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SUPERSEDES: **2007-11, VIII-1**

SUBJECT: **Plan of Care (POC)**

DISTRIBUTION CODE: **I a; V o; VI a,b,c,d**

EFFECTIVE: **October 1, 2011**

APPLICABILITY: **Global Options for Long-Term Care (GO) Medicaid Waiver and Jersey Assistance for Community Caregiving (JACC) Care Managers**

BACKGROUND: The Plan of Care (POC) [form WPA-2] remains the fundamental tool by which the State ensures the health and welfare of the individuals enrolled in the GO Medicaid Waiver or JACC program.

The POC Policy was last revised and distributed in 2007 to provide for greater participant involvement in the development of the POC. At that time, it was also updated to include the participant's personal goals, to reflect the participant's choice of services and providers, and to identify risk factors, back-up plans, and unmet needs as required by the Centers for Medicare and Medicaid Services (CMS).

Most recently, based on quality assurance audits of participant records and findings related to Plan of Care Assurances, conducted by both the Department of Health and Senior Services' Division of Aging and Community Services and the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), this POC Policy has been updated. It is being redistributed to emphasize the development process, use of the Needs Based Care Allocation Tool, and monitoring standards that must be met for all Plan of Care documents.

Included with this updated POC Policy are refinements that have been made to the POC Procedures, as well as the most recent version of the approved POC Form (WPA-2) and Instructions for its completion.

POLICY: The Plan of Care (POC) is the primary written document that specifies waiver, other services and any informal supports that are furnished to meet the assessed needs of a program participant to assist that person to remain in the community. In accordance with 42 CFR 441.301 (b)(1)(i), all waiver services must be furnished pursuant to a written POC that is developed for each waiver participant.

POLICY cont'd:

The requirements related to the POC are as follow:

- The POC includes an integration of assessment information including participant strengths, capacities, needs, preferences, goals, desired outcomes, health status, unmet needs, risk factors and any back-up plans.
- The POC must reflect the full range of a participant's needs and be inclusive of all the services and supports that are furnished to meet the assessed needs of the participant, including services that are funded from sources other than the Waiver (e.g., services that are obtained through the State Medicaid plan, from other public programs and/or through the provision of informal supports).
- The POC must contain the services that are furnished, the amount, duration and frequency of each service, and the type of provider to furnish each service. Meeting these standards is a condition of claiming Federal financial participation in the cost of waiver services furnished to a waiver participant.
- The planning process is completed in a timely manner to allow for a POC signed by the participant or participant's representative, Care Manager (CM), and Care Manager's Supervisor no more than 30 calendar days from the date that the CM receives the case file.
- Federal Financial Participation (FFP) may not be claimed for waiver services that are furnished prior to the development of the POC or for waiver services that are not included in an individual's POC. A POC may not be backdated.
- The POC must be reviewed and revised at least annually or whenever necessary due to a change in the participant's needs or circumstances.
- When non-waiver services and supports are included in the Plan of Care, the waiver administering agency is not responsible for ensuring their availability or actual delivery. As necessary and appropriate, activities should be undertaken to link, refer or advocate for such services. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored during the implementation of the service plan.
- CMS and the State maintain the use of person/family-centered planning methods in Plan of Care development. Such methods actively engage and empower the participant and individuals selected by the participant in leading and directing the design of the Plan of Care and, thereby, ensure that the plan reflects the needs and preferences of the participant (and/or family, if applicable).

PROTOCOLS:

A document with general Background Information has been provided for service planning practices outlined by the following topics:

- Responsibility for Service Plan Development
- Service Plan Development Safeguards
- Supporting the Participant in Service Plan Development
- Service Plan Development Process
- Risk Assessment and Mitigation
- Informed Choice of Providers
- Service Plan Review and Update
- Service Plan Implementation and Monitoring

An updated version of the previously issued Plan of Care Development Procedures & Protocols is also provided for utilization by all Care Managers.

JUSTIFICATION: Federal 1915(c) Medicaid Waiver Assurance: Service Plan (Plan of Care)

-Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

-The state monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of POCs.

-Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

-Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.

-Participants are afforded choice:

- Between waiver services and institutional care; and
- Between/among waiver services and providers.

§1915(c) of the Social Security Act and 42 Code of Federal Regulations (CFR)

42 CFR §441.302 State Assurances

(h) Reporting. Assurance that annually, the agency will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on--

(1) The type, amount, and cost of services provided under the State plan; and

(2) The health and welfare of recipients.

