



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Home & Community Based Provider Bi-Annual Conference

COMMITMENT TO QUALITY

Case Study Information

Thank you for participating in a Case Study for a participant on the Aged & Disabled Waiver. We are excited to have the opportunity to work with our providers to glean 'best practices' based on your participation. The information captured from this project will be used to provide important training to providers for our fall conference.

Instructions:

1. Print or save the Case Study materials
2. Read the Case Study
3. Read the Assessment Findings
4. Develop a Service Plan based on the Assessment Findings and the Case Study
5. Develop two weeks mock Progress Notes based on the Service Plan
6. Submit all materials no later than October 10, 2017 to Chris.Barrott@dhw.idaho.gov

Thank you for your participation in this important project!

57-Year-Old Male – Russell

Height: 6'1"

Weight: 156 lbs.

Russell is a divorced male. He has no family contact due to poor family dynamics. Client spent a total of 30 years in prison for threatening a federal official, and currently receives community-based rehabilitation services.

He currently is being treated for Colostomy as well as Atrial Fibrillation and Type 1 Diabetes. He has a history of bilateral hernias, Chronic Kidney Disease, Alcohol Abuse, Substance Abuse, Hypertension, Anxiety, Bipolar, Schizophrenia and Personality Disorder. Additionally, he has a history of Pneumonia and tobacco abuse.

Client has difficulty following the rules in an Assisted Living setting. He states that he enjoys his alone time daily. In the past, the client has had a history of not attending appointments and following Doctor orders. Client reports he is now attempting to be compliant with medical orders, including keeping his appointments and taking his medications appropriately, but does report that he may require daily reminders.

Client has had extensive alcohol and drug abuse history but denies any use in the last two months. He is easily escalated and has frequent anxiety. He is easily angered and volatile with verbal outbursts that include threatening others with taking their lives. He reports, however, that he is attempting to use new coping skills to redirect himself.

He reports he has a history of frequent combative or destructive behavior including being verbally assaultive to others. Client indicates he has frequent thoughts of self-harm when left alone. He occasionally reports episodes of paranoia of people trying to hurt or kill him. Client has a diagnosis of bipolar and reoccurring manic depression and frequently self isolates. Client also carries a diagnosis of Schizophrenia and occasionally reports auditory hallucinations. He receives monthly Invega injections as well as oral medication for treatment. Due to mental illness, he has a history of refusing to take his medications and frequently makes poor choices. Client states he has a payee to manage finances. Client reports short term memory loss but states he is able to recall long term distant memories. He appears to be alert to person, place and time. Due to his mental illness, the client is very vulnerable and easily swayed when on his own. It is recommended that the client be in a protected environment that is monitored by staff.

Client is on a therapeutic diabetic diet. Client has a history of poor diet management including choices of food which is reflected in his low weight and BMI. He states that he eats two meals per day and that he includes at least two servings of fruit and vegetables as well as milk and dairy products. Client denies use of daily alcohol. Reports he has mouth problems that makes it hard to chew, may benefit from dental consultation. Client reports that he requires assistance to shop, cook and/or feed himself. and needs reminding and cueing to make healthy choices and follow his diabetic diet. Client states he is able to make a simple meal and access the refrigerator and microwave, but has a history of being unsafe in the kitchen. He states that there have been issues in the past with him not monitoring the stove including leaving burners on.

Client states he is able to bathe independently but does require reminders and has a grab bar, bath bench and hand-held shower chair to help him. He is able to dress himself and denies assistance. States he has a cane but does not use it and can walk independently. He states he is awake most of the night and requires assistance 2-3 times per night due to tobacco use and colostomy cares as needed. Client appears to be self-neglecting, although he reports he is able to shave, complete oral care and comb his hair independently, but needs cues to complete tasks. Due to his diabetes, he requires toenail care and reports that he sees the podiatrist for this care. Client reports he is continent of bladder and can manage his colostomy on good days, but requires assistance on bad days.

