

**DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF AGING AND ADULT SERVICES (OAAS)
DOCUMENT CHECKLIST**

PARTICIPANT NAME: (First; Middle Initial; Last)	DATE:
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TYPE OF WAIVER: <input type="checkbox"/> EDA <input type="checkbox"/> ADHC	NF TRANSITION: <input type="checkbox"/> YES <input type="checkbox"/> NO	MY PLACE LA PARTICIPANT: <input type="checkbox"/> YES <input type="checkbox"/> NO
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SUPPORT COORDINATION AGENCY:	SUPPORT COORDINATOR:
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DOCUMENTS TO BE SUBMITTED TO OAAS REGIONAL OFFICE WITH THE POC

DOCUMENT	INITIAL POC	ANNUAL POC
148 W - Form	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached (status change only)
Personal Representative Form	<input type="checkbox"/> Attached	
ADHC Service Provider FOC (if applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
Companion Service Provider FOC (if applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
LT-PCS Service Provider FOC (if applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
PERS Service Provider FOC (if applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
Environmental Accessibility Adaptations (EAA) Provider FOC (if applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
OAAS Plan of Care (POC)	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached
OAAS Budget Sheet (Section O of POC)	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached
Client Assessment Protocols (CAPs)	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached
Physician Delegation (If applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
Power of Attorney (if applicable)	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
Statement of Medical Status (SMS) - Required for PW 3, 4, or 5 only	<input type="checkbox"/> Attached <input type="checkbox"/> N/A	<input type="checkbox"/> Attached <input type="checkbox"/> N/A
Provider Back Up Plan	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached

DOCUMENTS REQUIRED BUT MAY BE SUBMITTED LATER TO OAAS REGIONAL OFFICE

OAAS Emergency Plan & Agreement (Must submit no later than 14 days after POC has been submitted)	<input type="checkbox"/> Attached	<input type="checkbox"/> Attached
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DOCUMENTS NO LONGER REQUIRED FOR SUBMISSION WITH POC

Home Health Plan	Linkage Form	Rights & Responsibilities Form	Task List Provider Agreement
Linkage Form	MDS-HC	Task List	

COMMENTS