42 CFR §441.301 Contents of request for a waiver, (b)(1)(i)

...the waiver request must--

(1) Provide that the services are furnished--

(i) Under a written plan of care subject to approval by the Medicaid agency.

45 CFR § 92.42

Copies of service plans must be maintained in written or electronic facsimile form for a period of three years from their ending date (or longer when required by the state) – see below.

State Record Retention requirement

All supporting documents, statistical records, and other recipient records shall be retained for five (5) years from the date of termination or transfer by the care management site. These records must be readily retrievable, including when requested by CMS or the State.

Nancy E. Day, Acting Assistant Commissioner
Division of Aging and Community Service

Service Planning Policy - Background Information

A well-designed process for developing and implementing a Global Options for Long-Term Care and/or a Jersey Assistance for Community Caregiving program participant's service plan (Plan of Care) is possibly the most critical component of those two programs.

Service planning is the process through which each participant's needs, goals and preferences are identified and strategies are developed to address those needs, goals and preferences. It is the process through which the participant exercises choice and control over services and supports and through which risks are assessed and planned for. A well-designed process incorporates and maximizes the resources and supports present in the person's life and community. It is important that the planning process also enables and supports each participant (and/or family or legal representative, as appropriate) to fully engage in and direct the planning process to the extent he/she chooses. It is through the planning process that roles and responsibilities are clarified for participants who direct their own services (i.e., with the Participant Employed Provider option).

Global Options for Long-Term Care (GO)

The Plan of Care (POC) identifies the GO Waiver services as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization. In accordance with 42 CFR §441.301 (b)(1)(i), all waiver services must be furnished pursuant to a written Plan of Care that is developed for each waiver participant. The Plan of Care must reflect the full range of a participant's service needs and include both the Medicaid and non-Medicaid services along with informal supports that are necessary to address those needs.

Jersey Assistance for Community Caregivers (JACC)

The POC identifies the JACC services as well as other services and supports that a person needs in order to live successfully in the community. Code of Federal Regulation and federal Medicaid assurances do not apply to the state-funded JACC program, however, the JACC POC is subject to the same service planning Procedures and Protocols. The JACC POC must reflect the full range of a participant's service needs and include both the JACC services along with informal supports and other services in place that are necessary to address those needs.

Responsibility for Service Plan Development

Care Managers, employed by approved care management agencies, are responsible for the development of the POC. For Global Options for Long-Term Care Waiver participants residing in assisted living settings, it is also permissible for Assisted Living providers to develop General Service Plans, if approved as meeting the appropriate Medicaid standards by the participant's GO Care Manager, to serve as official Plans of Care in place of separate plans (WPA-2 forms) as developed by the Care Managers. See Policy 2011-6, VII-4.

Responsibility for the development of the POC means ensuring that all applicable POC Policies, Procedures and Protocols associated with service plan development are carried out. The se include but are not limited to the following:

(1) the participant has the opportunity to engage and/or direct the process to the extent they wish;

(2) those whom the participant wishes to attend and participate in developing the POC are provided adequate notice;

Service Planning Policy - Background Information

(3) the planning process is timely;

(4) needs are assessed and services meet the needs and,

(5) the responsibilities are identified.

It does not mean that the individual who is responsible for POC development has decision-making authority over the services included in the plan.

Service Plan Development Safeguards

Federal policy does not prohibit entities that might furnish other direct waiver services from having responsibility for POC development. However, safeguards should be established when such entities perform POC development to avoid the problems (e.g., self-referral) that may arise in this circumstance. These safeguards must include full disclosure to participants and assuring that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for POC development.

Supporting the Participant in Service Plan Development

An effective POC development process provides the waiver participant the opportunity to actively lead and engage in the development of the plan, including identifying individuals who will be involved in the process. The participant should be furnished with supports that are necessary to enable the participant to actively engage in the planning process, including providing information about the range of services and supports offered through the waiver in advance of POC development and engaging individuals to assist the participant or facilitate a person-centered planning process.

Service Plan Development Process

In general, the State must furnish CMS with a comprehensive description of the dimensions of the POC development process, including the sequence of activities, the integration of assessment information into service planning, and the distribution of roles and responsibilities. Further, when the POC development process results in an individual being denied the services of their choice or the providers of their choice, the State must afford the individual the opportunity to request a Fair Hearing.

When the Waiver provides for participant direction opportunities, the POC development process must include activities that are undertaken during that time that are specific to participant direction (e.g., furnishing information and assistance in learning about and setting up the Participant Employed Provider option).

