

**Louisiana Department of Health-Office for Citizen's with Developmental Disabilities
Plan of Care (POC) for Children's Choice Waiver**

POC TYPE: INITIAL ANNUAL

INDIVIDUAL'S NAME (LAST NAME, FIRST NAME)		DOB	LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER			RELATIONSHIP	
MEDICAID ID #			Is this a Legal Relationship as identified in Legal Status below?	
PHYSICAL ADDRESS			MAILING ADDRESS (if different)	
CITY/STATE/ZIP		PARISH	REGION	CITY/STATE/ZIP
DAYTIME PHONE	NIGHTTIME PHONE		DAYTIME PHONE	NIGHTTIME PHONE
SUPPORT COORDINATION AGENCY			PROVIDER NUMBER	
ADDRESS OF SUPPORT COORDINATION AGENCY			SUPPORT COORDINATOR (SC)	SC SUPERVISOR
CITY/STATE/ZIP			TELEPHONE NUMBER	

SEX: MALE FEMALE **RACE:** BLACK WHITE HISPANIC ASIAN OTHER: _____

EDUCATION: ATTENDS SCHOOL HOMEBOUND 9 MONTHS 10 MONTHS N/A

LEGAL STATUS: MINOR INTERDICTED POWER OF ATTORNEY COMPETENT MAJOR OTHER: _____

IDD: MILD MODERATE SEVERE PROFOUND OTHER: _____

PRIMARY DIAGNOSIS CODE: _____ **SECONDARY DIAGNOSIS CODE:** _____

ADAPTIVE FUNCTIONING: MILD MODERATE SEVERE PROFOUND OTHER: _____

90L: PHYSICIAN DATE: _____ SC REC'D: _____ **AMBULATION:** YES NO _____

SELF-EVACUATE HOME: YES NO **IF NO, INDIVIDUALIZED EVACUATION PLAN IS ATTACHED:** YES NO

EMERGENCY RESPONSE LEVEL: LEVEL 1-Total Assistance with Life Sustaining equipment LEVEL 2-Total Assistance
 LEVEL 3-Can respond/Needs transportation LEVEL 4-Can respond independently

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? YES NO IF YES, WHERE? _____

PROPOSED LIVING ADDRESS: _____

ARE THERE MULTIPLE INDIVIDUALS WITH WAIVERS IN THE HOME? YES NO IF YES, HOW MANY? _____

ARE THERE MULTIPLE INDIVIDUALS WITH DISABILITIES (without Waiver) IN THE HOME? YES NO IF YES, HOW MANY? _____

DOES THE POC INCLUDE PLANS FOR RESTRAINTS? YES NO

ARE PAID CAREGIVERS RELATED TO INDIVIDUAL? YES NO IF YES, RELATION & SERVICE _____

DO PAID CAREGIVERS LIVE WITH INDIVIDUAL? YES NO IF YES, NAME & SERVICE _____

PRESENT HOUSING ARRANGEMENT:

ICF/DD NURSING FACILITY Permanent Supportive Housing Unit: _____

OWN HOME (Parent/Guardian): OTHER'S HOME:

IF ELIGIBLE, DID THE PARTICIPANT RECEIVE AN OFFER TO CHANGE DIRECT SERVICE PROVIDERS? YES NO

WAS A CHANGE IN DIRECT SERVICE PROVIDER REQUESTED? YES NO

WAS A FREEDOM OF CHOICE OFFERED? YES NO

FOR LGE USE ONLY: HIGH RISK PARTICIPANT: YES NO (If Yes, OCDD will add to High Risk Tracking)

Final Packet Receipt Date: _____

POC Begin Date: _____ **POC End Date:** _____

SECTION I: EMERGENCY INFORMATION (Note: Individualized Emergency Evacuation/Response Plan must be attached.)

Individual's Name:	Age:
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Address:

Directions to home:

Persons responsible for evacuating, if necessary, or bringing supplies to participant's home:

Name:	Relationship:
Address:	
Home Phone:	Work/Other Phone:

Family members/others to contact in case of emergency:

Name:	Relationship:
Address:	
Home Phone:	Work/Other Phone:
Name:	Relationship:
Address:	
Home Phone:	Work/Other Phone:

Emergency equipment in home:(e.g., fire extinguishers, smoke detectors, first aid kits, home evacuation plan, specialized medical equipment)

Special Consideration: (e.g., assistive technology supporting independence, ventilator dependent, medications, etc.)

