

**OFFICE OF AGING AND ADULT SERVICES (OAAS)
PLAN OF CARE (POC)**

Program Choice <u>(Check all that apply):</u> <input type="checkbox"/> ADHC Waiver <input type="checkbox"/> LT-PCS <input type="checkbox"/> CCW		Plan Type: <input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> Provisional (Initials only) <input type="checkbox"/> Comprehensive (Only after Provisionals) <input type="checkbox"/> Revision: <input type="checkbox"/> Routine <input type="checkbox"/> Emergency		Individual Risk Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No		My Place Louisiana Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Self Direction: <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Liability (PLI): <input type="checkbox"/> Yes <input type="checkbox"/> No Monthly Amount \$ _____		Regional Office Review: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Justification for Revision (If applicable):				ADVERSE ACTION: <input type="checkbox"/> Denial <input type="checkbox"/> Discharge <input type="checkbox"/> Partial Denial/Reduction <input type="checkbox"/> None		Expedited CCW: <input type="checkbox"/> Yes <input type="checkbox"/> No		BAYOU HEALTH: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Aetna <input type="checkbox"/> Amerigroup <input type="checkbox"/> Amerihealth Caritas <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> United Healthcare Community Plan					
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: XXX-XX-		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 #:		Medicare : <input type="checkbox"/> YES <input type="checkbox"/> NO		Primary Physician:			Primary Physician Phone Number:		Medication Administration: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Private Insurance Name:				VA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Health: Contact Name: <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Phone Number :				Hospice: <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: RESPONSIBLE 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				
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 <input type="checkbox"/> Not Applicable													
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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SECTION E: PARTICIPANT PROFILE

1. Summary – (“Paint the Picture.” By writing ONLY 2-3 sentences per category, summarize the participant’s status in each of the following four (4) categories.)

Social Life:

Cognitive/Mental Health:

Physical/Functional:

Clinical:

2. Participant’s Individual Goals (Short and/or Long Term Goals) – Identify and describe the participant’s goals.

3. Primary Concerns of the Participant – Identify and describe the concerns of the participant.

4. Primary Concerns of the Assessor – Identify and describe the concerns of the assessor.

5. Primary Concerns of the Family/Caregiver – Identify and describe the concerns of the family/caregiver.

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SECTION F: CLINICAL ASSESSMENT PROTOCOLS (CAPs) SUMMARY- Attached

SECTION G: FLEXIBLE SCHEDULE - ADHC WAIVER OR CCW- Attached

SECTION H: EXCEL BUDGET WORKSHEET- ADHC WAIVER OR CCW- Attached

SECTION I: PLAN OF CARE (POC) PARTICIPANTS

All participants in the Plan of Care (POC) 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:

SECTION J: 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.*
- *I have been informed of the option to Self Direct my services.*

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

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

Date POC Approved:	Currently in NF: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Transitioned from NF to Community: (if applicable)	MDS-HC Assessment Date:	POC Begin Date:	POC End Date:	POC Revision Begin Date:	POC Revision End Date:	Date POC Packet Mailed/Faxed to Individual/DSP:
_____		_____	_____	_____	_____	_____	_____	_____

POC Denied
 Yes No Denial Reason:

POC Referred to Service Review Panel Yes No Date: _____ Findings: _____

 OAAS or Designee Authorized Representative's Signature Date

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FOR ADULT DAY HEALTH CARE (ADHC) WAIVER:

You have been approved to receive/continue to receive Adult Day Health Care (ADHC) Waiver services with or without Long Term -Personal Care Services (LT-PCS). You were assessed for these services on _____. The results of your assessment are in the following table.

MET LT-PCS PROGRAM REQUIREMENTS:	YOUR ADL INDEX	YOUR WEEKLY # OF LT-PCS HOURS	YOUR ANNUAL APPROVED BUDGET AMOUNT	BEGIN DATE
<input type="checkbox"/> YES <input type="checkbox"/> NO				

NOTE: The maximum # of weekly LT-PCS hours is 32.

FOR COMMUNITY CHOICES WAIVER (CCW):

You have been approved to receive/continue to receive CCW services. You were assessed for these services on _____. The results of your assessment are in the following table.

YOUR RUG SCORE	YOUR ANNUAL APPROVED BUDGET AMOUNT	BEGIN DATE

NOTE: The maximum annual budget amount for all services is \$39,445.