24-hour Plan of Care

(optional format of required document)

CHILD	PARENT/GUARDIAN	DATE OF BIRTH / AGE	DATE

OVERVIEW

Please complete your plan of care, describing a day of caring for your child. Include the amount of time and how often it takes for care to be done. Share the things that make care difficult so we may better understand the needs of the child, caregivers, and family members.

Examples may include; preparing/giving medications, suctioning, breathing support, medical equipment used, therapy, feedings, bathing, dressing, diaper changes, hurting themselves or others, emotional/physical outbursts, tantrums, etc.

(Boxes below will expand)

AMOUNT OF TIME AND HOW OFTEN	DESCRIBE THINGS DONE FOR YOUR CHILD
MORNING	
AFTERNOON	
EVENING	
BEDTIME	

AMOUNT OF TIME AND HOW OFTEN	DESCRIBE THINGS DONE FOR YOUR CHILD
NIGHT	

List the services/supplies you are trying to get and can not because your child does not have Medicaid:

Any other additional information that would be helpful in understanding the care for your child: