

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS (DHH)
OFFICE OF AGING AND ADULT SERVICES (OAAS)
PLAN OF CARE (POC)**

Program Choice (Check all that apply): <input type="checkbox"/> ADHC Waiver <input type="checkbox"/> EDA Waiver <input type="checkbox"/> LT-PCS			Plan Type: <input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> Status Change (Revision)			MY Place LA Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No		POC Approved without RO review: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Support Coordination Agency:					Name of Support Coordinator:				
SECTION A: IDENTIFYING INFORMATION									
First Name:			Middle Name		Last Name:			Suffix:	
Birthdate:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN:	Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other				
Medicaid No.:					Medicare No.				
Private Insurance Name:					VA Benefits: <input type="checkbox"/> Yes, <input type="checkbox"/> No				
Home Phone Number:				Alternate Phone Number/Cell:					
Street Address:				City:			State:		Zip Code:
Mailing Address:				City:			State:		Zip Code:
SECTION B: PERSONAL REPRESENTATIVE INFORMATION									
First Name:			Middle Name:		Last Name:			Suffix:	
Age:	Relationship:		Lives with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Contact : <input type="checkbox"/> Yes <input type="checkbox"/> No		Responsible for Evacuation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Power of Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No Type:
Home Phone Number:				Alternate Phone Number/Cell:					
Street Address:				City:			State:		Zip Code:
SECTION C: LEGAL STATUS									
<input type="checkbox"/> Full Interdiction <input type="checkbox"/> Limited Interdiction <input type="checkbox"/> Tutorship <input type="checkbox"/> Competent Major									
SECTION D: ADDITIONAL POWER OF ATTORNEY									
First Name:			Middle Name:		Last Name:			Suffix:	
Age:	Relationship:		Lives with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Contact : <input type="checkbox"/> Yes <input type="checkbox"/> No		Responsible for Evacuation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone Number:			Alternate Phone Number/Cell:			Type of Power of Attorney:			
Street Address:				City:			State:		Zip Code:

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3. Social Contacts

How often does Participant talk with children, family or friends, either during a visit or over the phone:

Children: No Children Daily Weekly Monthly Less than Monthly Never

Other Family: No other family Daily Weekly Monthly Less than Monthly Never

Friends/Neighbors: No Friends/Neighbors Daily Weekly Monthly Less than monthly Never

(Note preferences and other important information related to relationships for this participant (e.g. No immediate family or friends, would like to visit local church to develop friendships, participant has 4 children, 2 sons and 1 daughter, but only 1 of her sons lives close by and checks in on her daily, very close to his/her pets):

SECTION G: ASSISTANCE CURRENTLY PROVIDED/AVAILABLE

Describe assistance currently available to the participant either through informal caregivers or community programs. You may use the Routines Map and Relationships Map to collect the information for this section.

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SECTION H: SERVICES CURRENTLY UTILIZED

SERVICE	PROVIDER/FREQUENCY	SERVICE	PROVIDER/FREQUENCY	SERVICE	PROVIDER/FREQUENCY
<input type="checkbox"/> ADHC Waiver		<input type="checkbox"/> Home Delivered Meals		<input type="checkbox"/> Food Bank	
<input type="checkbox"/> EDA Waiver		<input type="checkbox"/> Support Coordination		<input type="checkbox"/> Grant Program Services	
<input type="checkbox"/> ADHC Service		<input type="checkbox"/> Mental Health Services (Inpatient/outpatient)		<input type="checkbox"/> Other, Specify: (e.g., Respite)	
<input type="checkbox"/> LT-PCS		<input type="checkbox"/> Councils on Aging Services			
<input type="checkbox"/> Home Health -List Type and Frequency (number of days/wk & number of hrs/day)			<input type="checkbox"/> Hospice - List Frequency (number of days/wk & number of hrs/day)		

SECTION I: PHYSICIAN CONTACT INFORMATION

Doctor's Name:	<input type="checkbox"/> Primary Care	Phone Number:
Doctor's Name:	<input type="checkbox"/> Specialty-Specify:	Phone Number:
Doctor's Name:	<input type="checkbox"/> Specialty-Specify:	Phone Number:
Doctor's Name:	<input type="checkbox"/> Specialty-Specify:	Phone Number:
Doctor's Name:	<input type="checkbox"/> Specialty-Specify:	Phone Number:

SECTION J: ALLERGIES

Allergies: Yes (If "Yes", specify below) No Known Allergies

Food Allergies (List):	(Describes what happens):
Medication Allergies (List):	(Describes what happens):
Environmental Allergies (List):	(Describes what happens):

Participant Name (First): _____

(Last): _____

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SECTION K: MEDICATIONS

Physician Delegation Attached if applicable Yes Not Applicable

Medication Management	Does Participant have any problems with medications? (check all that apply)	How does participant currently take medications? (check all that apply)
	<input type="checkbox"/> Adverse reactions/allergies (see above)	<input type="checkbox"/> Without assistance
	<input type="checkbox"/> Forgets to take medicine	<input type="checkbox"/> With assistance from family/friends
	<input type="checkbox"/> Getting to pharmacy	<input type="checkbox"/> Administered by paid caregiver
	<input type="checkbox"/> Cost of medication	<input type="checkbox"/> Administered by health professional (nurse, doctor, etc.)
	<input type="checkbox"/> Other, Specify:	<input type="checkbox"/> Other, Specify:

SECTION L: ASSISTIVE DEVICES/EQUIPMENT CURRENTLY UTILIZED

Check all that apply	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> Slide Board	<input type="checkbox"/> Dentures
	<input type="checkbox"/> Respirator	<input type="checkbox"/> Cane	<input type="checkbox"/> Shower Chair	<input type="checkbox"/> Glucometer:
	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Walker	<input type="checkbox"/> Communication Device	<input type="checkbox"/> Bedside Commode
	<input type="checkbox"/> Suction Machine	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Other, Specify:
	<input type="checkbox"/> CPAP Machine	<input type="checkbox"/> Hoyer Lift	<input type="checkbox"/> Eyeglasses	<input type="checkbox"/> Other, Specify:

SECTION M: ADL/IADL/OTHER TASKS

ADL Task	Needs Assistance	Level of Support Required Note: Though MDS should be reviewed, level may differ from what is indicated in MDS. Level is based on assistance needed, not on assistance received in last 7 days.	Describe what formal support will be expected to do in performing or assisting the participant to perform the task including participant preferences.
Eating	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	
Bathing	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	

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(Last): _____

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(continued) ADL Task	Needs Assistance	Level of Support Required Note: Though MDS should be reviewed, level may differ from what is indicated in MDS. Level is based on assistance needed, not on assistance received in last 7 days.	Describe what formal support will be expected to do in performing or assisting the participant to perform the task including participant preferences.
Dressing	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	
Grooming	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	
Transferring	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	
Ambulation	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	
Toileting	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Setup Help <input type="checkbox"/> Supervision <input type="checkbox"/> Hands on Assistance <input type="checkbox"/> Total Dependence	

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IADL TASKS

IADL Task	Needs Assistance	Level of Support Required Note: Though MDS should be reviewed, level may differ from what is indicated in MDS. Level is based on assistance needed, not on assistance received in last 7 days.	Describe what formal support will be expected to do in performing or assisting the participant to perform the task including Participant Preferences.
Light Housekeeping	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Food Preparation & Storage	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Grocery Shopping	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Laundry	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Medication Reminders	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	

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(continued) IADL Task	Needs Assistance	Level of Support Required Note: Though MDS should be reviewed, level may differ from what is indicated in MDS. Level is based on assistance needed, not on assistance received in last 7 days.	Describe what formal support will be expected to do in performing or assisting the participant to perform the task including Participant Preferences.
Assistance Arranging Medical Transportation	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Assistance Scheduling Medical Appointments	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Accompanying to Medical Appointments	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Independent <input type="checkbox"/> Some Help <input type="checkbox"/> Full Help	
Other Tasks	Needs Assistance	Type of Support Required, Justification of Need and Preferences	
Supervision or Assistance with Other Health Related Tasks	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Supervision or Assistance with Community Related Tasks	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Supervision or Assistance Related to Safety Purposes	<input type="checkbox"/> No <input type="checkbox"/> Yes		
OTHER COMMENTS:			

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SECTION N: See FLEXIBLE SCHEDULE

SECTION O: See EXCEL BUDGET WORKSHEET

SECTION P: PLAN OF CARE (POC) PARTICIPANTS

All participants in the plan of care development meeting must sign below indicating that he/she participated in the planning process.

Signatures of POC Attendees:	Relationship to Participant:	Date:
	Participant	
	Support Coordinator/Assessor	

Signature of Reviewing Support Coordinator/Assessor Supervisor:	Date of Review:
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SECTION Q: APPLICANT/PARTICIPANT ACKNOWLEDGMENT AND SIGNATURE

By signing below, I agree to the following statements:

- All information on the OAAS *Rights and Responsibilities for Applicants/Recipients/Participants of Home and Community-Based Services (HCBS) including information about how to report abuse, neglect, and critical incidents* has been reviewed/re-reviewed with me, and I have received a copy.
- I have been offered/reoffered freedom of choice of all providers of services contained in this plan and have exercised my right to freely choose these providers.
- I understand that I have the right to choose between institutionalization and home and community-based services and have opted to receive home and community-based services.
- My support coordinator has explained the services available in this waiver and allowed me the opportunity to choose the services which best meet my needs and has reviewed the contents of this plan with me.
- I understand I have the right to accept or to refuse all or part of the services identified in this plan.
- I understand that I have the responsibility to notify my support coordinator/assessor of changes in my status and/or my income which might affect my eligibility for and/or the effectiveness of these services. I also understand the reasons that may cause me to lose these supports and services.

X _____
 Participant's Signature or Personal Representative's Signature Date: _____

SECTION R: OAAS OR DESIGNEE PLAN OF CARE (POC) ACTION

Date POC Accepted as Complete:	Approval Date:	POC Begin Date:	POC End Date:
<input type="checkbox"/> POC Denied	Denial Reason:		
<input type="checkbox"/> POC Referred to Service Review Panel	Date:	Findings:	

_____	_____
OAAS or Designee Authorized Representative's Signature	Date