

**SECTION 4:**  
**ADMISSION RECORDS**



# INTRODUCTION TO ADMISSION RECORDS

## MAINTAINED BY THE PROVIDER

The following are to be completed, maintained, and kept up to date. Admission records must be kept confidential in accordance with IDAPA 16.03.19.270.01. Maintain records for five (5) years from the date of service.

### Day of Admission:

- Admission Agreement
- Resident Information and Social History
- If the resident has a representative, a copy of the legal document authorizing the appointment
- Make a copy of the policies and procedures for Resident Rights (pages 90-96 in this manual), provide the resident or resident's representative with the copy, and document a verbal review of these policies and procedures on the Residents Rights Policy Review Log
- Advance Directives Notification
- If the resident or resident's representative chooses to formulate advance directives, the Living Will and Durable Power of Attorney form
- Belongings Inventory, or pictures of the resident's belongings
- Results of a history and physical examination performed within the past 12 months by the resident's health care professional reflecting the resident's current health status
  - The Adult DD Medical Care form does NOT contain the full results of this examination; please ask the health care professional for their full narratives from the visit
- If not already included in the results from the resident's history and physical examination, a list of current prescription medications, treatments, and special diets (if any) signed and dated by the resident's health care professional

### Within 14 Days of Admission:

- Over-the-Counter (OTC) Medications
- If the resident wishes to be responsible for his or her own medications, Approval to Self-Administer Medication
- Assessment
  - If the resident receives services through the Developmental Disabilities (DD) Waiver or Self Direction, either the Scales of Independent Behavior – Revised (SIB-R) or Supports Intensity Scale – Adult (SIS-A) completed by the Department
  - If the resident receives services through the Aged & Disabled (A&D) Waiver, Medicare/Medicaid Coordinated Program (MMCP), Idaho Medicaid Plus, State Only Personal Care Services (PCS), the Uniform Assessment Instrument (UAI) Findings completed by the Department
  - If the resident is private-pay, conduct or direct completion of the UAI or similar assessment meeting the requirements of IDAPA 16.03.19.225.02.

- Plan of Service (negotiated with the resident or resident's representative)
  - If the resident receives services through the DD Waiver, the Individual Support Plan (ISP) authorized by the Department
  - If the resident receives services through Self Direction, the Support and Spending Plan (SSP) authorized by the Department
  - If the resident receives services through the A&D Waiver, MMCP, Idaho Medicaid Plus, or State Only PCS, the Service Agreement authorized by the Department
  - If the resident is private-pay, complete the Service Agreement or similar care plan meeting the requirements of IDAPA 16.03.19.250.01-02
- Any care plan that is prepared for the resident by an outside service provider

Helpful Information:

- To maintain privacy and confidentiality, keep separate files or binders for each resident and store them in a secure location
- All forms requiring signatures must be signed and dated by the resident (or the resident's representative, if applicable) and the provider
- Medications:
  - Only relinquish responsibility for the resident's medications to the resident after obtaining the completed Approval to Self-Administer Medications form from the resident's health care professional and verifying that the resident has met each evaluation criterion
  - Do not allow any prescription medications that are not listed by the resident's health care professional into your home
  - Obtain a drug information sheet from the pharmacy for each current medication and keep them in the resident's records

# ADMISSION AGREEMENT

## SECTION 1: GENERAL TERMS OF AND PARTIES TO THE AGREEMENT

a. Agreement. This agreement is between the Certified Family Home (CFH) certificate holder (aka, CFH provider) and the resident or resident's representative (i.e., the resident's legal guardian or durable power of attorney for health care), if applicable. The provider agrees to provide housing in his or her home and care to the resident as established in this agreement, in the resident's individual plan of service, and as required under Idaho Administrative Procedures Act (IDAPA) 16, Title 03, Chapter 19, "Rules Governing Certified Family Homes." The resident or resident's representative agrees to abide by the terms of this agreement. This agreement continues on a month-to-month basis unless otherwise terminated as provided in Section 7 of this agreement.

If the resident's care is fully or partially publicly-funded, the provider and resident or resident's representative will also comply with Home and Community Based Services (HCBS) setting requirements.

b. Name of CFH Provider. The provider is the adult member of the home named on the CFH certificate and is primarily responsible for maintenance of the home and providing care to the resident. The provider is identified as:

\_\_\_\_\_

c. Name of Resident. The resident is an adult who lives in the CFH provider's home and requires care, help in daily living activities, protection and security, supervision, personal assistance, and/or encouragement toward independence. The resident is identified as:

\_\_\_\_\_

d. Resident Representative. The resident's representative, if applicable, is an adult making decisions on behalf of the resident. Has the resident been appointed a legal guardian through a court, or is an adult appointed by the resident acting as POA due to the resident's current incapacitation?

Yes  No

If "Yes" above, the provider will ensure the representative's information is reflected in the admission records, including maintaining a copy of the document confirming the representative's appointment in the resident's records.

## SECTION 2: CHARGES TO THE RESIDENT

a. Room and Board Charge. The charge for the resident's room, utilities and three (3) daily meals as described in IDAPA 16.03.19.175 is \$\_\_\_\_\_ per month.

This charge is due on or before the \_\_\_\_\_ day of each month. Failure to pay room and board when due may result in eviction if payment in full is not made within three (3) days of a written notice per IDAPA 16.03.19.260.05.b.i.

b. Care Charge. The charge for care to the resident is \$\_\_\_\_\_ per month for the services described in IDAPA 16.03.19.170. This amount is billed directly to the resident or the resident's representative and excludes amounts the provider may claim from Medicaid. Services for which Medicaid pays the provider as authorized in the resident's plan of service will not be charged to the resident per IDAPA 16.03.09.210.03, except when the resident has a share of cost per IDAPA 16.03.18.

