

**PLAN OF CARE (POC)**

<b>Program Choice (Check all that apply):</b> <input type="checkbox"/> ADHC Waiver <input type="checkbox"/> EDA Waiver <input type="checkbox"/> LT-PCS		<b>Plan Type:</b> <input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> Status Change (Revision)	
<b>SECTION A: IDENTIFYING INFORMATION</b>			
First Name:	Middle Name	Last Name:	Suffix:
Birthdate:	Age:	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	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN:	
Race:  <input type="checkbox"/> American Indian/Alaskan Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander  <input type="checkbox"/> White/Caucasian  Ethnicity: <input type="checkbox"/> Hispanic or Latino	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: LA      Zip Code:
Mailing Address:		City:	State: LA      Zip Code:
<b>SECTION B: PERSONAL REPRESENTATIVE INFORMATION</b>			
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:	
Street Address:		City:	State:      Zip Code:

**SECTION C: LEGAL STATUS**

Full Interdiction  Limited Interdiction  Tutorship  Competent Major

**SECTION D: POWER OF ATTORNEY #1**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Lives with Participant:  Yes  No Emergency Contact:  Yes  No Responsible for Evacuation:  Yes  No

List Type of Power of Attorney: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_ Alternate Phone Number/Cell: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**POWER OF ATTORNEY #2**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Lives with Participant:  Yes  No Emergency Contact:  Yes  No Responsible for Evacuation:  Yes  No

List Type of Power of Attorney: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_ Alternate Phone Number/Cell: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**SECTION E: HOUSEHOLD MEMBERS (Other than Participant)**

NAME (First, Middle, Last & Suffix)	Age:	Relationship	This person requires Assistance to perform daily task: <input type="checkbox"/> Yes <input type="checkbox"/> No	This person receives HCBS (e.g., EDA, ADHC, LT-PCS, etc.) List Type(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	Works: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", List Work Start/End Times	Attends School <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", List School Start/End Times	Currently Provides Support: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid Approximate hours per week:
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid

**SECTION F: FAMILY NATURAL SUPPORT/NOT LIVING IN HOUSEHOLD**

NAME (First, Middle, Last & Suffix) AND ADDRESS (Street, City, State, Zip)	Age:	Relationship	This person requires Assistance to perform daily task: <input type="checkbox"/> Yes <input type="checkbox"/> No	Works: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", List Work Start/End Times	Attends School <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", List School Start/End Times	Currently Provides Support: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid Approximate hours per week:
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Paid <input type="checkbox"/> Paid

**SECTION G: PHYSICIAN CONTACT INFORMATION**

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

SECTION H: DISEASE DIAGNOSIS				
HEART/CIRCULATION	NEUROLOGICAL	MUSCULO/SKELETAL	PSYCHIATRIC/MOOD	OTHER DISEASES
<input type="checkbox"/> Cerebrovascular Accident	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Arthritis	<input type="checkbox"/> psychiatric diagnosis (Specify)	<input type="checkbox"/> Cancer (In past 5 years – not including skin cancer)
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Dementia other than Alzheimer's Disease	<input type="checkbox"/> Hip Fracture	<b>INFECTIONS</b>	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Other Fractures (e.g., wrist, vertebral)		<input type="checkbox"/> HIV Infection
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hemiplegia/Hemiparesis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Irregular Pulse	<input type="checkbox"/> Multiple Sclerosis	<b>SENSES</b>	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid Disease (Hyper/Hypo)
<input type="checkbox"/> Periph. Vascular Disease	<input type="checkbox"/> Parkinsonism		<input type="checkbox"/> Cataract	<input type="checkbox"/> Glaucoma
		<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Urinary Tract Infection (In last 30 days)	<input type="checkbox"/> Other Current Diagnosis (Specify)
SECTION I: ALLERGIES				
Allergies: <input type="checkbox"/> Yes (If "Yes", specify below) <input type="checkbox"/> No Known Allergies				
Food Allergies (Describe what happens):				
Medication Allergies (Describe what happens):				
Environmental Allergies (Describe what happens):				