Risk Assessment and Mitigation

The presence of risks does not mean that an individual should not be offered GO Waiver services, or that they should not have decision-making authority over their services. The identification of potential risks to waiver participants and the development of strategies to mitigate such risks are integral to enabling participants to live as they choose in the community while assuring their

health and welfare. Critical risks should be addressed during the POC development process by incorporating strategies into the plan to mitigate whatever risks may be present. Methods to identify potential risks may include the use of risk assessment tools/instruments to systematically identify risks.

Strategies to mitigate risk should be designed to respect the needs and preferences of the waiver participant. Such strategies might include supports other than waiver services and the use of individual risk agreements that permit the participant to acknowledge and accept the responsibility for addressing certain types of risks.

When individuals are supported in their own private residence or other settings where staff might not be continuously available, the POC should include a Back-Up Plan to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled to provide necessary services and when the absence of the service presents a risk to the participant's health and welfare. An effective Back-Up Plan is one that is crafted to meet the unique needs and circumstances of each waiver participant. The response to this item should also describe the types of Back-Up arrangements that are employed. Such arrangements may include arranging for designated provider agencies to furnish staff support on an on-call basis as necessary

Informed Choice of Providers

GO Waiver participants have the right to freely select from among any willing and qualified provider of waiver services (except when an HCBS waiver operates concurrently with a §1915(b) waiver of free choice of provider). In order to effectively exercise this right, participants should have ready access to accessible information about the qualified waiver providers that are available to furnish the services included in the plan. Such information may be furnished as part of the service plan development process or by other means (e.g., making available resource directories in printed form or via the Internet).

Service Plan Review and Update

The POC is the fundamental tool for assuring the participant's health and welfare. As such, it must be subject to periodic review and update. Such reviews determine the ongoing appropriateness and adequacy of the services and supports identified in the plan and ensure that the services furnished are consistent with the nature and severity of the individual's disability and continue to be responsive to the individual's needs and preferences. ***A service plan must be reviewed and updated no less than annually***. A state may not provide for the automatic continuation of service plans. The plan must be reviewed and updated as necessary.

Service Plan Implementation and Monitoring

In order to assure participant health and welfare and the effective delivery of Waiver services, active, continuous monitoring of the implementation of the POC is an essential component of the waiver. The purpose of monitoring is to ensure that Waiver services are furnished in accordance with the POC, meet the participant's needs and achieve their intended outcomes. Monitoring also

is conducted to identify any problems related to the participant's health and welfare that may require action.

The on-going monitoring of POC implementation is conducted by care management agencies.

At a minimum, monitoring methods shall strive to determine whether:

- Services are furnished in accordance with the POC;
- Participants have access to waiver services identified in the POC (e.g., has the participant encountered problems in securing services authorized in the POC?);
- Services meet the needs of the participant;
- Back-up plans are effective;
- Participant health and welfare is assured;
- Participants exercise free choice of providers; and,
- Participants have access to non-waiver services identified in the POC, including access to health services.

Additionally, methods shall be in place to ensure prompt follow up of identified problems, including problems identified by participants, service providers and others.

Plan of Care (POC) Development Procedures & Protocols
Form # WPA-2

I. ASSESSMENT OF PARTICIPANT

New Jersey Choice (NJChoice) is the formal evaluation tool (standardized assessment and level of care instrument) utilized to complete the clinical evaluation determining nursing facility level of care eligibility for Medicaid applicants. These comprehensive assessments/level of care evaluations are performed by professional staff designated by the Department of Health and Senior Services.

Once an applicant has been determined eligible and appropriate for program enrollment, the assigned Care Manager reviews the assessment and works with the participant to identify both the individual's areas of strength and areas of need in day-to-day living in order to develop an effective Plan of Care.

A. The Care Manager (CM):

- Reviews the participant's file.

New program enrollees-

As per Program Instruction **GQ PI– 2011-01**, issued by DACS in January 2011, the Office of Community Choice forwards the following comprehensive assessment forms to Care Management agencies as part of each individual initial Referral Packet:

- Client Face Sheet
- NJ Choice Care Management Assessment
- NJ Choice Narrative Summary
- Service Authorization
- NJ Choice Identified Needs for Care Planning/Triggers Report
- Interim Plan of Care/Consumer Planning Worksheet
- Options Counseling Attestation Statement

Specifically, when developing Plans of Care (WPA-2) for participants of either the Global Options for Long-Term Care (GO) Medicaid Waiver program, Care Managers are advised to reference the above listed assessment forms for each participant. The information on these assessment forms is to be carefully reviewed and seriously considered by Care Managers as the identification of an individual's assessed needs which, in turn, are to be reflected in his or her initial Plan of Care. For Jersey Assistance for Community Caregiving (JACC) program participants Care Managers are advised to review all JACC application, screening, and NJEASE abbreviated assessment/Mini-CAT documentation when developing Plans of Care.