Client states he does not drive, and relies on others for transportation needs. It appears that client can be impulsive and requires supervision while in the community. He can assist with light household chores but has difficulty bending over due to colostomy and needs assist with heavy housework. He states he can assist with laundry by sorting and folding if he is seated. However, he is not able to load and unload laundry into the machines due to colostomy and hernia repair. Client has a history of improper spending on personal shopping items and needs supervision while shopping for personal needs.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Findings

Client Information:

Client Name		Home Phone	
Address		Medicaid #	
City		Date Of Birth	
State	ID	Marital Status	
Zip		Assessment Date	
Language	English	Admission Date	
Gender		Next Review Date	
Housing Arrangement	Residential Care or Assisted Living	Facility Name	
Region	Region 4	Facility Phone	
Assessment Type	Annual		

Contacts:

Contact	Relationship	Phone Number

Participant Strengths:

Client making attempts to be compliant with MD orders, including keeping appointments.

Participant Preferences:

Client likes his alone time daily.

Substitute Decision Maker:

Decision Maker	None
Name	
Relationship	
Phone	() -

Comments:

Primary Physician:

Name		Phone	
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Client Name

Medicaid #

Abuse, Neglect, or Exploitation Evaluation:

No indication of any abuse, neglect, exploitation

Pertinent History (Physical and Mental Health):

Pertinent History:	Medical History: Client has history of Alcohol Abuse, Substance Abuse, HTN, DM, Anxiety, Bipolar, Personality Disorder. PNA, Tobacco Abuse, CKD, Colostomy.
Last Hospitalization (Date and Reason):	Date of last Hospitalization was:7/1/2016 And the reason was:Internal Bleed, Abdominal Pain
Treatment/Therapies	Psychotherapy Licensed Nursing Care/Assessment
Vision	Impaired - sees large print, but not regular print in newspaper / books
Hearing	Adequate - no difficulty in normal conversation, social interaction, listening to TV
Receptive Speech	Usually Understands - misses some part/intent of message, but comprehends most conversation
Expressive Speech	Usually understood - difficulty communicating some words or finishing thoughts but if given time or some prompting is able to be understood
Nutritional Risk	Has Tooth Or Mouth Problems That Makes It Hard To Chew Requires Assistance To Shop, Cook, And Feed Their self
Diet Information	Currently On A Special Diet: Yes Regular Diet: No Therapeutic Diet: Yes Diet Description: Diabetic diet - low concentrated sweets Height in Feet: 6 Height in Inches: 1 Weight in Pounds: 156 Comments:
Assistive Devices and Medical Equipment	Mobility - Cane: Has Dietary - Testing Supplies: Has Bathing - Bathing Bench: Has Bathing - Grab Bar/Tub Rail: Has Bathing - Handheld Shower: Has Respiration - Nebulizer: Has Toileting - Grab Bars: Has

Client Name

Medicaid #

Psychological/Social/Cognitive :

Alcohol/Drug Abuse	Comments
Current or frequent history of alcohol or drug abuse which causes moderate problems with peers, family members, law officials, etc., and may require some professional intervention. May have behavior management plan in place.	History of extensive ETOH and Drug Abuse. None in the last two (2) months.
Anxiety	Comments
Current or history of frequent anxiety which interferes with functioning and may require medication and routine monitoring by behavioral health professional. May have behavior management plan in place.	Becomes agitated easily. Reports he is attempting to use new coping skills including deep breathing, redirection by staff, sees a mental health specialist. Currently on medication.
Assaultive/Destructive Behavior	Comments
Current or history of frequent combative or destructive behaviors, and may require professional consultation or staff training. May have behavior management plan in place.	Client has history of being verbally assaultive to others in a Residential Assisted Living Setting setting. History of threatening a Federal Official and spent prison time.
Danger to Self	Comments
Current or frequent history of self-injurious behavior, self-neglect, head banging, suicidal thoughts, self-mutilation, and behavioral control. Intervention and/or medication may be required to manage behavior. May have behavior management plan in place.	Client has history of frequent thoughts of harming self when left alone. In 2006 due to a suicide ideation, client injured self which resulted in colostomy.
Delusions	Comments
Current or history of frequent delusions which interfere with functioning and may require medication and routine monitoring by a behavioral health professional. May have behavior management plan in place.	Admits to episodes of paranoia. Believes people are trying to hurt him and/or take his life. Client reports this to his Parole Officer.
Depression	Comments
Current or history of frequent depression which interferes with functioning and may require medication and routine monitoring by behavioral health professional. May have behavior management plan in place.	Client diagnosed with Bipolar. Has manic and depressive cycles. Easily angered and volatile. Frequently isolates. Client is on medication to manage depression and other mental health disorders.
Disruptive/Socially Inappropriate Behavior	Comments
Current or history of frequent disruptive, aggressive, or socially inappropriate behavior. May require professional consultation or staff training. May have behavior management plan in place.	Due to mental illness, client has a history of frequent verbal outbursts. History of threatening other residents in the facility including death threats. Spent 30 years in prison for threatening a federal official.
Hallucinations	Comments
Current or history of occasional hallucinations which interfere with functioning, but currently well controlled. May be taking medication. May have behavior management plan in place.	Has a diagnosis of Schizophrenia. Occasionally has auditory or visual hallucinations of people trying to hurt or kill him. Receives monthly Invega injections as well as oral meds.
Judgment	Comments

