Prescribed Pediatric Extended Care Center (PPECC) Plan of Care

Section A: Client Information	
Client's name:	Date of birth:
Date last seen by ordering physician:	Medicaid number:

Section B: PPECC Provider Information		
Name:	Fax number:	Telephone:
Hours of operation: Open: _____ a.m. Close: _____ p.m. ☐ Central Time ☐ Mountain Time		
Address:	PPECC provider license number:	
TPI:	NPI:	Taxonomy:
Date of PPECC nursing assessment:		
Registered Nurse's name:	Telephone:	
Title and credentials of RN:		

Section C: Private Duty Nursing (PDN) Provider Information (If known, PPECC to complete this section if the client receives PDN services)		
Name:	Fax number:	Telephone:
Address:		
TPI:	NPI:	

Section D: Prescribing Physician Information	
Name:	Telephone:
TPI:	NPI:

Section E: Plan of Care Information			
Status (check one):	☐ Initial / New client	☐ Recertification	☐ Revision
Requested start date:	Requested end date:		
Services client receives from other agencies, and if applicable, from the client's school:			
Client schedule:			
Diagnoses, including known allergies:			
Functional limitations / Permitted activities:			
Nutritional requirements (type, method of administration and frequency):			
Mental status:			
Prognosis:	Rehabilitation potential:		

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Section E: Plan of Care Information (cont.)	
Safety precautions:	
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if OT/PT requested, permitted activities, etc.):	
PPECC transportation required? ☐ Yes ☐ No If no, who will provide transportation?	
Client and/or responsible adult training needs:	
Responsible adult:	Telephone:
Emergency contact:	Telephone:
Wound description and ordered care:	
Nursing services requested:	
Therapies (OT, PT, ST) to be provided in the PPECC:	
Therapies (OT, PT, ST) provided outside of PPECC:	
Equipment or supplies required. Will the equipment required be brought from home, or provided at the PPECC?	

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Section E: Plan of Care Information (cont.)

Other prescribed services, including the amount, frequency and duration that are provided in the PPECC, including functional development and psychosocial services:

Prescribed Medication	Route	Dose	Frequency		Prescribed Medication	Route	Dose	Frequency

Signed contingency plan in place? ☐ Yes ☐ No

Section F: Required Signatures

The RN signing below should be the same RN named in Section B, above. The physician's signature on this form is required to be from the same physician who signed the CCP Prior Authorization Request Form. This signature serves as the physician order for PPECC services.

Responsible adult signature:	Date signed:
RN signature:	Date signed:
Prescribing physician signature:	Date signed:

Conflict of Interest Statement

PPECC Prescriber Conflict of Interest Statement:

By signing this form, I certify that I am in compliance with federal or state rule or law prohibiting self-referral or kick-backs (check the appropriate box below):

- ☐ I do have a financial interest that complies with federal or state rule or law prohibiting self-referral or kick-backs.
- ☐ I do *not* have a financial interest, and comply with federal or state rule or law prohibiting self-referral or kick-backs.