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 _____