Client Name

Medicaid #

Judgment is always poor. Cannot make appropriate decisions for self or makes unsafe decisions and needs intense supervision. (Intense supervision is needed to prevent danger to self or others). May have behavior management plan in place.

Due to mental health cannot make appropriate decisions for himself. Client has history of refusing meds, unable to manage finances appropriately and has a Payee. Frequently lends money to others, requires cueing and reminding to comply with Diabetic diet.

Memory**Comments**

Current or history of occasional difficulty remembering and using information. Requires some direction and reminding from others. May be able to follow written instructions. May have behavior management plan in place.

Reports long term memory is intact. Able to recall distant memories. Has short term memory issues including forgetting to take medications, remembering medical appointments, etc. Staff remind client for meds and appointments.

Orientation**Comments**

Oriented to person, place, time, and/or situation.

Alert and oriented. Denies issues.

Self-Preservation/Victimization**Comments**

Current or history of frequent inability to discern and avoid situations that he/she may be abused, neglected, or exploited. May have behavior management plan in place.

Vulnerable adult due to mental illness. Easily taken advantage of. Lives in protected environment.

Wandering**Comments**

No history of wandering.

Denies

Client Name

Medicaid #

Functional Abilities :**Access to Transportation**

Assistance Required Extensive	Identify the participant's ability to get to and from stores, medical facilities, and other community activities, considering the ability both to access and use transportation.	Available Support Minimal	Unmet Needs Moderate
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Client does not drive. Relies on facility to set up transportation for medical appointment through Medicaid transportation vendor. He also relies on facility transportation and/or friends.

Bathing

Assistance Required Minimal	Identify the participant's ability to bathe and wash hair.	Available Support None	Unmet Needs Minimal
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Client showers two times per week. Staff remind and direct client to shower. Client showers independently. Denies further assist.

Dressing

Assistance Required Moderate	Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.	Available Support None	Unmet Needs Moderate
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Client has difficult bending due to colostomy, may require assistance with lower extremities including; putting socks on, assisting with legs into pants.

Eating Meals

Assistance Required Minimal	Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup.	Available Support None	Unmet Needs Minimal
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Client is Type 1 Diabetic and needs frequent cues to follow diabetic diet. Client able to carry plate to dining room table. Able to cut up food and feed himself. Denies choking, however client does have poor dentition and reports it is hard to chew. Could benefit from a dental consultation.

Emergency Response

Client Name

Medicaid #

Assistance Required	Identify the participant's ability to recognize the need for and to seek emergency help.	Available Support	Unmet Needs
Minimal		None	Minimal

Due to mental illness client may become overwhelmed and need direction to exit safely.

Housework

Assistance Required	Identify the participant's ability to clean surfaces and furnishings in his/her living quarters, including dishes, floors and bathroom fixtures and disposing of household garbage.	Available Support	Unmet Needs
Moderate		None	Moderate

Client is able to assist with light housework including; making his bed, dusting furniture and taking dishes to the sink and rinsing them off. Staff to assist with deep cleaning with housekeeping items that require bending or standing for long periods of time.