SECTION K: MEDICAL PROCEDURES/TREATMENTS/THERAPIES					
Type	Frequency	Administered by: <input type="checkbox"/> Self (S) <input type="checkbox"/> Family (F) Medical Professional (MP) <input type="checkbox"/> Other, Specify (O,S):	Type	Frequency	Administered by: <input type="checkbox"/> Self (S) <input type="checkbox"/> Family (F) Medical Professional (MP) <input type="checkbox"/> Other, Specify (O,S):
<input type="checkbox"/> Oxygen		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Ventilator-Related Interventions		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> Respirator or assistive breathing		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Transfusions		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> Tracheal suctioning/care		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Chemotherapy		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> Nebulizers		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Dialysis		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> C-PAP		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Ostomy		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
Tube Feeding <input type="checkbox"/> NG-Tube <input type="checkbox"/> Peg Tube		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Exercise Therapy		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> IV Fluids/Medications		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> Wound Care <input type="checkbox"/> Decubitus Care		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:
<input type="checkbox"/> Other, Specify:		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:	<input type="checkbox"/> Other, Specify:		<input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> MP <input type="checkbox"/> O,S:

Physician Delegation Attached if applicable Yes Not Applicable

SECTION L: 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"/> Councils on Aging Services	
<input type="checkbox"/> EDA Waiver		<input type="checkbox"/> Home Health		<input type="checkbox"/> Food Bank	
<input type="checkbox"/> LT-PCS		<input type="checkbox"/> Hospice		<input type="checkbox"/> Grant Program Services	
<input type="checkbox"/> Support Coordination		<input type="checkbox"/> Mental Health Services (Inpatient/outpatient)		<input type="checkbox"/> Other, Specify: (e.g., Respite)	

**SECTION M: ASSISTIVE DEVICES/EQUIPMENT CURRENTLY UTILIZED**

<b>Assistive Devices/ Equipment (Check all that apply)</b>	<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"/> Other, Specify:
	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Walker	<input type="checkbox"/> Communication Device	<input type="checkbox"/> Other, Specify:
	<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 N: EMERGENCY EVACUATION INFORMATION**

**Ambulation/Locomotion:**  No Problems  Limited Ability  Ambulatory with Aide or Device(s)  Non-Ambulatory

<b>Mode of Locomotion (Check all that apply):</b>	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair with Assistance	<input type="checkbox"/> Scooter without Assistance
	<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair without Assistance	<input type="checkbox"/> Other, Specify:

<b>Emergency Response Level:</b>	<input type="checkbox"/> Level 1: Evacuate with Total Assistance and Life Sustaining Equipment
	<input type="checkbox"/> Level 2: Evacuate with Total Assistance
	<input type="checkbox"/> Level 3: Can Self-Evacuate but needs Transportation
	<input type="checkbox"/> Level 4: Can Self-Evacuate Independently

<b>Emergency Equipment In the Home:</b>	<input type="checkbox"/> Fire Extinguisher, Specify Location:
	<input type="checkbox"/> Home Evacuation Plan, Specify Location:
	<input type="checkbox"/> Smoke Detector(s), Specify Location:
	<input type="checkbox"/> Emergency Preparedness Kit, Specify Location:
	<input type="checkbox"/> First Aid Supplies, Specify Location:
	<input type="checkbox"/> Specialized medical Equipment (e.g., Ventilator, Suction Machine, Oxygen, etc.), Specify Location:
<input type="checkbox"/> Other, Specify:	

<b>Primary Person Responsible for Evacuation:</b>	First Name:	Middle Name:	Last Name:	Suffix:
	Home Phone Number:	Work/Office Number:	Cell Number:	
	Street Address:		Relationship:	
	City:	State:	Zip Code:	
	Lives with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No Works: <input type="checkbox"/> Yes <input type="checkbox"/> No Attends School: <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Secondary Person Responsible for Evacuation:</b>	First Name:	Middle Name:	Last Name:	Suffix:
	Home Phone Number:	Work/Office Number:	Cell Number:	
	Street Address:		Relationship:	
	City:	State:	Zip Code:	
	Lives with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No Works: <input type="checkbox"/> Yes <input type="checkbox"/> No Attends School: <input type="checkbox"/> Yes <input type="checkbox"/> No			

**SECTION O: PARTICIPANT PROFILE**

**Primary Concern(s)**

Primary reason(s) or concern(s) that led participant/personal representative/family to seek services (Document participant's/personal representative's/family's perspective regarding what kind of assistance is being requested at this time, and why.):

**Current Living Situation**

Describe participant's current living situation (e.g., lives alone, lives with family/friends, 32 year old daughter lives with participant and currently provides some ADL and IADL assistance, participant new to this neighborhood, released from nursing facility/rehab. Facility 2 months ago, etc.)

**SECTION O: PARTICIPANT PROFILE**

**Communication**

- Can fully communicate with no impairment or only minor impairment (e.g., slow speech)
- Can fully communicate with use of assistive devices (e.g., communication board)
- Can communicate only basic needs to others
- No effective communication, depends on others to communicate needs
- Can understand others without difficulty
- Has problems understanding others (e.g., gets confused easily, does not process information well, etc.)
- Other, Specify:

Note preferences, and other important information related to communication for this participant (e.g., speak slowly and modify tone, turn down volume on TV/radio before addressing participant, speak in direction of "good ear", make sure participant can see your lips when speaking to him/her, etc.):

**Vision**

- Can see adequately without assistive devices
- Can see adequately with use of assistive devices (e.g., eyeglasses, magnifier, etc.)
- Impaired - Sees large print, but not regular print
- Moderately Impaired – Limited vision, not able to see newspaper print but can identify objects
- Highly Impaired – Object identification in question, but eyes appear to follow objects
- Severely Impaired – No vision or sees only light, colors, or shapes, eyes do not appear to follow objects

Note preferences, and other important information related to vision for this participant (e.g., place objects to right side and in front of participant, touch lightly on hand to let participant know where objects are placed, place eyeglasses by bedside, etc.):

**SECTION O: PARTICIPANT PROFILE – Continued**

**Cognition**

- No memory impairments evident during assessment process
- Short Term Memory Problem (e.g., unable to recall items after 5 minutes)
- Procedural Memory Problem (e.g., could not perform steps in multitask sequence without cues for initiation)
- No problems with Daily Decision Making
- Problems with Daily Decision Making
- Can make safe decisions in familiar/routine situations, but needs some help with decision making when faced with new tasks or situations
- Needs help with reminding, cueing, even with familiar routine
- Other, Explain:

Note preferences, and other important information related to cognition for this participant (e.g. use, calm even voice when cueing, provide assistance with initiation of task such as placing food on fork, make brushing motion to help initiate tooth brushing, etc.):

**Behavior**

- Wanders (Moves without rational purpose, seemly oblivious to needs or safety)
- Daytime wandering but sleeps nights
- Wanders at night or during the day
- Verbally abusive behavioral symptoms (e.g., threatens or screams at others)
- Physically abusive behavioral symptoms (e.g., hits, shoves, scratches)
- Socially Inappropriate/Disruptive Behavioral symptoms (e.g., makes disruptive sounds, noises, screams)
- Resist care: Resisted taking medications/injections, ADL assistance, eating, or changes in position (related to cognitive issues, and not due to right to refuse care)

Note preferences, and other important information related to cognition for this participant (e.g. Use, calm even voice, gently place hand on elbow and redirect movements away from front door, back in house, make sure all door s are securely locked, etc.):

**SECTION O: PARTICIPANT PROFILE – Continued**

**Nutrition**

- No special diet or dietary restrictions
- Special Diet, Specify (e.g., Diabetic Diet, No/Low Salt, No/Low Sugar, Low Fat/Cholesterol, Thickened Liquids to prevent choking):
- Dietary Restrictions, Specify (e.g., no nuts due to allergies):
- Tube feed
- Problems with Swallowing
- Problems Chewing/Chokes when eats/drinks, Specify below
- Problems with teeth or gums that hampers eating

Note preferences, and other important information related to nutrition for this participant (e.g., Followed by primary care physician for diabetes, prefers all liquids at room temperature, has dentures, but does not use due to painful gums, etc.):

**Social Participation/Community Involvement/Leisure Activities**

Are there things that the participant does that she/he finds especially enjoyable?

- Solitary Activities, Specify:
- With Groups/Clubs, Specify:
- Religious Activities, Specify:
- Visiting with friends and family
- Watching Television programs
- Other, Specify:

Are there socialization activities participant has indicated an interest in pursuing?  Yes  No

If "Yes", Specify:

Period of time Participant spends alone:  Never or hardly ever  About one hour  Long periods of time  All of the time

Note preferences, and other important information related to social participation, community involvement, or leisure activities for this participant (e.g. enjoys visiting with family and friends, but becomes agitated when activity takes more than one hour):

**SECTION O: PARTICIPANT PROFILE – Continued**

**RELATIONSHIPS**

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):

**Vocational**

- Retired
- Not Employed
- Employed full time
- Employed part-time
  
- Not interested in pursuing a job/new job
- Interested in pursuing a job/new job

Note preferences, and other important information related to vocational issues for this participant (e.g. Currently working at McDonalds, but would like to work at Wal-Mart):

**Educational**

- Educational Level Completed:
- Can currently read:  Yes  No
- Can currently write:  Yes  No
- Currently enrolled in Educational Program:  Yes  No
- Not interested in pursuing educational program/new educational program
  - Interested in pursuing educational program/new program

Note preferences, and other important information related to educational issues for this participant (e.g. Would like to take a class to learn how to read.)

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES						
ACTIVITIES OF DAILY LIVING (ADLs)						
<b>Codes: MDS-HC Section H2:</b> 0. Independent 1. Setup Help 2. Supervision (oversight, encouragement or verbal cueing)		<b>Codes: MDS-HC (continued):</b> 3. Limited Assistance (physical help in guided maneuvering – non-weight-bearing asst.) 4. Extensive Assistance (weight-bearing asst., active participant involvement – 50% or more of time) 5. Maximal Assistance (weight-bearing, 50% or less participant involvement) 6. Total Dependence (full performance of activity by another – participant not involved at all) 8. Activity Did Not Occur (regardless of ability)		<b>Needs Asst.</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Current Support</b> How does this ADL happen for participant now? Does participant do on his/her own? Assistance devices used? Other person(s) assist? If so, who currently assist?	<b>Type of Support Required &amp; Preferences</b> What is required, when, how often to assist/assure this ADL happens for participant? Who will provide support? What are participant's preferences?
ADL Task	Needs Asst.	Current Support	Type of Support Required and Preferences	Frequency and Duration of Paid Supports (Days & Approximate length of time required)		
Eating	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes					
MDS-HC Code:						
Bathing	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes					
MDS-HC Code:						
Dressing	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes					
MDS-HC Code:						

**SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued**

ADL Task	Needs Asst.	Current Support	Type of Support Required and Preferences	Frequency and Duration of Paid Supports (Days & Approximate length of time required)
Grooming	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
MDS-HC Code:				
Transferring	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
MDS-HC Code:				
Ambulation	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
MDS-HC Code:				
Toileting	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
MDS-HC Code:				

**SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued**

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADLs)**

Codes: MDS-HC (Section H. 1 A): 0. Independent 1. Some Help 2. Full Help 3. By Others 8. Activity Did Not Occur		Codes: MDS-HC (Section H. 1 B): 0. No Difficulty 1. Some Difficulty 2. Great Difficulty		Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes	Current Support How does this ADL happen for participant now? Does participant do on his/her own? Assistance devices used? Other person(s) assist? If so, who currently assist?	Type of Support Required and Preferences What is required, when, how often to assist/assure this ADL happens for participant? Who will provide support? What are participant's preferences?
IADL Task	Needs Asst.	Current Support		Type of Support Required and Preferences		Frequency and Duration of Paid Supports (Days & Approximate length of time required)
Light Housekeeping	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes					
MDS-HC Codes: A= B=						
Food Preparation & Storage	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes					
MDS-HC Codes: A= B=						
Grocery Shopping	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes					
MDS-HC Codes: A= B=						

**SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued**

IADL Task	Needs Asst.	Current Support	Type of Support Required and Preferences	Frequency and Duration of Paid Supports (Days & Approximate length of time required)
Laundry				
MDS-HC Codes: A= B=	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
Medication Reminders				
MDS-HC Codes: A= B=	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
Assistance Scheduling Medical Appointments	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
Assistance Arranging Medical Transportation	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
Accompanying to Medical Appointments	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			

**SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued**

**Other Tasks (Not provided by LT-PCS)**

Other Task	Needs Asst.	Current Support	Type of Support Required and Preferences	Frequency and Duration of Paid Supports (Days & Approximate length of time required)
Supervision or Assistance with Other Health Related Task	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
Supervision or Assistance with Community Related Task	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			
Supervision or Assistance Related to Safety Purposes	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes			

**SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued**

**Other Services/Supports (Not provided by LT-PCS)**

Other Services/ Supports	Needs Asst.	Current Support	Type of Support Required and Preferences
Personal Emergency Response System (PERS)	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes		
Environmental Accessibility Adaptations	Needs Asst. <input type="checkbox"/> No <input type="checkbox"/> Yes		

**SECTION P ADDITIONAL COMMENTS/NOTES**

**SECTION Q: PARTICIPANT/CLIENT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE**

CAPs	Triggered <input type="checkbox"/> "X" "if triggered	Planning CAP <input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time	Identified Issue/Concern	How is Issue/concern currently addressed/not addressed? What resources are available? What else is needed to address concern/Issue, if anything?	Interventions/Strategies	What is Anticipated Outcome?
<b>FUNCTIONAL PERFORMANCE</b>						
<b>ADL/Rehab Potential</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>IADLs</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Health Promotion</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Institutional Risk</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>SENSORY PERFORMANCE</b>						
<b>Communication Disorders</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Visual Function</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				

**SECTION Q: PARTICIPANT/CLIENT ASSESSMENT PROTOCOLS (CAPs) SUMMARY PAGE**

CAPs	Triggered <input type="checkbox"/> "X" "if triggered	Planning CAP <input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time	Identified Issue/Concern	How is Issue/concern currently addressed/not addressed? What resources are available? What else is needed to address concern/Issue, if anything?	Interventions/Strategies	What is Anticipated Outcome?
<b>MENTAL HEALTH</b>						
<b>Alcohol Abuse &amp; Hazardous Drinking</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Cognition</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Behavior</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Depression &amp; Anxiety</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
<b>Elder Abuse</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes				
<b>Social Function</b>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				

**SECTION Q: PARTICIPANT/CLIENT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE**

CAPs	Triggered <input type="checkbox"/> "X" if triggered	Planning CAP <input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time	Identified Issue/Concern	How is Issue/concern currently addressed/not addressed? What resources are available? What else is needed to address concern/issue, if anything?	Interventions/Strategies	What is Anticipated Outcome?
<b>HEALTH PROBLEMS/ SYNDROMES</b>						
Cardio-Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Dehydration	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Falls	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Nutrition	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Oral Health	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Pain	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Pressure Ulcers	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Skin & Foot Condition	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				

SECTION Q: PARTICIPANT/CLIENT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE - Continued						
CAPs	Triggered "X" if triggered	Planning CAP <input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time	Identified Issue/Concern	How is Issue/concern currently addressed/not addressed? What else is needed to address concern/Issue, if anything?	Interventions/Strategies	What is Anticipated Outcome?
<b>OVERSIGHT</b>						
Adherence	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Brittle Support System	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Medication Management	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Palliative Care	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Preventative Health	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Psychotropic Drugs	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Reduction in Formal Services	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Environmental Assessment	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				

SECTION Q: PARTICIPANT/CLIENT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE - Continued						
CAPs	Triggered "X" if triggered	Planning CAP <input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time	Identified Issue/Concern	How is Issue/concern currently addressed/not addressed? What else is needed to address concern/Issue, if anything?	Interventions/Strategies	What is Anticipated Outcome?
OVERSIGHT						
CONTINENCE						
Bowel Management	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participant declined intervention at this time				

**SECTION R: PLAN OF CARE (POC) Budget Page**

CPOC Start Date:		CPOC End Date:				Total # of CPOC Days:		
Service Type:	Provider Name	Provider #	Procedure Code:	# of Units:	Cost Per Unit:	Total Cost:	Start Date:	End Date:
LT-PCS								
<b>EDA Waiver</b>								
Support Coordination								
Transition Intensive SC								
Transition Services								
Environmental Accessibility Adaptations								
Adult Day Health Care								
Companion Services								
Shared CS for 2								
Shared CS for 3								
PERS Installation								
PERS								
<b>ADHC Waiver</b>								
Support Coordination								
ADHC								
		<b>Total Weekly LT-PCS Costs:</b>		<b>Total Annual LT-PCS Costs:</b>		<b>Total Annual Waiver Costs:</b>		
					<b>Total Annual Cost (LT-PCS Cost + Waiver Cost):</b>			

