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 No. _____

DATE OF MOST RECENT EXAMINATION BY PRIMARY CARE PHYSICIAN _____/_____/_____

ASSESSMENT

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

Name	Dose	Frequency	Route	(X) If Self-Administered
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

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

☐ Wandering ☐ Verbally Abusive ☐ Physically Abusive ☐ Resists Cure ☐ Suicidal ☐ Homicidal ☐ Disruptive Behavior/Socially Inappropriate	☐ Injurious to: ☐ Self ☐ Others ☐ Property Is the resident currently receiving medications 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
   Specifically 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

Resident: _____

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: **O -** 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/LOCOMATION								
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