Laundry

Assistance Required	Identify the participant's ability to do own laundry either at home or at laundromat.	Available Support	Unmet Needs
Moderate		None	Moderate

Client is able to sort and fold laundry while sitting down. Reports he can hang some items up. Staff to wash and dry and help client fold and put away as needed.

Medication

Assistance Required	Identify the participant's ability/willingness to administer his/her own medication.	Available Support	Unmet Needs
Extensive		None	Extensive

Client was non-compliant with medications in the community. Staff monitor and ensure client takes oral medication daily.

Mobility

Assistance Required	Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed.	Available Support	Unmet Needs
None		None	None

Client has a can but reports he never uses it. Nurse observed client walking down the hallway in the facility without assistive device or any assistance. Denies further needs.

Night Needs

Assistance Required Moderate	Identify the participant's need for assistance during the night.	Available Support None	Unmet Needs Moderate
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Client needs assistance at least 2 to 3 times per night, due to smoking, and assistance with colostomy as needed.

Personal Hygiene

Assistance Required Moderate	Identify the participant's ability to shave, care for mouth, and comb hair.	Available Support Minimal	Unmet Needs Minimal
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Client reports he is able to shave, complete oral care and comb his hair independently. Needs cues to complete tasks. Client is diabetic and requires podiatrist for all nail care.

Preparing Meals

Assistance Required Moderate	Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on.	Available Support None	Unmet Needs Moderate
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Client has a mini-fridge in his room and is able to make a simple meal such as a sandwich or a microwave meal. Difficult for client to make a complete meal. Client has a history of being unsafe in the kitchen including leaving the stove burners on. Facility provides three (3) meals per day and snacks.

Shopping

Assistance Required Moderate	Identify the participant's ability to shop for food and personal items.	Available Support None	Unmet Needs Moderate
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Client goes shopping once every two (2) weeks. Requires supervision when at the store due to client being impulsive and purchasing items not needed. Staff accompany client to the store.

Supervision

Client Name		Medicaid #	
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Assistance Required Extensive	Identify the participant's ability to manage his/her life, including needs and activities.	Available Support None	Unmet Needs Extensive
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Due to mental illness and poor judgment see the Psychological/Social/Cognitive Assessment.

Toileting

Assistance Required Moderate	Identify the participant's ability to get to and from the toilet (including commode, bedpan, and urinal), manage colostomy or other devices, to cleanse after eliminating, and to adjust clothing.	Available Support None	Unmet Needs Moderate
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Client reports he is continent of bladder. Has colostomy and needs HOA at times. Reports he is managing it currently.

Transferring

Assistance Required None	Identify the participant's ability to transfer when in bed or wheelchair.	Available Support None	Unmet Needs None
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Nurse observed client get up and down from dining room chair unassisted multiple times during the assessment.

Diagnosis Information :

General Information: Alcoholism Substance Abuse Checked
 Cardiovascular: Heart Condition Checked
 Cardiovascular: High blood pressure Checked
 Cardiovascular Comments: Atrial Fibrillation
 Digestive Comments: History of bilateral hernias
 Endocrine: Diabetes Checked

UAI Summary Sheet

Client Name:

MID Number:

Assessment Date:

Functional Abilities	Hours per Month
Preparing Meals	25.00
Eating Meals	6.08
Toileting	9.12
Mobility	0.00
Transferring	0.00
Personal Hygiene	3.64
Dressing	4.56
Bathing	2.44
Access to Transportation	0.00
Shopping	0.90
Laundry	0.90
Housework	7.60
Night Needs	18.24
Emergency Response	0.00
Medication	2.40
Supervision	24.32

Transportation Miles	0	Licensed Nurse Visit - Hrs/Visit Per Month	1.00
Transportation Total	0.00		
Daily Rate	\$54.42		

Level of Care Points :	21.00	Weekly Hours :	24.28
Redetermination Due :		Weekly Units :	97.11
		Monthly Hours :	105.20
		Monthly Units :	420.80
		Other Home Services :	

Reviewer Signature:

I acknowledge that this electronic signature is the legally binding equivalent of my written signature.

Name: **Barrott, Chris** Date: **8/14/2017**



IDAHO DEPARTMENT OF HEALTH & WELFARE

SERVICE AGREEMENT

Client Information:

Client Name		Home Phone	
Address		Medicaid #	
City		Date Of Birth	
State	ID	Marital Status	
Zip		Assessment Date	
Language	English	Admission Date	
Gender		Next Review Date	
Housing Arrangement	Residential Care or Assisted Living Fac	Facility Name	
Region	Region 4	Facility Phone	
Assessment Type	Annual		

Primary Physician:

Physician Name	Phone
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Goals	Outcomes

Participant Strengths:	Participant Preferences:
Client making attempts to be compliant with MD orders, including keeping appointments.	Client likes his alone time daily.

General information
Health monitoring (blood level checks, oxygen, etc.), special diets etc. Medical appointments including dental, vision, general medical and medical specialty appointments. Identify medical transportation. CFH Only: Document requests for Time Alone in this section.
Client has spent a total of 30 years in prison. Made threats to federal official via mail. Has family that live in-state but due to family dynamics there is no contact.

Client Name		Medicaid #	
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Preparing Meals

Assistance Required: Moderate	Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on.	Available Support: None	Unmet Needs: Moderate
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Client has a mini-fridge in his room and is able to make a simple meal such as a sandwich or a microwave meal. Difficult for client to make a complete meal. Client has a history of being unsafe in the kitchen including leaving the stove burners on. Facility provides three (3) meals per day and snacks.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Eating Meals

Assistance Required: Minimal	Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup.	Available Support: None	Unmet Needs: Minimal
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Client is Type 1 Diabetic and needs frequent cues to follow diabetic diet. Client able to carry plate to dining room table. Able to cut up food and feed himself. Denies choking, however client does have poor dentition and reports it is hard to chew. Could benefit from a dental consultation.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Toileting

Assistance Required: Moderate	Identify the participant's ability to get to and from the toilet (including commode, bedpan, and urinal), manage colostomy or other devices, to cleanse after eliminating, and to adjust clothing.	Available Support: None	Unmet Needs: Moderate
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Client reports he is continent of bladder. Has colostomy and needs HOA at times. Reports he is managing it currently.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Mobility

Assistance Required: None	Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed.	Available Support: None	Unmet Needs: None
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Client has a can but reports he never uses it. Nurse observed client walking down the hallway in the facility without assistive device or any assistance. Denies further needs.

Client Name	Medicaid #
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Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Transferring

Assistance Required:	Identify the participant's ability to transfer when in bed or wheelchair.	Available Support:	Unmet Needs:
None		None	None

Nurse observed client get up and down from dining room chair unassisted multiple times during the assessment.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Personal Hygiene

Assistance Required:	Identify the participant's ability to shave, care for mouth, and comb hair.	Available Support:	Unmet Needs:
Moderate		Minimal	Minimal

Client reports he is able to shave, complete oral care and comb his hair independently. Needs cues to complete tasks. Client is diabetic and requires podiatrist for all nail care.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Dressing

Assistance Required:	Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.	Available Support:	Unmet Needs:
Moderate		None	Moderate

Client has difficult bending due to colostomy, may require assistance with lower extremities including; putting socks on, assisting with legs into pants.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Bathing

Client Name		Medicaid #	
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Assistance Required: Minimal	Identify the participant's ability to bathe and wash hair.	Available Support: None	Unmet Needs: Minimal
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Client showers two times per week. Staff remind and direct client to shower. Client showers independently. Denies further assist.

Provider Care Plan Frequency: ___ Daily ___ Weekly ___ Monthly ___ As Needed
Responsible Party: _____

Written Care Plan (Comments):

Access to Transportation

Assistance Required: Extensive	Identify the participant's ability to get to and from stores, medical facilities, and other community activities, considering the ability both to access and use transportation.	Available Support: Minimal	Unmet Needs: Moderate
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Client does not drive. Relies on facility to set up transportation for medical appointment through Medicaid transportation vendor. He also relies on facility transportation and/or friends.

Provider Care Plan Frequency: ___ Daily ___ Weekly ___ Monthly ___ As Needed
Responsible Party: _____

Written Care Plan (Comments):

Shopping

Assistance Required: Moderate	Identify the participant's ability to shop for food and personal items.	Available Support: None	Unmet Needs: Moderate
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Client goes shopping once every two (2) weeks. Requires supervision when at the store due to client being impulsive and purchasing items not needed. Staff accompany client to the store.

Provider Care Plan Frequency: ___ Daily ___ Weekly ___ Monthly ___ As Needed
Responsible Party: _____

Written Care Plan (Comments):

Laundry

Assistance Required: Moderate	Identify the participant's ability to do own laundry either at home or at laundromat.	Available Support: None	Unmet Needs: Moderate
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Client is able to sort and fold laundry while sitting down. Reports he can hang some items up. Staff to wash and dry and help client fold and put away as needed.

Client Name		Medicaid #	
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Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Housework

Assistance Required: Moderate	Identify the participant's ability to clean surfaces and furnishings in his/her living quarters, including dishes, floors and bathroom fixtures and disposing of household garbage.	Available Support: None	Unmet Needs: Moderate
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Client is able to assist with light housework including; making his bed, dusting furniture and taking dishes to the sink and rinsing them off. Staff to assist with deep cleaning with housekeeping items that require bending or standing for long periods of time.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Night Needs

Assistance Required: Moderate	Identify the participant's need for assistance during the night.	Available Support: None	Unmet Needs: Moderate
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Client needs assistance at least 2 to 3 times per night, due to smoking, and assistance with colostomy as needed.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Emergency Response

Assistance Required: Minimal	Identify the participant's ability to recognize the need for and to seek emergency help.	Available Support: None	Unmet Needs: Minimal
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Due to mental illness client may become overwhelmed and need direction to exit safely.

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
 Responsible Party: _____

Written Care Plan (Comments):

Medication

Client Name		Medicaid #	
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Assistance Required: Extensive	Identify the participant's ability/willingness to administer his/her own medication.	Available Support: None	Unmet Needs: Extensive
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Client was non-compliant with medications in the community. Staff monitor and ensure client takes oral medication daily.

Provider Care Plan Frequency: ___ Daily ___ Weekly ___ Monthly ___ As Needed
Responsible Party: _____

Written Care Plan (Comments):

Supervision

Assistance Required: Extensive	Identify the participant's ability to manage his/her life, including needs and activities.	Available Support: None	Unmet Needs: Extensive
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Due to mental illness and poor judgment see the Psychological/Social/Cognitive Assessment.

Provider Care Plan Frequency: ___ Daily ___ Weekly ___ Monthly ___ As Needed
Responsible Party: _____

Written Care Plan (Comments):

Community Supports and Other Services

Special Equipment:

Equipment to meet the special needs for physical/emotional disability or impairment. Including; wheelchairs, walkers, canes, hearing aids, orthopedic supports, glasses, contacts, etc.

Community Supports / Behavior Management:

Use of community services such as day treatment, workshop programs, financial or legal services, vocational training, case management, targeted service coordination, transportation, etc. Please include family support, physicians, attorneys, social workers, etc.

Is there a Behavior Management Plan? *If YES please attach to the Service Plan*

Client Name	Medicaid #
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Health & Safety Risks:

Intervention:

Identify health & safety risks such as falling, memory/cognitive impairment, behavioral issues that present a risk to the participant or others, etc.	Identify intervention needed to address each health or safety risk during service delivery

Backup Plan :

I will accept a substitute caregiver if my caregiver is not available	
I will use informal supports if my caregiver is not available	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Communication Plan (include detailed instructions for contacting caregiver(s) and/or informal supports and include the participant's urgent needs and any actions that are required to ensure service delivery):	

The signers have read and agree to the provisions of this document. Each has retained a copy for their records. If there is any disagreement, such should be noted. Attach any signed and dated physician's orders, admission records and documentation concerning special needs.

Participant

My signature indicates that I participated in the development of my service plan, and that I agree to the delivery of services as outlined in my plan.

Participant

Date

Legal Guardian

Date

Service Provider

My signature indicates service will be delivered according to the service plan and consistent with home and community based requirements.