Long-standing program participants -

Specifically, when developing Plans of Care (WPA-2) for participants who are not new to the program, but have been enrolled for a period of time, Care Managers are advised to reference any updates to the above listed assessment forms for each participant, as well as whatever current information is available to them in order to consider any and all changes to the individuals' assessed care needs which, in turn, are to be reflected in his or her updated Plan of Care.

- Determines to what degree the participant desires to participate in the POC development process.
- Schedules a visit in the participant's residence. If the participant would like others present for the visit, the Care Manager shall assist in the notification process.

B. During the face-to-face meeting, the Care Manager continues the evaluation process started by the Community Choice Counselor (CCC) / Aging and Disability Resource Connection (ADRC) Assessor and:

1. Observes:
   - Participant's interactions with those present;
   - Participant's ambulation/navigation ability;
   - Physical environment; and
   - Appropriateness of participant's appearance.

2. Asks:
   - About changes in participant's support system(s), health conditions, hospitalizations/rehabilitations, ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), goals or preferences, new needs and preferences, and overall functioning and independence level since the previous assessment.

3. Identifies:
   - What services are currently being provided to the participant, including
     - what Health Plan/Health Maintenance Organization (HMO) the participant is a member of to ensure adequate care coordination and curb the potential for duplication of State Plan Services and Waiver services.
   - What informal supports are currently being provided to the participant.
   - Risk factors and the need for back-up plans.

4. Completes:
   - An assessment, using the Long-Term Care Re-evaluation form (WPA-1) ONLY if the Care Manager intends to establish a new time line for the annual Re-evaluation of Level of Care.
   - A Need Based Allocation Tool (NBCAT)

     a. This tool shall be completed when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. This tool shall be used in conjunction with the following documents as applicable:
        - NJ Choice Assessment
        - NJ Choice Narrative Summary
        - Service Authorization
        - NJ Choice Identified Needs for Care Planning/Triggers Report
        - Interim Plan of Care/Consumer Planning Worksheet
        - Long Term Care Re-evaluation Form (WPA-1)

     b. The NBCAT is a guide to assist Care Managers in determining a participant's care needs. This tool is meant to be a guide only and each individual's needs may vary. A copy of this tool is to be kept in the participant's active case record.

     c. The Needs Based Care Allocation Tool assists the state in demonstrating that services available are equal in amount, duration, and scope for all GO participants based on their individual assessed needs. All services authorized by the Care Manager, which are identified in the participants Plan of Care, are based on the individual's assessed needs.

d. Waiver services are arranged to complement and/or supplement (not replace) the services that are already available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide. The GO program is not intended to off-set the cost of agencies paid for privately by other parties.
e. A Need Based Care Allocation Tool is utilized as a consistent and objective means of assisting Care Managers (CM) in determining the hours of home and community based services a GO participant requires. GO participants are provided services based on the information recorded on the NJChoice/comprehensive assessment, LTC Re-evaluation, and the Need Based Care Allocation Tool while also considering the professional judgment of the Care Manager in determining hours of service.

See NBCAT Policy Memorandum for more information.

II. DEVELOPMENT OF PLAN OF CARE

Although the first step in service planning is beginning with an accurate and comprehensive care needs assessment (NJChoice), it is important to understand that the initial assessment should be followed by regular reassessments (re-evaluations) as often as the participant's status demands.

Service planning is an essential part of a participant's long term care, but is often misunderstood or regarded as a waste of time. The Plan of Care is a living document that is to be updated as often as necessary to accurately reflect the care a participant needs and is receiving at any given time. Without a specific document delineating the Plan of Care, important issues are likely to be neglected. Service planning provides a "road map" of sorts, to guide all who are involved with a participant's care needs. To be effective and comprehensive, the service planning process must involve the participant and his or her representative as well as informal supports who are involved in the care of the participant.

A. Initial Step

1. Information is made available to the participant and/or representative to promote active engagement in the POC process.

   Information may include but not be limited to:
   - A program brochure or Fact Sheet
   - The Participant Handbook
   - The Participant Enrollment Agreement

B. Identification of Assessed Needs and Services

1. Participant's strengths, capacities, needs, preferences, personal goals, desired outcomes, and health status are assessed.
2. Participant is informed of services available through the program, limitations of the services, and cost caps.
3. Unmet needs are identified and prioritized.
4. Risk factors regarding participant's personal safety, health condition, behavior, environment, and/or medications are identified; those that trigger the need for a back-up plan are evaluated.
5. Back-up plans, i.e., alternative arrangements for the delivery of services that are critical to participant well being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them, are created.

C. Participant's Choices

1. Participant is informed of service providers available through the program.
   - If the Care Management Agency provides other direct services to the participant, such as Home Based Supportive Care, Home Health, or Adult Day Health Services, that agency must establish safeguards to document that POC development is conducted in the best interests of the participant and avoids the conflict of interest problems that could arise in this circumstance.
   - These safeguards must include full disclosure to participants and assurances that participants are supported in exercising their right to free choice of providers and are provided information about the full range of Waiver services and providers, not just the services furnished by the Care Management Agency.

2. Those in attendance reach agreement on the service options that effectively meet the participant's needs, considering respect for the participant's preferences, optimization of available resources, and service cost effectiveness and feasibility.

3. Participant's preferences for the day(s), time and frequency of services are identified.

4. Steps needed to obtain special services, e.g., environmental modifications or hiring a Participant-Employed Provider (PEP), are reviewed and followed up for timely placement and provision.
   - Identify any specific training or qualifications required of PEP's.
   - Determine who is responsible for completing these steps.

D. Finalizing the Plan of Care

1. The preliminary POC document is completed.
   - This includes completion of all required date fields on the POC form (i.e. Plan of Care Date; Plan of Care renewal date which is to occur at least annually or as needed; signature dates; date each assessed need is identified; & Plan of Care updates)

2. Each assessed need is addressed in the POC.

3. The POC includes information gathered through the evaluations:
   - Problem statements, need codes, services, units, frequency and projected costs, risk factors, back-up plans, unmet needs, and personal preferences and goals.

4. Responsibilities of all parties identified in the POC are discussed and agreed upon.

E. Signing the Plan of Care

1. All who participate in the POC development must sign the POC in a timely manner (within 30 days of the date that the Care Manager receives the record).
   - Securing all Plan of Care (WPA-2) and Plan of Care Approval Form (AL-2) signatures is a requirement (i.e. that of the participant, Care Manager, and Care Management Supervisor, and Assisted Living staff, if applicable).
   - Timeliness of POC completion means adherence to the agreed upon timeframe of a completed, signed POC within 30 days of the date that the Care Manager receives the record; as well as POC updates.

2. The participant and/or representative sign the document as verification that:
   - They have participated in the development of the POC;
   - They are aware of the limitations of the POC;
   - Risk factors have been identified;
   - Back-up plans have been developed to address risk factors;
   - They have had a choice of services and available providers; and
   - They agree with the POC.

3. If the participant is unable to sign the POC, he or she may make an X on the signature line. If the participant has a representative, that person may sign for the participant. If the participant refuses to sign the POC, the Care Manager must write "Refused to sign" on the POC signature line and indicate the reason in the Monitoring Record.

4. The CM shall sign the POC as indication that the POC addresses all of the participant's assessed needs (including health and safety risk factors and any unmet needs) and personal goals.

5. The CM's Supervisor signs the POC as confirmation that he or she has reviewed the POC in its entirety, agrees that the POC identifies all of the participant's assessed needs, provides appropriate available services, and has been developed in accordance with the POC Policy.
   - If the Supervisor or Care Coordinator has prepared the POC, a designated qualified staff person may sign the POC as the reviewer.

6. The participant and any representative who signed the POC must receive a copy of the completed signed POC no later than the next quarterly visit. The original is retained as part of the case file.

7. Documentation in the Monitoring Record (WPA-3) of the circumstances of any delay in completing the Plan of Care or obtaining signatures is expected as explanatory evidence.

III. MONITORING THE PLAN OF CARE

In order to assure ongoing participant health and welfare and the effective delivery of Waiver services, active, and continuous monitoring of the implementation of the POC is essential. The purpose of monitoring is to ensure that Waiver services 1) are furnished in accordance with the POC, 2) meet the participant's needs, and 3) achieve the intended outcomes. Monitoring also is conducted to identify any problems related to the participant's health and welfare that may require action.

A. The Care Manager (CM) must:

1. Contact the participant monthly and visit the participant quarterly. At a minimum, every other quarterly visit must take place in the participant's home.

