Louisiana Department of Health & Hospitals

Comprehensive Plan of Care

EPSDT - Targeted Support Coordination

CPOC Type: _____ Annual, Initial, Interim

Participant's Name:	Participant's DOB:	Region:
Social Security Number	Guardian:	
Medicaid Number:	Relationship:	
Address:	Address (if different) :	
City/State/Zip:	City/State/Zip:	
Home Phone: Other Phone:	Home Phone: Other Phone:	
Support Coordination Agency:	Provider Number:	
Support Coordination Agency's Address:	Contact Person:	
City/State/Zip:	Phone:	
Healthy Lousiana Agency:	Healthy Louisiana Agency Phone:	
Healthy Louisiana Agency:	Healthy Louisiana Agency Phone:	

Sex: ____ 1. Male 2.Female

Race: ____ 1. White 2. Black/African American 3. Asian Pacific Islander 4. American Indian 5. Alaskan 6.Other

Education: ____

01 Early Intervention	05 Regular and Special Education	09 Post-secondary: Colleg	13 Employed	98 N/A
02 Non-Categorical	06 Special Education Only	10 Post-secondary: Vocationa	14 Unemployed	99 Other
03 Regular Kindergarten	07 Homebound Full Time	11 Pre-vocational Trainin	15 Working toward GED	
04 Regular Education Only	08 Graduated	12 Supported Employmen	16 Home Schooled	

Legal Status: ____ 1. Competent Major 2. Minor 3. Interdicted -- Full 4. Interdicted -- Limited 5. Tutorship 6. Commitment 7. Custody 8. O

Is able to direct his/her own care: _____ Yes, No

ID: _____ Mild, Moderate, Severe, Profound, Special Needs

Adaptive Functioning: _____ Mild, Moderate, Severe, Profound, Special Needs

Diagnosis Code (ICD9) : _____

Residential Placement: ____

01 Homeless	07 Community Home with 6 or less beds	13 Lives Independently with Other
02 Incarcerated	08 Supervised Apartment-OCDD Contract	14 Lives Independently
03 Temporary Quarters	09 Supported Living/Residential Habilitation	15 Psychiatric Facility
04 Nursing Home	10 Subsitute Family Care	16 General Medical Facility
05 ICF/DD with 16 or more beds	11 OCS Foster Care	99 other
06 ICF/DD with 7 to 15 beds	12 Lives with Family/Friends	

Number of other individuals in home who are ID/DD/Special Needs who receive Medicaid Services: _____

Names: _____

FOR LDH USE ONLY

CPOC Begin Date: CPOC End Date:

Signature of DHH: Date:

Participant Name: Medicaid ID: CPOC: Begin Date: End Date:

SECTION II: Medical/Social/Family History

PAST: Pertinent Historical Information: (date age and Cause of disability. If not known, put unknown. Placement situations that impact care; response to interventions in the past summary of events leading to request for services at this time.)

PRESENT: Describe Current Living Situation: (describe current family situation; identify all available natural supports; identify family's understanding of individual's situation/condition - knowledge of disability and consequences of non-compliance with CPOC; economic status; relevant social environmental 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. Does home environment adequately meet the needs of individual or will environmental modifications be required ?)

HEALTH STATUS:

Physician Name: _____

Date of Last Appointment: _____

Immunizations Current: Yes No

Medical Diagnoses and Concerns/Significant Medical History:
(Include findings of last physical)

Dates of Evaluations/Documentation used to develop this CPOC

_____ Social
_____ Pyschological
_____ Psychiatric
_____ Special Education
_____ Individual Education Plan
_____ Behavior Management Plan
_____ Home Health Plan of Care
_____ 90 or Medical Records
_____ SOA
_____ Pediatric Day Health Care P
☐ SOA Permanent
_____ Other _____

Psychiatric/Behavioral Concerns:

Information included on this page is relevant to the individual's life today and provides a means of sharing medical/social/family history not addressed in the content of the CPOC. Include information that is important to share and relevant to supporting and achieving the goals determined by the person.

Participant Name: Medicaid ID: CPOC: Begin Date: End Date:

SECTION III: CPOC SERVICE NEEDS AND SUPPORTS

Service Strategy/ Descript	How was need determined?	Requested by participant/family	Why Not	Goal(s)	Receiving Service	Medicaid	School	Community	Family	OCDD	Requires PA	tracked by S. C.	Amount Approved	Reason for not Tracking
Personal Care Service		☐			☐	☐	☐	☐	☐	☐	☐			
Home Health Service		☐			☐	☐	☐	☐	☐	☐	☐			
Medical Equipment & Supplie		☐			☐	☐	☐	☐	☐	☐	☐			
OT		☐			☐	☐	☐	☐	☐	☐	☐			
Physical Therapy		☐			☐	☐	☐	☐	☐	☐	☐			
Speech Therapy		☐			☐	☐	☐	☐	☐	☐	☐			
Specialized Behavioral Heal		☐			☐	☐	☐	☐	☐	☐	☐			
Dental Services		☐			☐	☐	☐	☐	☐	☐	☐			
Eyeglasses		☐			☐	☐	☐	☐	☐	☐	☐			
Transportation Services		☐			☐	☐	☐	☐	☐	☐	☐			
Diapers		☐			☐	☐	☐	☐	☐	☐	☐			
School		☐			☐	☐	☐	☐	☐	☐	☐			
Vocational		☐			☐	☐	☐	☐	☐	☐	☐			
Employment		☐			☐	☐	☐	☐	☐	☐	☐			
Transition		☐			☐	☐	☐	☐	☐	☐	☐			
Pediatric Day H.C.		☐			☐	☐	☐	☐	☐	☐	☐			
Applied Behavior Analysis		☐			☐	☐	☐	☐	☐	☐	☐			
Home Modifications		☐			☐	☐	☐	☐	☐	☐	☐			
Community Services		☐			☐	☐	☐	☐	☐	☐	☐			
Redetermination		☐			☐	☐	☐	☐	☐	☐	☐			
OCDD Services		☐			☐	☐	☐	☐	☐	☐	☐			
CSoC		☐			☐	☐	☐	☐	☐	☐	☐			
Evaluation		☐			☐	☐	☐	☐	☐	☐	☐			
EPSDT Screening Exam		☐			☐	☐	☐	☐	☐	☐	☐			
Hearing Aids		☐			☐	☐	☐	☐	☐	☐	☐			
Hospice Services		☐			☐	☐	☐	☐	☐	☐	☐			
Physician/Professional		☐			☐	☐	☐	☐	☐	☐	☐			
Other		☐			☐	☐	☐	☐	☐	☐	☐			

Participant Name:	Medicaid ID:	CPOC: Begin Date:	End Date:

Service Strategy List:

Personal Care Service, Home Health Service, Medical Equipment & Supplies, OT, Physical Therapy, Speech Therapy, Specialized Behavioral Health, Dental Services, Eyeglasses, Transportation Services, Diapers, School, Vocational, Employment, Transition, Pediatric Day H.C., Applied Behavior Analysis , Home Modifications, Community Services, Redetermination, OCDD Services, CSoC, Evaluation, EPSDT Screening Exam, Hearing Aids, Hospice Services, Physician/Professional, Other

Reason for not tracking List:

PA not Required , PA issued monthly, EHH Nurse Tracks (Medical Equipment and Supplies only), Placed on Waitlist, PA from Magellan (Specialized Behavioral Health only), Receiving without PA (OT, PT, ST only)

If the above has not been completed, the CPOC will be returned. All services requested shall be included and shall be re-addressed at each quarterly meeting.

Participant/Guardian's Signature: _____ **Date:** _____

Additional Information about Service Needs and Supports:

SECTION V: CPOC PARTICIPANTS

PLANNING PARTICIPANTS	TITLE & AGENCY NAME

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies in addition to the therapies received at school through the IEP. Yes No
If not why not:

Support Coordinator has reviewed the Medicaid Services Chart with me: Yes No
If not why not:

Support Coordinator has provided me with information on Medicaid EPSDT Services: Yes No
If not why not:

Support Coordinator has provided me with information on EPSDT Screening Services: Yes No

If not why not:

EPSDT Screening Services requested: _____

I have reviewed and agree with the services contained in this plan. I understand it is my responsibility to notify the Support Coordinator of any change in my status which might affect the effectiveness of the services provided. I further agree to notify the Support Coordinator of any change in my income which might affect my child's financial eligibility. I understand the services in this plan of care are not authorized by the Support Coordinator and the services may begin as soon as I am notified of their approval whether or not this plan of care has been approved.

_____ _____

Participants/Guardian's Signature Date

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant's need and that services are being provided. The CPOC will be reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

_____ _____

Support Coordinator's Signature Date

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

_____ _____

Support Coordinator Supervisor's Signature Date

SECTION VI: CARE PLAN ACTION

Participant Name: _____ Date Approvable CPOC Rec'd by LDH: _____

CPOC Status: _____

Approval or denial of this CPOC does not approve or deny any of the services the participant may be eligible for, and only addresses the Support Coordinator's required services implementation and documentation.

Approved CPOC: Begin Date: _____ End Date: _____

Signature/Title of LDH Representative: _____

Notes: _____

Section VI: Typical Weekly Schedule **Confidential**

For Planning Purposes Only. If needs change, I will contact my Support Coordinator as soon as possible.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE
F = Family/Friends
S = Self
Sc = School
ST = Speech Therapy
OT = Occupational Therapy
PCS = EPSDT Personal Care Services
EHH = Extended Home Health
PT = Physical Therapy

COMMENTS:

Above is the schedule of services requested by the individual and should be provided at these times. PCS may be provided

Participant Name: _____ CPOC Begin Date: _____ End Date: _____