This charge is due on or before the \_\_\_\_\_ day of each month. Failure to pay care charges when due may result in eviction if payment in full is not made within three (3) days of a written notice per IDAPA 16.03.19.260.05.b.i.

c. Basic Needs Allowance. If the resident receives public assistance to pay for his care in full or in part, the charges specified in Subsections 2.a and 2.b in this agreement will leave the resident with at least the funds from his or her monthly income in the amount specified as the Basic Needs Allowance required under IDAPA 16.03.19.200.04.

d. Partial Month Refund. When the resident has paid the care charges for a given month but does not receive services from the CFH provider due to an emergency temporary placement as provided in Section 8 of this agreement, or the resident otherwise chooses not to receive CFH services from the provider or the provider's substitute caregiver(s), the provider will refund a prorated amount of the resident's care charges as specified in Subsection 2.b of this agreement for those days CFH services were not rendered.

When the resident leaves the home permanently under any circumstances or passes away, the CFH provider will only retain room and board funds prorated to the last day of the applicable notice period as stated in Section 7 of this agreement, or upon the resident moving from the home, whichever is later.

Refunds will be made to the following individual:

Name: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Refunds will be made within the following timeframe:

\_\_\_\_\_

### SECTION 3: MEDICATIONS

a. Responsibility for Medications. Upon admission, the CFH provider assumes responsibility for the resident's medications. If the resident wishes to be responsible for administering his or her own medications, the provider will obtain an evaluation and approval (see form: Approval to Self-Administer Medications) from the resident's primary healthcare professional indicating the resident is capable of self-administration before relinquishing responsibility for the medications to the resident.

Does the resident wish to be responsible for administering his or her own medications? Yes  No

b. Orders. The CFH provider will offer assistance with medications to the resident only as ordered by the resident's health care professional(s). The CFH provider will not alter dosage, discontinue or add medications (including over-the-counter medications and supplements) or discontinue, alter, or add treatments or special diets without first consulting the resident's health care professional and obtaining an order for the change as required under IDAPA 16.03.19.400.02.

c. Assistance with Medications. While the CFH provider is responsible for the resident's medications, the provider and any CFH staff who assist with medications will comply with IDAPA 16.03.19.402.

### SECTION 4: INSURANCE

a. Liability Insurance. The homeowner's or renter's insurance on the CFH provider's home has the following liability coverage: \$\_\_\_\_\_.

b. Resident's Personal Belongings. Does the homeowner's or renter's insurance policy for the CFH provider's home cover the resident's personal belongings? Yes  No

If "No" above, the resident is advised that he or she may purchase his or her own renter's insurance policy.

### SECTION 5: RESIDENT'S PERSONAL FUNDS AND BELONGINGS

a. Responsibility for Funds. If the resident's funds are turned over to the CFH provider for any purpose other than those described in Section 2 of this agreement, or if the provider, a relative of the provider, or any other member of the provider's household acts as the resident's representative payee, the provider is deemed to be managing the resident's funds.

Will the provider be managing the resident's funds? Yes  No

If "No" above, complete the following:

Will the resident be managing the his or her own funds? Yes  No

If "No" above, complete the following:

Contact information for the person responsible for assisting the resident in managing his or her funds is as follows:

Name: _____ Phone Number(s): _____ Address: _____ Email: _____
<p>b. Resident Funds Managed by the CFH Provider. If the provider manages the resident's funds, the provider will comply with IDAPA 16.03.19.275.02.</p> <p>If the resident leaves the home permanently under any circumstances or passes away, the provider will only use the resident's funds for that resident's expenses until a new payee is appointed.</p>
<p>c. Return of Resident Possessions. When the resident leaves the home under any circumstances, the CFH provider will immediately return all personal funds belonging to the resident, and any medication, supplement or treatment belonging to the resident.</p> <p>Within three (3) business days, the provider will return all possessions indicated on the resident's belongings inventory and any other item belonging solely to the resident, including personal documents. Additionally, if the provider was managing the resident's funds, a copy of the final accounting of such will be supplied by the provider.</p> <p>Return of the items in this subsection will be made to the following individual within the timeframes specified above:</p> <p>Name: _____          Phone Number(s): _____          Address: _____          _____          Email: _____</p> <p>Arrangement for the return of these items is as follows: _____          _____          _____</p>
<p>d. Personal Loans. The provider prohibits personal loans to the resident unless the resident is a relative of the provider, the provider's relative, or any other member of the provider's household.</p> <p>When a personal loan complying with the above is made, the provider will ensure the terms of the loan are described in a written contract signed by the resident or resident's representative. This contract will be maintained in the resident's record. The provider will immediately update documentation of repayments towards the loan.</p>

<b>SECTION 6: CONSENT</b>
<p>a. Medical Procedures. If the resident is unable to make his or her medical decisions, the CFH provider will obtain consent from the resident's legal guardian or POA before a medical procedure is conducted.</p>
<p>b. Health Care Providers. If the resident is unable to give medical consent, the CFH provider will give the name and contact information of the resident's representative to any health care provider upon request.</p>
<p>c. Resident Information. The CFH provider and the resident or resident's representative agree to allow the provider to share pertinent information from the resident's record to a hospital, nursing home, residential care or assisted living facility, or other certified family home on an as-needed basis if the resident will be accessing these services.</p>

<b>SECTION 7: ADVANCE NOTICE OF CHANGE</b>
<p>a. Changes to CFH Charges. The CFH provider will provide to the resident, or if applicable, to the resident's representative, advance written notice at least fifteen (15) days prior to increasing the charges identified in Subsections 2.a or 2.b of this agreement. The agreed period is _____ days advance written notice.</p>

b. Termination of this Agreement by the CFH Provider. Excepting the scenarios described in Subsection 7.c of this agreement, if the provider wishes to terminate this agreement, written advance notice will be provided to the resident, or if applicable, to the resident's representative, at least thirty (30) days prior to termination of the agreement and discharge of the resident. The agreed period is \_\_\_\_\_ days advance written notice.

c. Three-day Eviction Notice. The CFH provider may provide the resident, or if applicable, the resident's representative with three (3) days written notice as described below in advance of terminating this agreement and evicting the resident for any, and only, one of the following scenarios:

1. Failure to Make Timely Payments to the CFH Provider: The resident or responsible party fails to pay the charges agreed upon as specified in Section 2 of this admission agreement. This notice will include the charges owed to the provider and advise the resident or responsible party of a three-day right to pay. If the payment is made within three (3) days of receipt of the written notice, the provider will rescind the termination notice. If payment is not made, the resident will move to another placement within three (3) days of receipt of the notice, unless the resident, or if applicable, the resident's representative, appeals the eviction through the process described in Subsection 7.d of this agreement.
2. Violation of Mutually Established Conditions: The resident violates any of the terms of this agreement. This notice will specify the terms that were violated and advise the resident of a three-day right to cure the violation. If the violation is cured within three (3) days of receipt of this notice, the provider will rescind the termination notice. If the violation persists, the resident will move to another placement within three (3) days of receipt of the notice, unless the resident, or if applicable, the resident's representative, appeals the eviction through the process described in Subsection 7.d of this agreement.
3. Unlawful Delivery, Production, or Use of a Controlled Substance: The resident engages in unlawful delivery, production, and/or use of a controlled substance on the premises of the certified family home. The resident has no three-day right to correct the activity, but will move to another placement within three (3) days of receipt of the notice, unless the resident, or if applicable, the resident's representative, appeals the eviction through the process described in Subsection 7.d of this agreement.

d. Eviction Appeal Process. When the CFH provider issues a three-day notice to terminate this agreement for any of the three scenarios described in Subsection 7.c, the provider will immediately inform the Department's regional certifying agent by either fax or email and include a copy of the notice.

The resident or, if applicable, the resident's representative will have the right within that three-day timeframe to make a written request to the Department's regional certifying agent for a review of the eviction if it is believed that the reason for the eviction does not meet one of the three scenarios in Subsection 7.c. The request for review must be signed by the resident or the resident's representative and state specifically the reasons that the CFH provider's decision to evict did not meet one of the three scenarios.

If, after the expiration of the three days, the resident has not complied with the notice, then the CFH provider may request the Department's regional certifying agent to approve the eviction.

In either case, the Department will have twelve (12) calendar days from the request to review the eviction notice and provide a determination in writing to both parties regarding its validity. The CFH provider will allow the resident to remain in the home during the Department's review process and continue to provide services in accordance with this agreement, the resident's individual plan of service, and IDAPA 16.03.19.

- If the Department finds on the part of the CFH provider, the resident will have three (d) days to find alternate placement and move out of the home, during which time the provider must continue to provide services in accordance with this agreement, the resident's individual plan of service, and IDAPA 16.03.19.
- If the Department finds on the part of the resident, the eviction notice will be null and void and the resident may continue living in the home and the CFH provide will provide services in accordance with this agreement, the resident's individual plan of service, and IDAPA 16.03.19.

Nothing in this agreement will prevent the CFH provider, the resident, or if applicable, the resident's representative, from utilizing the termination provisions contained in Subsections 7.b and 7.e of this agreement.

e. Termination of this Agreement by the Resident. If the resident or resident's representative wishes to terminate this agreement, written advance notice will be provided to the CFH provider at least thirty (30) days prior to termination of this agreement. The agreed period is \_\_\_\_\_ days advance written notice.

**SECTION 8: EMERGENCY TEMPORARY PLACEMENT**

a. Conditions for an Emergency Temporary Placement. The CFH provider and the resident or, if applicable, the resident's representative, agree that the following emergency conditions may require a resident to transfer out of the home immediately to a temporary placement without advance notice:

- 1. Deterioration of Health: The resident's mental or physical condition deteriorates to a level requiring evaluation or services that cannot be provided in the CFH; or
- 2. Protection from Harm: Emergency conditions requiring the resident to transfer out of the home to protect the resident or other people in the home from harm.

b. Continuation of This Agreement. Upon the resident's transfer to an emergency temporary placement, this agreement will remain in force and effect, except for the CFH provider's responsibility for care to the resident, and the resident's, or if applicable, the resident's representative, responsibility to pay the provider for CFH care charges according to Section 2.b of this agreement while the resident is receiving services in another care setting.

Upon improvement of the resident's health or removal of the danger requiring the emergency temporary placement, the resident may return to the home and resume CFH services provided that this agreement has not otherwise been terminated as described in Section 7 of this agreement.

c. Safeguarding Plan. The CFH provider will follow the safeguarding plan described below if the resident is not able to carry out self-preservation and either of the scenarios described in Subsection 8.a of this agreement occur: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 9: ADDITIONAL CONDITIONS**

c. Additional Conditions. The following additional condition(s) are agreed between the CFH provider and the resident, or if applicable, the resident's representative, provided there is no contradiction with any requirement of IDAPA 16.03.19:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 10: ADMISSION AGREEMENT VERIFICATION**

a. Effective Date. This agreement commences on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

DAY MONTH YEAR

b. Signature of the CFH Provider. The provider's signature below signifies adoption of this agreement.

\_\_\_\_\_  
CFH PROVIDER'S SIGNATURE

\_\_\_\_\_  
DATE

c. Signature of the Resident or Resident's Representative. The resident's, or if applicable, resident's representative's, signature below signifies adoption of this agreement.

\_\_\_\_\_  
RESIDENT'S OR RESIDENT'S REPRESENTATIVE'S SIGNATURE

\_\_\_\_\_  
DATE





**Emergency Contacts**

Name:	Relationship to Resident:
Telephone:	Email:
Name:	Relationship to Resident:
Telephone:	Email:

**Health Care Professionals**

Name:	Telephone:
Services Provided to the Resident:	
Name:	Telephone:
Services Provided to the Resident:	
Name:	Telephone:
Services Provided to the Resident:	

**Pharmacy**

Name:	
Address/Location:	Telephone:

**Supportive Services** *(any individual/agency providing supportive services to the resident)*

Name:	Services Provided:
Address:	Telephone:
Name:	Services Provided:
Address:	Telephone:

<b>Name of the Person Completing This Form:</b>
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# ADVANCE DIRECTIVES INFORMATION

## FROM THE OFFICE OF THE ATTORNEY GENERAL

### Living Wills and Idaho's Natural Death Act

We plan for many important events in life. We plan for retirement, a wedding, vacations, and for a child's education. Sadly, the health choices that are made at the end of life are seldom planned and many times they are made for us. Decisions are put off and desires are not expressed because it is difficult to contemplate or discuss death.

There are many things to plan for at the end of life. Transfer of property and the wellbeing of a spouse or child are all issues to be considered and planned for. However, the topic discussed here involves end of life health care issues, the importance of living wills, and advance directives. The principle way to ensure that your desires are fulfilled if you are no longer able to communicate your wishes is through a Living Will.

Idaho law provides for individuals to ensure that their wishes about their healthcare are carried out in the event they become incapacitated and are not able to speak for themselves. Generally, there are two kinds of Advance Directives. The first is called a Living Will, and the second is called a Durable Power of Attorney for Health Care. During the 2005 Idaho Legislative session, a modification was made to the Natural Death and Medical Consent Act. Consequently, in Idaho, it is now possible to complete one (1) form for both a Living Will and a Durable Power of Attorney for Healthcare.

A Living Will sets forth your instructions for dealing with life-sustaining medical procedures in the event you are unable to decide for yourself. A Living Will directs your family and medical staff on whether to continue, withhold, or withdraw life-sustaining systems, such as tube feeding for hydration (water) and nutrition (food), if you are incapable of expressing this yourself due to an incurable and terminal condition or persistent vegetative state.

A Durable Power of Attorney for Health Care allows you to appoint a person to make all decisions regarding your health care, including choices regarding health care providers and medical treatment, if you are not able to make them yourself for any reason.

You should not execute an Advanced Directive without having first thought about end of life issues, considered your personal values, and discussed your end of life wishes with your family, physicians, attorney, and clergy.

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When does a Living Will take effect?

Your Living Will takes effect when a medical doctor certifies that you have a terminal and incurable illness or you are permanently unconscious or in a persistent vegetative state.

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When does a Durable Power of Attorney take effect?

Although both a living will and Durable Power of Attorney are available on the same form, they have separate legal significance. The Durable Power of Attorney takes effect when you are no longer able to communicate with your healthcare provider.

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If my living will says to withhold medical treatment, will medical personnel, such as paramedics, withhold treatment based on a living will alone?

No. As noted in the answer to the first question, a living will is not self-activating. It takes effect only when one doctor has certified that you have a terminal condition and that death is imminent. When conditions are met, a Do Not Resuscitate ("DNR") Order is issued by your physician. In Idaho, DNR Orders are often included in Physician Orders for Scope of Treatment ("POST"). The POST form can be obtained only through a physician. It is completed and signed by a patient or his/her representative and the patient's physician and acts as the physician's standing orders. Paramedics will comply with the instructions provided on a POST form but will not generally follow directives in a living will.

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Am I eligible to have a Living Will?

Anyone over the age of 18, that is of sound mind, and acting of his or her own free will, can complete a Living Will.

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What is the difference between a Living Will and an ordinary will?

A Living Will only specifies healthcare wishes. An ordinary Will deals with the disposition of property upon your death.

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What life support choices do I have within my Living Will?

There are three different choices you can make in regards to life-sustaining measures:

Option 1 - It is your desire to have doctors do everything in their power to keep you alive.

Option 2 - The only life-sustaining measures you desire to have is artificial tube feeding for nutrition (food) and hydration (water).

Option 3 - You wish to have all artificial life-sustaining treatment withheld, including nutrition and hydration.

No matter which of these three options you choose, you will always be provided all necessary pain medication and comfort medication.

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What if I am pregnant when I become incapacitated?

Life sustaining measures will continue regardless of any directive to the contrary until the pregnancy is complete.

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What if I change my mind about my options?

If at any time while you are of sound mind and acting of your own free will, you can make a new Living Will. At any time you may revoke or terminate an existing Living Will without creating a new one.

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Who can I appoint to be my Health Care Agent?

The choice of an individual to serve as your Health Care Agent is a very important one. You should discuss your wishes at length with the individual you plan on appointing. Make sure the person you plan to appoint is comfortable with the directives in your living will and is willing and able to carry out your wishes. It is also recommended that you discuss your options and wishes with your family, physicians, attorney, and clergy. None of the following people may be designated as your agent:

1. your doctor or other treating health care provider;
  2. a non-relative employee of a hospital, your doctor, or other treating health care provider;
  3. an operator of a nursing home, assisted living facility, or community care facility; or
  4. a non-relative employee of a nursing home, assisted living facility, or community care facility.
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When do my Health Care Agent's responsibilities and authority begin?

The only time your agent will be able to make decisions is when you are unable to make your own decisions.

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Must a living will be witnessed or notarized to be valid?

No. As a result of changes to Idaho law made by the 2005 legislature, it is no longer necessary to have either a witness to your execution of a Living Will, nor to have your signature notarized. Having your signature on your Living Will witnessed or notarized is a good idea, and is certainly permissible, but is not necessary.

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Do I need a lawyer to draft a living will for me?

No. The assistance of a lawyer in drafting any legal document is always a good idea, but is not necessary. A Living Will is a document of great importance and significant ramifications. Discuss your wishes and what you want included in your living will with your family, trusted friends, your physician, your clergy, and your lawyer.

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What if I already had a living will before the new legislation?

So long as the living will was in compliance with the existing law at the time it was executed or if it substantially conforms to the new law then it is valid. It is recommended that you review your living will and confirm that it substantially meets the requirements of the new law.

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What if I have a living will that was created in a state other than Idaho?

If the living will created in a state other than Idaho conforms substantially to Idaho's living will statutes then it will be recognized as valid.

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If I do not have a living will, and am unable to communicate, can a family member still make health care decisions on my behalf?

Yes. Idaho Code § 39-4504 provides a list, in order of authorization, that allows for an individual to deny, or consent to care, for a second individual who has been rendered unable to communicate. The issue is always made more complex in the absence of a Living Will or other written directive from you.

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What if the executor of my living will is somehow incapacitated and unable to communicate my desires?

The law provides that your living will may list alternates should the primary executor be unable to communicate your desires. If, for some reason, none of the executors listed in your living will are able to communicate your desires then the authorization will pass on to the next available individual as listed in Idaho Code § 39-4504.

# ADVANCE DIRECTIVES NOTIFICATION

Per IDAPA 16.03.19.200.11.h, the provider must inform, in writing, each resident of his or her right to formulate advance directives; this written information is found in the Certified Family Home Provider Manual under "Advance Directives Information," or on the website for the Office of the Attorney General at [www.ag.idaho.gov](http://www.ag.idaho.gov) (search "Living Wills").

I, the Certified Family Home provider, have informed \_\_\_\_\_  
of his/her right to formulate advance directives as described in Title 39, Chapter 45, Idaho Code.

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Resident's or Representative's Signature

\_\_\_\_\_  
Date

If the resident chooses to formulate advance directives, keep the documents with the resident's records and make them available to hospital, medical, dental, surgical and other health care providers when questions of the resident's end-of-life wishes arise.

# LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Date of Directive: \_\_\_\_\_

Name of person executing Directive: \_\_\_\_\_

Address of person executing Directive: \_\_\_\_\_  
\_\_\_\_\_

## A Living Will A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:
  - a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:
    1. That such injury, disease, illness or condition is terminal; and
    2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
    3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

**OR**

- b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

Check one box and initial the line after such box:



\_\_\_\_\_ I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

**OR**

\_\_\_\_\_ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows:

*(If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)*

Check one box and initial the line after such box:

\_\_\_\_\_ A. Only hydration of any nature, whether artificial or non-artificial, shall be administered.

\_\_\_\_\_ B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

\_\_\_\_\_ C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

**OR**

\_\_\_\_\_ I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.
3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.
4. Check one box and initial the line after such box:

\_\_\_\_\_ I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

**OR**

\_\_\_\_\_ I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

A Durable Power of Attorney for Health Care

**1. DESIGNATION OF HEALTH CARE AGENT**

*None of the following may be designated as your agent:*

- (1) your treating health care provider;*
- (2) a non-relative employee of your treating health care provider;*
- (3) an operator of a community care facility; or*
- (4) a non-relative employee of an operator of a community care facility.*

*If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.*

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.

*(Insert name, address and telephone number of one individual only as your agent to make health care decisions for you.)*

Name of Health Care Agent: \_\_\_\_\_

Address of Health Care Agent: \_\_\_\_\_

Telephone Number of Health Care Agent: \_\_\_\_\_

For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical condition.

## **2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

By this portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

## **3. GENERAL STATEMENT OF AUTHORITY GRANTED**

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

*(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", below. You can indicate your desires by including a statement of your desires in the same paragraph.)*

## **4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS**

*(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations:

*(You may attach additional pages or documents if you need more space to complete your statement.)*

**5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH**

**A. General Grant of Power and Authority**

Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

- (1) Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
- (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information;
- (3) Consent to the disclosure of this information; and
- (4) Consent to the donation of any of my organs for medical purposes.

*(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", above.)*

**B. HIPAA Release Authority**

My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

## **6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES**

Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following:

- (a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital Against Medical Advice"; and
- (b) Any necessary waiver or release from liability required by a hospital or physician.

## **7. DESIGNATION OF ALTERNATE AGENTS**

*(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1 above, in the event that agent is unable or ineligible to act as your agent. If an alternate agent you designate is your spouse, he or she becomes ineligible to act as your agent if your marriage is thereafter dissolved.)*

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive, such persons to serve in the order listed below:

A. First Alternate Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

B. Second Alternate Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

C. Third Alternate Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

**8. PRIOR DESIGNATIONS REVOKED**

I revoke any prior durable power of attorney for health care.

**DATE AND SIGNATURE OF PRINCIPAL**

*(You must date and sign this Living Will and Durable Power of Attorney for Health Care.)*

I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form at:

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(City, State)



# APPROVAL TO SELF-ADMINISTER MEDICATION

In accordance with IDAPA 16.03.19.401, before allowing a resident to self-administer his or her medications, the CFH provider must obtain approval from the resident's health care professional.

**RESIDENT**

The resident is the adult receiving care in the provider's certified family home.

Full Legal Name: _____	Date of Birth: _____
Diagnoses: _____ _____	

**EVALUATION**

This evaluation is based on the resident's current condition assessed today. If his or her condition should change, the certified family home provider must have this assessment reevaluated by the health care professional. The health care professional has evaluated the resident in the following areas:

The resident understands the purpose of each medication.	Yes <input type="checkbox"/> No <input type="checkbox"/>
The resident is oriented to time and place and knows the appropriate dosage and times to take the medication.	Yes <input type="checkbox"/> No <input type="checkbox"/>
The resident understands the expected effects, adverse reactions, or side effects, and knows what actions to take in case of an emergency.	Yes <input type="checkbox"/> No <input type="checkbox"/>
The resident is able to take the medication without assistance or reminders.	Yes <input type="checkbox"/> No <input type="checkbox"/>

**HEALTH CARE PROFESSIONAL APPROVAL**

The health care professional's signature below indicates the resident listed on this form is approved to self-administer medications. All elements listed in the evaluation must be assessed as "Yes" before the health care professional may give approval.

Printed Name: _____	Business Phone: (     ) _____
Practice Name: _____	
_____ HEALTH CARE PROFESSIONAL'S SIGNATURE	_____ DATE

**CERTIFIED FAMILY HOME PROVIDER**

The provider is the adult responsible for maintaining the certified family home and providing care to residents. Please return this completed form as follows:

Provider Name: _____		
Telephone Number: (     ) _____	Email: _____	
Mailing Address: _____		
Mailing City: _____	Mailing State: _____	Mailing ZIP: _____



# IDAHO DEPARTMENT OF HEALTH & WELFARE

## Uniform Assessment Instrument Findings

### PARTICIPANT INFORMATION

Participant Name		Home Phone	
Address		Medicaid ID#	
City		Date of Birth	
State		Marital Status	
Zip		Assessment Date	
Language		Admission Date	
Gender		Redet Date	
Housing Arrangement		Facility Name	
Region		Facility Phone	

### CONTACTS

Contact	Relationship	Phone
		-

### SUBSTITUTE DECISION MAKER

Decision Maker		Comments
Name		
Relationship		
Phone		

### SECONDARY SOURCE OF INFORMATION

Source	Name	Phone	Relationship
Medical Record			
Physician			
Other			

### ABUSE/NEGLECT/EXPLOITATION

- No indication of any abuse, neglect or exploitation
- Indication of material abuse, neglect or exploitation that involves misuse of funds, property or resources. The client is not in danger of any physical injury or pain
- Indication of psychological abuse, neglect or exploitation such as verbal assaults, threats, isolation, coercion, etc.

Indication of physical abuse, neglect or exploitation and extreme violation of rights where the participant's health and safety are in danger.

## HEALTH INFORMATION

### PRIMARY PHYSICIAN

Name	Phone

**Bladder Control:**

**Bowel Control:**

**Comments:**

#### Cardiovascular

- Circulation
- Congestive Heart Failure
- Heart Condition
- High Blood pressure

#### Dementia

- Dementia Alzheimer's
- Dementia Non-Alzheimer's

#### Developmental Disabilities

- Intellectual Disabilities
- Autism
- Cerebral Palsy

#### Endocrine

- Endocrine Diabetes
- Endocrine Thyroid
- Eye Disorders
- Immune System Disorders

#### General Information

- Alcoholism Substance Abuse
- Blood Related Problems
- Obesity
- Cancer

Cancer Type:

**Comments**

#### Health Information

Pertinent History

Last Hospitalization Date:

Reason:

#### Muscular/ Skeletal

- Arthritis
- Rheumatoid Arthritis
- Osteoporosis

#### Neurological

- TBI
- Seizure Disorder
- Spinal Cord Injury
- CVA

#### Psychiatric

- Anxiety Disorders
- Bipolar
- Major Depression
- Personality Disorder
- Schizophrenia

#### Respiratory

- Chronic Obstructive Pulmonary disease
- Pneumonia

#### Urinary/Reproductive

- Renal Failure
- Prostate Condition

Other problems:

**Treatment/Therapies**

- Behavioral Management Program      Frequency:
- Bladder Control Program      Frequency:
- Bowel Control program      Frequency:
- Catheter Care      Frequency:
- Chemo/Radiation Therapy      Frequency:
- Decubitus Care      Frequency:
- Developmental Therapy      Frequency:
- Diabetic Management      Frequency:
- Dialysis Treatment      Frequency:
- Hospice      Frequency:
- Licensed Nursing Care/Assessment      Frequency:
- Medication Management      Frequency:
- Occupational Therapy      Frequency:
- Ostomy Care      Frequency:
- Other      Frequency:
- Physical Therapy      Frequency:
- Psychotherapy      Frequency:
- Range of Motion/Strengthening      Frequency:
- Recreation Therapy      Frequency:
- Respiratory Therapy      Frequency:
- Restorative Therapy Program      Frequency:
- Speech Therapy      Frequency:
- Tracheostomy suctioning      Frequency:
- Tube Feeding      Frequency:
- Wound or Skin Care      Frequency:

Comments:

**DIET INFORMATION**

Are you currently on a Special Diet? Select      Diet Type: Select

Description:

Height Feet

Height Inches

Weight Pounds

Comments:

**NUTRITIONAL RISK**

Do you eat less than 2 meals/day?

Do you eat more than 2 servings each of fruits, vegetables, and milk/dairy products a day?

Do you have two to three drinks of beer, liquor or wine per day?

Do you have tooth or mouth problems that make it hard to chew?

Do you ever run out of money for food?

Do you frequently eat alone?

Do you take three or more different prescribed or over the counter drugs?

Have you gained or lost ten pounds in the last six months without wanting to?

Do you require assistance to shop, cook and/or feed yourself?

Do you have difficulty swallowing?

## ASSISTIVE DEVICES

<b>BATHING</b>	
Bathing Bench	
Grab Bar Tub Rail	
Handheld Shower	
Hydraulic Lift	
<b>COMMUNICATION</b>	
Electronic communication	
Glass Corrective Lenses	
Hearing Aid	
Interpreter	
Interpreter Sign	
<b>PERS</b>	
Magnifying Glass	
Picture Book	
Symbol Book	
Teletypewriter	
<b>DIETARY</b>	
Dentures	
Hand Splint Braces	
Infusion Pump	
Special Utensil Plate	
Glucose Testing Supplies	
<b>CANE</b>	
Cane	
Crutches	
Service Animal	
Hospital Bed	

Hoyer Lift	
Leg Braces	
Prosthesis	
Ramp Access	
Transfer Board	
Walker	
Wheelchair Electric	
Wheelchair Manual	
Wheelchair Cushion	
<b>RESPIRATION</b>	
Bipap	
CPAP	
Nebulizer	
Oxygen	
Volume Ventilator	
Oxygen Concentrator	
<b>SKIN CARE</b>	
Special Mattress	
Special Mattress Pad	
Whirlpool	
<b>TOILETING</b>	
Bedpan/Urinal	
Pads Incontinence	
Commode	
Grab Bars	
Raised Toilet	
Toilet Safety Frame	

Comments:

## PSYCHOLOGICAL/SOCIAL/COGNITIVE

### Alcohol/Drug Abuse

*Psychoactive substance use to the extent that it interferes with functioning*

No history of alcohol or drug abuse

- Current or occasional history of alcohol or drug abuse which may cause some interpersonal and/or health problems, but does not significantly impair overall independent functioning. May have behavior management plan in place.
- Current or frequent history of alcohol or drug abuse which cause moderate problems with peer, family members, law officials, etc. And may require some professional intervention. May have behavior management plan in place.
- Current or history of frequent alcohol or drug abuse which causes significant problems with others and severely impairs ability to function independently. May have behavior management plan in place.

Comments:

### **Anxiety**

*Indicated by excessive worry, apprehension, fear, nervousness or agitation*

- No history of anxiety
- Current or history of occasional anxiety which interferes with functioning, but currently well controlled, may be taking medication. May have behavior management plan in place.
- 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.
- Presently displays anxiety which significantly impairs the ability for self-care, may require medication or may need routine monitoring by behavioral health professional. May have behavior management plan in place.

Comments:

### **Assaultive/Destructive Behavior**

*Assaultive or combative toward others (throws objects, strikes or punches, bites, scratches, kicks, makes dangerous maneuvers with wheelchair, destroys property, sets fires, etc.*

- No history of combative or destructive behaviors
- Current or history of occasional combative or destructive behaviors. Requires special tolerance or staff training, but does not require professional consultation and/or intervention. May have behavior management plan in place.
- Current or history of frequent combative or destructive behaviors, and may require professional consultation or staff training. May have behavior management plan in place.
- Is assaultive, and requires constant supervision, a professionally authorized behavioral management program, and/or professional consultation and intervention. May have behavior management plan in place.

Comments:

### **Danger to Self**

*Indicated by self-neglect, head banging, suicidal thoughts, self-mutilation, suicide attempts, etc.*

- No history of self-injurious behavior.
- Current or occasional history of self-injurious behavior (i.e., self-mutilation, suicidal ideation/plans, and suicide gestures), but can be redirected away from these behaviors. May have behavior management plan in place.

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.

Displays self-injurious behavior and requires constant supervision, with behavioral control intervention and/or medication. Requires an assessment and/or referral for help. May have behavior management plan in place.

Comments:

### **Delusions**

*Beliefs not based on fact, such as having special powers, being persecuted, being spied upon.*

No history of delusions.

Current or occasional history of delusions which interfere with functioning, but currently well controlled, maybe taking medication. May have behavior management plan in place.

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.

Presently has delusion(s) which significantly impair the ability for self-care, may or may not be taking medication. May have behavior management plan in place.

Comments:

### **Depression**

*Indicated by feelings of hopelessness, despair, sleep disturbance, appetite impairment, change in energy level, lack of motivation, thoughts of death.*

No history of depression

Current or history of occasional depression which interferes with functioning but currently well controlled, may be taking medication. May have behavior management plan in place.

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.

Presently displays depression which significantly impairs the ability for self-care, may or may not be taking medication. My have behavior management plan in place.

Comments:

### **Disruptive /Socially Inappropriate Behavior**

*Inappropriate behavior such as making excessive demands for attention, taking another's possessions, being verbally abusive, disrobing in front of others and displaying inappropriate sexual behavior.*

No history of disruptive, aggressive or socially inappropriate behavior.

Current or history of occasional disruptive, aggressive or socially inappropriate behavior, either verbally or physically threatening. May require special tolerance or staff training. May have behavior management plan in place.

- 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.
- Is dangerous or physically threatening and requires constant supervision, a professionally authorized behavioral management program, and/or professional consultation and intervention. May have behavior management plan in place.

Comments:

### **Hallucinations**

*Visual, auditory, tactile, olfactory or gustatory perceptions that have no basis in reality.*

- No history of hallucinations.
- 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.
- Current or history of frequent hallucinations which interfere with functioning and may require medication and routine monitoring by behavioral health professional. May have behavior management plan in place.
- Presently has hallucination(s) which significantly impair ability for self-care, may or may not be taking medication. May have behavior management plan in place.

Comments:

### **Judgment**

*Ability to make appropriate decisions, solve problems or respond to major life changes.*

- Judgment is good. Makes appropriate decisions.
- Current or history of occasional poor judgment. May make inappropriate decisions in complex or unfamiliar situations. Needs monitoring and guidance in decision making. May have behavior management plan in place.
- Current or history of frequent poor judgment. Needs protection and supervisions because participant makes unsafe or inappropriate decisions. May have behavior management plan in place.
- Judgment is always poor. Cannot make appropriate decisions for self or makes unsafe decisions and needs intense supervision (Intense supervisions is needed to prevent danger to self or others.) May have behavior management plan in place.

Comments:

### **Memory**

*Ability to recall and use information.*

- Does not have difficulty remembering and using information. Does not require directions or reminding from others.
- 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.
- Current or history of frequent difficulty remembering and using information, and requires direction and reminding from others. Cannot follow written instructions. May have behavior management plan in place.

Cannot remember or use information. Requires continual verbal prompts. May have behavior management plan in place.

Comments:

### **Orientation**

*Ability to relate to person, place, time and/or situation.*

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

Current or history of occasional disorientation to person, place, time or situation that does not interfere with functioning in familiar surroundings. Requires some direction and reminding from others. May have behavior management plan in place.

Current or history of frequent disorientation to person, place, time or situation even if in familiar surroundings and requires supervision and oversight for safety. May have behavior management plan in place.

Always disoriented and requires constant supervision and oversight for safety. Extensive intervention needed to manage behavior.

Comments:

### **Self-Preservation / Victimization**

*Ability to avoid situations in which person may be easily taken advantage of and to protect him/herself and his/her property from others.*

No history of self-preservation, victimization or exploitation. Participant is clearly aware of surroundings and is able to discern and avoid situations in which he/she may be abused neglected or exploited.

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

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.

Requires constant supervision due to inability to discern and avoid situations in which he/she may be abused, neglected or exploited. May have behavior management plan in place.

Comments:

### **Wandering**

*Moving about aimlessly; wandering without purpose or regard to safety.*

No history of wandering.

Current or occasional history of wandering within the residence or facility and may wander outside, but does not jeopardize health or safety (of self or others.) May have behavior management plan in place.

Current or frequent history of wandering within the residence or facility. May wander outside; health or safety may be jeopardized but participant is not combative about returning and does not require professional consultation or intervention. May have behavior management plan in place.

Wanders outside and leaves immediate area. Has consistent history of leaving immediate area, getting lost or being combative about returning. Requires constant supervision, a professionally authorized behavioral management program and/or professional consultation and intervention. May have behavior management plan in place.

Comments:

## FUNCTIONAL ABILITIES

### Attendant Care

#### Bathing

Identify the participant's ability to bathe and wash hair

Assistance Required:	Available Support:
Comments:	

#### Dressing

Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing

Assistance Required:	Available Support:
Comments:	

#### Eating Meals

Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup

Assistance Required:	Available Support:
Comments:	

#### Emergency Response

Identify the participant's ability to recognize the need for and to seek emergency help

Assistance Required:	Available Support:
Comments:	

#### Medication

Identify the participant's ability/willingness to administer his/her own medication

Assistance Required:	Available Support:
Comments:	

#### Mobility

Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed

Assistance Required:	Available Support:
Comments:	

#### Night Needs

Identify the participant's need for assistance during the night

Assistance Required:	Available Support:
Comments:	

#### Personal Hygiene

Identify the participant's ability to shave, care for mouth and comb hair

Assistance Required:	Available Support:
Comments:	

#### Supervision

Identify the participant's ability to manage his/her life, including needs and activities

Assistance Required:	Available Support:
Comments:	

#### Toileting

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

Assistance Required:	Available Support:
Comments:	

#### Transferring

Identify the participant's ability to transfer when in bed or wheelchair

Assistance Required:	Available Support:
Comments:	

#### Homemaker

##### Access to Transportation

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

Assistance Required:	Available Support:
Comments:	

##### Housework

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

Assistance Required:	Available Support:
Comments:	

### Laundry

Identify the participant's ability to do own laundry either at home or at the Laundromat

Assistance Required:	Available Support:
Comments:	

### Preparing Meals

Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on

Assistance Required:	Available Support:
Comments:	

### Shopping

Identify the participant's ability to shop for food and personal items

Assistance Required:	Available Support:
Comments:	

## SURVEY

### Participant Experience

1. Do your service providers treat you with respect and dignity?
2. Does your service provider understand and respect your choices and preferences on how services are delivered to you?
3. Have you ever gone without services because the service provider did not show up?
4. Are you happy with the care your service provider gives you?
5. Are you satisfied with your current level of community engagement?

### Participant Record

1. Is there a copy of Progress Notes in the participant's residence?
2. Do the Progress Notes document that services are delivered as authorized by IDHW?

### Service Plan

1. Is there a current Service Plan in the participant's residence?
2. Does the Service Plan include and address all needs outlined on the UAI?
3. Are Risk Factors properly addressed in the Service Plan?
4. Are Personal Goals & Outcomes identified on the Service Plan?
5. Is the Service Plan signed by the Participant/Legal Guardian and Provider?



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

**SERVICE AGREEMENT**

**Client Information:**

Client Name		Home Phone	
Address		Medicaid #	
City		Date Of Birth	
State		Marital Status	
Zip		Assessment Date	
Language		Admission Date	
Gender		Next Review Date	
Housing Arrangement		Facility Name	
Region		Facility Phone	
Assessment Type			

**Primary Physician:**

Physician Name		Phone	
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Goals	Outcomes

Participant Strengths:	Participant Preferences:

General information

**Preparing Meals**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
---	---	---	---

**Provider Care Plan** Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Eating Meals**

<b>Assistance Required:</b> <input type="text"/>	Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
---	---	---	---

**Provider Care Plan** Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Toileting**

<b>Assistance Required:</b> <input type="text"/>	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.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
---	--	---	---

**Provider Care Plan** Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Mobility**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
---	--	---	---

**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Transferring**

Assistance Required: <input type="text"/>	Identify the participant's ability to transfer when in bed or wheelchair.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
--	---	--	--------------------------------------

**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Personal Hygiene**

Assistance Required: <input type="text"/>	Identify the participant's ability to shave, care for mouth, and comb hair.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Dressing**

Assistance Required: <input type="text"/>	Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Bathing**

Assistance Required: <input type="text"/>	Identify the participant's ability to bathe and wash hair.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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<b>Provider Care Plan</b> Frequency: ___Daily ___Weekly ___Monthly ___As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  <div style="height: 60px;"></div>
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**Access to Transportation**

Assistance Required: <input type="text"/>	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: <input type="text"/>	Unmet Needs: <input type="text"/>
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<b>Provider Care Plan</b> Frequency: ___Daily ___Weekly ___Monthly ___As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  <div style="height: 60px;"></div>
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**Shopping**

Assistance Required: <input type="text"/>	Identify the participant's ability to shop for food and personal items.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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<b>Provider Care Plan</b> Frequency: ___Daily ___Weekly ___Monthly ___As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  <div style="height: 60px;"></div>
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**Laundry**

Assistance Required: <input type="text"/>	Identify the participant's ability to do own laundry either at home or at laundromat.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Housework**

<b>Assistance Required:</b> <input type="text"/>	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.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Night Needs**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's need for assistance during the night.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Emergency Response**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to recognize the need for and to seek emergency help.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Medication**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability/willingness to administer his/her own medication.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan**    Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Supervision**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to manage his/her life, including needs and activities.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**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*

**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:
<b>Communication Plan</b> (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.

\_\_\_\_\_  
Service Provider Name

\_\_\_\_\_  
Date