

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS (DHH)  
OFFICE OF AGING AND ADULT SERVICES (OAAS)  
**Clinical Assessment Protocols Summary**

| <b>SOCIAL LIFE ISSUES CATEGORY</b>   |   |                  |
|--|---|------------------|
| Participant Name:  | (First ) (Last)   | Medicaid Number: |
| <b>CAP Triggered</b><br><i>X = Triggered: Addressed Here</i><br><i>O = Triggered: Addressed in Another Category</i><br><i>A = Triggered: Participant does <u>not</u> want to address</i><br><i>N = <u>Not</u> Triggered: But Participant wants to plan</i> | ___ Brittle Supports    ___ Social Functioning  |                  |
| Related CAPS:  |   |                  |
| <b>CAP Goals:</b><br><u>Trigger Levels</u><br>– Prevent Decline<br>– Improve Functioning<br>– Monitor  | (Short Term)  | (Long Term)      |
| <b>Intervention Needed &amp; Participant Preference for <u>Family/Informal</u> Supports</b>  | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.). Identify who will assist and what kind of assistance they will provide, as well as any recommendations.</i>           |                  |
| <b>Intervention Needed &amp; Participant Preference for <u>Formal</u> Services</b>   | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.) Also, include waiver services and any other paid services currently being provided as well as any recommendations.</i> |                  |

Participant Name:

Reissued : October 1, 2012  
Replaces: July 12, 2012

Medicaid Number:

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| <b>COGNITIVE/MENTAL HEALTH ISSUES CATEGORY</b>   |   |                     |                    |  |  |
|--|---|---------------------|--------------------|--|--|
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| Related CAPS:  |   |                     |                    |  |  |
| <b>CAP Goals:</b><br><b>Trigger Levels</b><br>– Prevent Decline<br>– Improve Functioning<br>– Monitor  | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center; padding: 2px;"><i>(Short Term)</i></th> <th style="width: 50%; text-align: center; padding: 2px;"><i>(Long Term)</i></th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"></td> <td style="height: 40px;"></td> </tr> </tbody> </table>  | <i>(Short Term)</i> | <i>(Long Term)</i> |  |  |
| <i>(Short Term)</i>  | <i>(Long Term)</i>  |                     |                    |  |  |
|  |   |                     |                    |  |  |
| Intervention Needed & Participant Preference for <u>Family/Informal</u> Supports   | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.). Identify who will assist and what kind of assistance they will provide, as well as any recommendations.</i>           |                     |                    |  |  |
| Intervention Needed & Participant Preference for <u>Formal</u> Services  | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.) Also, include waiver services and any other paid services currently being provided as well as any recommendations.</i> |                     |                    |  |  |

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**PHYSICAL/FUNCTIONAL ISSUES CATEGORY**

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| <b>Related CAPS:</b>   |   |                    |
| <b>CAP Goals:</b><br><u>Trigger Levels</u><br>– Prevent Decline<br>– Improve Functioning<br>– Monitor  | <i>(Short Term)</i>   | <i>(Long Term)</i> |
| <b>Intervention Needed &amp; Participant Preference for <u>Family/Informal</u> Supports</b>  | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.). Identify who will assist and what kind of assistance they will provide, as well as any recommendations.</i>           |                    |
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**Clinical Issues Category**

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| <b>Related CAPS:</b>   |  |                    |
| <b>CAP Goals:</b>  | <i>(Short Term)</i>  | <i>(Long Term)</i> |
| <b>Trigger Levels</b><br>– Prevent Decline<br>– Improve Functioning<br>– Monitor   |  |                    |
| <b>Intervention Needed &amp; Participant Preference for Family/Informal Supports</b>   | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.). Identify who will assist and what kind of assistance they will provide, as well as any recommendations.</i>  |                    |
| <b>Intervention Needed &amp; Participant Preference for Formal Services</b>  | <i>This is what actually needs to be done. Indicate if participant prefers certain activities at a particular time of day or has any other specific routines he/she would like to have followed (i.e. order of day, use of special products, etc.) Also, include waiver services and any other paid services currently being provided as well as any recommendations.</i>  |                    |

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