List nursing services, including amount, duration, and frequency.
Therapies provided in PPECC	State the therapies (i.e., OT, PT, ST) to be provided in the PPECC. Therapies provided in the PPECC must be authorized and billed separately.
Therapies provided outside of PPECC	State the therapies (i.e., OT, PT, ST) the client receives outside of the PPECC.
Equipment or supplies required	List each piece of durable medical equipment (DME) or supplies required by the client, and clarify if the DME or supplies will be brought by the client to the PPECC, or provided by the PPECC during PPECC services.
Other treatments or prescribed services	List other treatments or prescribed services, including the amount, frequency, and duration that are provided in the PPECC, including functional development and psychosocial services.
Prescribed medications	List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable).
Confirmation that a signed contingency plan is in place	Affirm that a plan is in place in the event that PPECC services are unavailable, and for emergencies that occur while the client is in the PPECC's care.
Section F: Required Signatures	
RN signature, date signed	The signature and date this form was filled out and completed by the RN. The RN who signs the PPECC Plan of Care must be the same RN named in Section B.
Physician signature, date signed, printed physician name	Provide the requesting physician's signature and date signed. This signature serves as the physician order for PPECC services. The PPECC Plan of Care and the CCP Prior Authorization Request Form must be signed by the same physician.
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.