Agencies involved with the individual: (Service Providers, DCFS, APS, LRS, churches, etc.)	
Agency:	Phone:
Contact Person:	
Agency:	Phone:
Contact Person:	
Agency:	Phone:
Contact Person:	

Individual's Doctor(s):

Doctor's Name	Specialty	Phone

SECTION II: CURRENT STATUS OF THE INDIVIDUAL'S PERSONAL OUTCOMES AND SUPPORTS

1. IDENTITY: People choose personal goals; People choose where & with whom they live; People choose where they work; People have intimate relationships; People are satisfied with services; People are satisfied with their personal situations.

Current Status:

Supports:

2. AUTONOMY: People choose their routine; People have time, space & opportunity for privacy; People decide when to share personal information; People use their environment.

Current status:

Supports:

3. AFFILIATION: People live in integrated environments; People participate in the life of the community; People interact with other members of the community; People perform different social roles; People have friends; People are respected.

Current status:

Supports:

4. ATTAINMENT: People choose services; People realize personal goals.

Current Status:

Supports:

**SECTION II: CURRENT STATUS OF THE INDIVIDUAL'S PERSONAL OUTCOMES AND SUPPORTS
(CONTINUED)**

5. SAFEGUARDS: People are connected to natural support networks; People are safe.

Current Status:

Supports:

6. RIGHTS: People exercise rights; People are treated fairly.

Current Status:

Supports:

7. HEALTH AND WELLNESS: People have the best possible health; People are free from abuse and neglect; People experience continuity and security.

Current Status:

Supports:

SECTION III: HEALTH PROFILE

A. HEALTH STATUS

1. PHYSICAL:

2. MEDICAL DIAGNOSES/CONCERNS/SIGNIFICANT MEDICAL HISTORY:

3. PSYCHIATRIC/BEHAVIORAL CONCERNS:

4. BEHAVIOR PLAN (if needed) (Attach copy to POC): YES NO

5. INCIDENT REPORTS (for past 6 months):

- A. Incidents # _____
- B. Non-critical Incidents # _____
- C. Hospital Admissions # _____
- D. Emergency Visits # _____
- E. Psych Hospital Admissions # _____

6. SUMMARY:

B. LIST OF TREATMENTS: (e.g., catheterization, tube feeding, dressing changes, splints, braces, suction, etc.)

C. ALLERGIES:

Medications: _____ Food: _____ Airborne: _____
What does the reaction look like, or what occurs with the reaction? **(BE SPECIFIC)**

SECTION IV: PARTICIPANT PROFILE

A. PERTINENT HISTORICAL INFORMATION: (Date, age at time of onset, and cause of disability. If not known, enter "unknown." Placement history; recurring situations that impact care; response to interventions in the past; summary of events leading to request for service at this time.)

B. CURRENT LIVING SITUATION: (Describe current family situation; level of education attainment; identify family's understanding of individual's situation/condition, knowledge of disability and consequences of non-compliance with POC; economic status; relevant social environment and health factors that impact individual (i.e., health of care givers, home in rural/urban area, accessibility to resources); own home/rental/living with relatives/extended family or single family dwelling. Is the home environmentally safe? Does the home environment adequately meet the needs of individual or will environmental modifications be required?)

C. NATURAL SUPPORTS: [List family members, names and ages. How they are involved/not involved? Who is the primary care giver (PCG)? Is the PCG employed? Are any of the care givers paid for supports? If there are no natural supports, has guardianship been considered? Description of complete social support network-list friends and other community resources involved in supporting the individual on a daily basis.]

D. COMMUNITY SUPPORTS/OTHER AGENCY INVOLVEMENT: (Individual's significant life events, which may include family issues and issues with social/law enforcement agencies. Does individual have social services caseworker or Probation Officer assigned? Will you have to interact with that agency/individual?)

