LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

PLAN OF CARE (POC)

Program Choice (Check all that apply): ☐ADHC Waiver ☐LT-PCS ☐CCW	**Plan Type:** ☐Initial ☐Annual ☐Provisional **(Initials only)** ☐Comprehensive **(Only after Provisional)** ☐Revision: ☐Routine ☐ Emergency	**Individual Risk Agreement:** ☐Yes ☐No	**My Place Louisiana Participant**: ☐Yes ☐No	**My Choice Louisiana Participant**: ☐Yes ☐ No	**Self-Direction**: ☐Yes ☐No	**Patient Liability (PLI):** ☐Yes ☐No **Monthly Amount$______**

Justification for Revision (If applicable):	**ADVERSE ACTION:** ☐ Partial Denial/Reduction ☐ None	**Expedited CCW:** ☐ Yes ☐ No **THSCI:** ☐ Yes ☐ No	**HEALTHY LOUISIANA:** ☐ Yes ☐ No ☐ Aetna Better Health ☐ AmeriHealth Caritas Louisiana ☐ Health Blue ☐ Louisiana Healthcare Connections ☐ 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: ☐ Male ☐ Female	SSN: **XXX-XX-**	Marital Status: ☐Never Married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Medicaid #:	Medicare : ☐ YES ☐ NO	Primary Physician:	Primary Physician Phone Number:	Medication Administration: ☐ Yes ☐ No

Private Insurance Name:	**VA Benefits:** ☐Yes ☐No	**Home Health:** ☐Yes ☐No Contact Name: Contact Phone Number :	**Hospice:** ☐Yes ☐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: ☐Yes ☐No	Emergency Contact: ☐Yes ☐No	Responsible for Evacuation: ☐ Yes ☐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

First Name:	Middle Name:	Last Name:	Suffix:

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

Home Phone Number:	Alternate Phone Number/Cell:	Type of Power of Attorney:

Street Address:	City:	State:	Zip Code:

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.

SECTION F: CLINCAL 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:* ☐ Yes ☐ 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***

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
☐ YES ☐ 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 $46,090.