ADULT CARE HOME
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
☐ Significant Change___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT _____ SEX (M/F) ____ DOB ____/____/____ MEDICAID ID NO. _____

FACILITY _____

ADDRESS _____

_____PHONE _____ PROVIDER NUMBER _____

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN _____/_____/_____

ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	**Dose**	**Frequency**	**Route**	(✓) **If Self-Administered**
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

☐ Wandering
☐ Verbally Abusive
☐ Physically Abusive
☐ Resists care
☐ Suicidal
☐ Homicidal
☐ Disruptive Behavior/ Socially Inappropriate

☐ Injurious to:
☐ Self ☐ Others ☐ Property

Is the resident currently receiving medication(s) for mental illness/behavior?
☐ YES ☐ NO

Is there a history of:
☐ Substance Abuse
☐ Developmental Disabilities (DD)
☐ Mental Illness

Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? ☐ YES ☐ NO

Has a referral been made? ☐ YES ☐ NO

If YES:

Date of Referral _____

Name of Contact Person _____

Agency _____

Social/Mental Health History: _____
_____
_____
_____
_____
_____
_____
_____

Resident _____

3. AMBULATION/LOCOMOTION: ☐ No Problems ☐ Limited Ability ☐ Ambulatory w/ Aide or Device(s) ☐ Non-Ambulatory
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

4. UPPER EXTREMITIES: ☐ No Problems ☐ Limited Range of Motion ☐ Limited Strength ☐ Limited Eye-Hand Coordination
Specify affected joint(s) _____ ☐ Right ☐ Left ☐ Bilateral
☐ Other impairment, specify _____
_____
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

5. NUTRITION: ☐ Oral ☐ Tube (Type) _____ Height _____ Weight _____
Dietary Restrictions: _____
_____
_____
_____
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

6. RESPIRATION: ☐ Normal ☐ Well Established Tracheostomy ☐ Oxygen ☐ Shortness of Breath
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

7. SKIN: ☐ Normal ☐ Pressure Areas ☐ Decubiti ☐ Other _____
Skin Care Needs _____
_____
_____

8. BOWEL: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
☐ Ostomy: Type _____ Self-care: ☐ YES ☐ NO

9. BLADDER: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
Catheter: Type _____ Self-care: ☐ YES ☐ NO

10. ORIENTATION: ☐ Oriented ☐ Sometimes Disoriented ☐ Always Disoriented

11. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

12. VISION: ☐ Adequate for Daily Activities ☐ Limited (Sees Large Objects) ☐ Very Limited (Blind); Explain_____
Uses: ☐ Glasses ☐ Contact Lens ☐ Needs repair or replacement
Comments _____
_____

13. HEARING: ☐ Adequate for Daily Activities ☐ Hears Loud Sounds/Voices ☐ Very Limited (Deaf); Explain _____
☐ Uses Hearing Aid(s) ☐ Needs repair or replacement
Comments _____

14. SPEECH/COMMUNICATION METHOD: ☐ Normal ☐ Slurred ☐ Weak ☐ Other Impediment ☐ No Speech
☐ Gestures ☐ Sign Language ☐ Writing ☐ Foreign Language Only _____ ☐ Other ☐ None
☐ Assistive Device(s) (Type _____) Has device(s): ☐ Does not use ☐ Needs repair or replacement

CARE PLAN

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: **0 -** INDEPENDENT, **1 -** SUPERVISION, **2 -** LIMITED ASSISTANCE, **3** - EXTENSIVE ASSISTANCE, **4** - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

ACTIVITIES OF DAILY LIVING (ADL) *DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:*	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	**PERFORMANCE CODE**
EATING								
TOILETING								
AMBULATION/LOCOMOTION								
BATHING								
DRESSING								
GROOMING/PERSONAL HYGIENE								
TRANSFERRING								

OTHER: (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)

ASSESSOR CERTIFICATION

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

☐ Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

Name _____ Signature _____ Date _____

PHYSICIAN AUTHORIZATION

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

☐ The resident may take therapeutic leave as needed.

Name _____ Signature _____ Date _____

INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

RESIDENT INFORMATION: In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

DATE OF MOST RECENT EXAMINATION: Includes a yearly physical by the resident's attending physician.

ASSESSMENT:

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.

2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.

   - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.

   - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

TOP OF SECOND PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.

4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.

5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.

6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.

7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.

8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.

10. **ORIENTATION:** Check appropriate box.

11. **MEMORY:** Check appropriate box.

12. **VISION:** Check appropriate box. Expand on concerns in comments area.

13. **HEARING:** Check appropriate box. Expand on concerns in comments area.

14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

TOP OF THIRD PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

CARE PLAN:

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

    ACTIVITIES OF DAILY LIVING: Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

    ASSESSOR CERTIFICATION: Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

    PHYSICIAN AUTHORIZATION: The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.