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.