E. DAILY LIVING SKILLS: (Describe activities of daily living that must be completed by others. What skills can individual complete independently? With assistance? Require total assistance?)

Information included on this page is relevant to the individual's life today and provides a means of sharing social/family history not addressed in the content of the POC. Include information that the individual and/or his/her family feels is important to share and relevant to supporting and achieving the outcomes determined by the individual/family.

SECTION V: PERSONAL PREFERENCES

A. GIFTS AND TALENTS:	B. THINGS THAT WORK: LIKES/NEGOTIABLE	C. THINGS THAT DON'T WORK: DISLIKES/NON-NEGOTIABLE

NAME: _____
Issued: May 01, 2017
Replaces all previous issuances

SECTION VI: POC SERVICES, NEEDS AND SUPPORTS

Utilize this form to complete the support coordination and provider plan of care. Reference each Service Area. This form may be duplicated as necessary.

SERVICES:

- | | | | | |
|---|---------------------------------|-------------------------------|---------------------|------------------------------|
| SUPPORT COORDINATION | CRISIS SUPPORT | SPECIALIZED MEDICAL EQUIPMENT | AQUATIC THERAPY | HIPPO THERAPY |
| FAMILY SUPPORT | CRISIS SUPPORT / 2 | AND SUPPLIES | ART THERAPY | THERAPEUTIC HORSEBACK |
| FAMILY SUPPORT / 2 CHILDREN | CHILDREN | ENVIRONMENTAL ACCESSIBILITY | MUSIC THERAPY | RIDING |
| FAMILY TRAINING | CRISIS SUPPORT/
CENTER BASED | ADAPTATIONS | SENSORY INTEGRATION | FAMILY /VOLUNTEER |
| ACTIVITIES (e.g., games, crafts, reading) | CENTER BASED | PSH-HOUSING STABILIZATION | | NON-MEDICAID |
| | RESPIRE | TRANSITION | | RESOURCES |
| | | | | OTHER RESOURCES
(SPECIFY) |

PERSONAL OUTCOMES “What” the individual wants for his/her self	SUPPORT STRATEGY NEEDED “What” is needed to achieve the Personal Outcome? “How” will the support be delivered? “Who” will deliver the support? (paid/unpaid support) “Where” will the support be provided? “Will” assistive devices be required? <u>Be specific.</u>	HOW OFTEN FOR SUPPORTS AND SERVICES List the service/support and “How often” it will be provided?	REVIEW / ACCOMPLISHMENT DATE “When” will the support be reviewed/the Personal Outcome be achieved?
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	4.
4.	4.	4.	5.

Note: Planning must include and reflect emergency back-up plans for services and emergencies.

SECTION VII: POC TYPICAL WEEKLY SCHEDULE (Planning Worksheet)

FOR PLANNING PURPOSES ONLY: IF MY NEEDS CHANGE, I WILL CONTACT MY SUPPORT COORDINATOR AS SOON AS POSSIBLE. I HAVE INCLUDED ALL THE PCS, STATE PLAN, HOME HEALTH, RESPITE AND OTHER SERVICES I PLAN TO USE.

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
12:00 AM							
01:00 AM							
02:00 AM							
03:00 AM							
04:00 AM							
05:00 AM							
06:00 AM							
07:00 AM							
08:00 AM							
09:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
01:00 PM							
02:00 PM							
03:00 PM							
04:00 PM							
05:00 PM							
06:00 PM							
07:00 PM							
08:00 PM							
09:00 PM							
10:00 PM							
11:00 PM							

Comments: Include proposed waiver and non-waiver services on weekly schedule. No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice Waiver services cannot be provided on the same day at the same time as any other waiver or state plan services. Services cannot be provided in a school setting.

SECTION VIII (B): IDENTIFIED SERVICES, NEEDS, AND SUPPORTS

CONFIDENTIAL

IDENTIFIED SERVICES AND SUPPORTS THAT WILL HELP ME MAINTAIN AND/OR ACHIEVE MY PERSONAL OUTCOMES.

Children’s Choice Waiver (Super Provider)	Children’s Choice Waiver (Individual Providers)	Medicaid Funded Services	Non- Waiver Supports
<input type="checkbox"/> Family Supports	<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> EPSDT/ PCS	<input type="checkbox"/> OCDD/LGE Family Supports
<input type="checkbox"/> Shared Supports	<input type="checkbox"/> Art Therapy	<input type="checkbox"/> Dental	<input type="checkbox"/> DCFS
<input type="checkbox"/> Center-Based Respite	<input type="checkbox"/> Music Therapy	<input type="checkbox"/> Eye Glasses	<input type="checkbox"/> Natural Supports
<input type="checkbox"/> Environmental Accessibility Adaptations	<input type="checkbox"/> Hippotherapy	<input type="checkbox"/> Home Health Extended	<input type="checkbox"/> Community Supports
<input type="checkbox"/> Specialized Medical Equipment and Supplies	<input type="checkbox"/> Therapeutic Horseback Riding	<input type="checkbox"/> Hospice	
<input type="checkbox"/> Family Training	<input type="checkbox"/> Sensory Integration	<input type="checkbox"/> Medical Transportation	
	<input type="checkbox"/> PSH- Housing Stabilization	<input type="checkbox"/> Mental Health	
	<input type="checkbox"/> PSH- Housing Stabilization Transition	<input type="checkbox"/> Podiatry Services	
		<input type="checkbox"/> Substance Abuse	
		<input type="checkbox"/> Prescriptions/Medication	<input type="checkbox"/> Others
		<input type="checkbox"/> Others	

Support Coordinator Signature: _____

SECTION IX: POC SIGNATURE PAGE

SIGNATURES OF ALL PLANNING MEETING PARTICIPANTS

Planning Participant/Relationship

Planning Participant/Relationship

SUPPORT COORDINATOR SIGNATURE

Date

	Participant/Authorized Representative Initials
I have been offered a choice between waiver and institutional services and I have chosen (check one): _____ waiver _____ institutional	
I have been informed of the available support coordination agencies and I have chosen: (Name of Agency Chosen) _____	
I have been offered the choice of available direct service providers from the OCDD Provider Freedom of Choice Listing and I have chosen: (List all Chosen Providers)	
I have been informed of all state plan services.	
I have been informed of my rights and responsibilities regarding home and community-based waiver services and have been given the WSS Rights and Responsibilities Form (OCDD-R-17-003) which includes information on how to report abuse, neglect, exploitation, or extortion.	
My support coordinator has provided me with the toll-free number to contact the Health Standards Section if I want to report a complaint about my support coordinator or waiver service provider(s). That number is 1-800-660-0488.	

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify my support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify my support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.

I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion with OCDD/LGE and/or a fair hearing by requesting a fair hearing/appeal within 30 days of the approved/denied decision. I will contact the LGE for an informal discussion. I understand that a LDH Appeal may be requested by contacting OCDD/LGE, by calling or writing the Division of Administrative Law-Louisiana Department of Health Section, P.O. Box 4189, Baton Rouge, LA 70821-4189.

Participant/Guardian Signature

Date

Witness

Date

Reviewed by Support Coordinator Supervisor - Signature/Title: _____ Date: _____

Plan of care reviewed and approved by Support Coordinator Supervisor. WSS Representative has reviewed approval documentation and is in agreement as indicated by stamp date and signature. _____

FOR LGE-WSS USE ONLY:

PARTICIPANT NAME: _____ PROGRAM TYPE: _____
 DATE COMPLETED POC RECEIVED _____ LGE-WSS PRE-CERT HOME
 IN LGE-WSS: _____ VISIT DATE: _____
 THIS POC MEETS THE IDENTIFIED NEEDS OF THE INDIVIDUAL: APPROVED DENIED
 WITHOUT THE SERVICES AVAILABLE THROUGH THIS WAIVER, THE PARTICIPANT WOULD QUALIFY FOR INSTITUTIONAL CARE:
 Yes No
 APPROVED POC BEGIN DATE: _____
 APPROVED POC END DATE: _____
 SERVICES APPROVED:

SIGNATURE/TITLE OF LGE- WSS REPRESENTATIVE:

DATE: