



Peaks & Plains, Inc.

Phone 1-800-585-4201; Fax 1-800-886-3122

Incontinence Care Plan for Glove Supplies Facility Statement of Medical Necessity

Facility Name: _____

Facility Address: _____

Resident Name: _____

Date of Birth: _____

Date of Toileting Plan Started _____ Date of Toileting Plan Ended: _____

- Please use the chart below to show a sample of your daily toileting plan.
- A full month's toileting plan is available on line at: www.peaks-plains.com/toiletingplan.pdf

Product Used: Pullups ___ Briefs ___ Liners ___

Client is toileted every _____ hours

Incontinence is: Bladder ___ Bowel ___ Full Assist ___ Partial Assist ___

HRSA will allow 4 boxes of gloves for clients where they live in facilities where caregivers must wear gloves to assist with changing the incontinent product. This will be handled by an EPA process that will allow 4 boxes depending on where the client lives.

Date: _____ Date: _____

Time	Toileted	Wet	Dry	Initials		Time	Toileted	Wet	Dry	Initials

Signature of Facility Care Giver: _____ Date: _____

Print Name of Facility Care Giver: _____