2. If the participant is non-communicative or cognitively impaired, the CM must document that fact and explain it in the Monitoring Record. If the participant has a representative, the CM should contact him or her for updated information.

- If the participant is institutionalized when the Monthly Contact is due, the CM must document that fact in the Monitoring Record. The CM must contact the participant within two business days of notification of the individual's discharge from the institution.
- If the participant is institutionalized when the Quarterly Visit is due, the CM must document that fact in the Monitoring Record and visit the participant within fourteen calendar days of notification of the individual's discharge from the institution.
    - This visit may either establish a new quarterly visit schedule or comply with the original schedule.

3. Document all participant/representative contacts in the Monitoring Record. The CM should use a brief and pertinent narrative to update information about the client's well being, any changes in supports or health condition(s), significant happenings since the previous contact, and comments about the services. The CM should always ask about service delivery and satisfaction with the services and include responses in the narrative. The CM should not enter "No change" in the Monitoring Record to document a Quarterly Visit or Monthly Contact.

4. Check at least quarterly with the provider of services to verify service delivery and to determine whether the provider has any concerns regarding the participant's well being.

5. Methods instituted by the Care Manager to monitor the Plan of Cares shall include and address the effectiveness of Backup Plans. Through ongoing care management monitoring (Monthly Contacts and face-to-face Quarterly Visits) of the participant's individual care and service needs, the Care Manager shall assess and identify any potential risks to the participant's well-being. Backup Plan development and risk assessment are critical components of on-going care management monitoring. As the participant's needs and high-risk circumstances change, Backup Plans and service considerations are to be modified. Monitoring the effectiveness of Backup Plans for any change/interruption/failure in needed service delivery is essential in order to modify or establish a new Backup Plan that will be effective as necessary.

6. Verification of services may also include the following:
    - Observation of the participant for cleanliness and the general state of his or her home, apartment, or living unit
    - Face-to-face visit with participant while service is occurring
    - Speak with the participant about services received and satisfaction with them
    - Speak with the participant's representative regarding care and satisfaction with services provided
    - Speak with the participant's Health Plan/HMO representative to discuss service authorizations, utilization, and other matters of relevance.
    - Review service log (in AL facility)
    - Review time sheets, vouchers, or invoices of services delivered
    - Home and Community-Based Services (HCBS) Reports

IV. EVALUATION OF PLAN OF CARE

The POC is a living document that should be revised when the participant's needs and/or informal supports change. The POC must address new needs by identifying them and the services necessary to meet them.

A. The Care Manager is authorized to make changes in the POC that are designed to promote the participant's health and well being and that are within the individual's approved spending cap.

- If the need exceeds the approved spending cap, the Care Manager should discuss the increased needs and costs with his or her Supervisor.
- The Supervisor follows the Global Options (GO) protocol for increasing the cap on the Plan of Care for GO participants.
- For a JACC participant, the increased need that exceeds the allowable spending cap should be included on the POC as an unmet need.

B. Changes in the POC must be noted on the POC that is kept in the participant's file.

1. Any change to a POC requires that the CM make the change on the POC, initial and date it, and enter an explanation for the change in the Monitoring Record.
2. If a change reflects an increase, addition, decrease or termination of an existing service, the change must be initialed and dated by the participant or his or her representative no later than the date of the next scheduled visit.
    - The initials are necessary to show the participant is aware of and agrees with the changes. It is especially important when services are decreased or terminated because any reduction or termination of services could be the basis for a Fair Hearing and it is important that there is confirmation that the participant agrees with them.
        - Care Manager must inform participant of the right to appeal any reduction or termination of services.
    - If the participant is unable to initial and/or date the changes on the POC, he or she may make an X in the appropriate column.
    - If the participant refuses to initial the changes, the Care Manager must document that fact on the POC and the reason in the Monitoring Record.

V. CARE PLAN PROCESS FOR ASSISTED LIVING PARTICIPANTS

See Policy Memorandum **PM 2011-6, VII-4,** Dated February 11, 2011 entitled:
"Care Plan Approval for GO participants in Assisted Living Residences (ALR), Comprehensive Personal Care Homes (CPCH), or Assisted Living Programs (ALP) in subsidized housing"

VI. PLAN OF CARE RETENTION

The POC and all participant records should be retained for five years, effective after the final action or death of the participant.

New Jersey Department of Health and Senior Services
Division of Aging and Community Services

PLAN OF CARE

1. Participant Name *(print)*	2. Plan of Care Date *(mm/dd/yyyy)*	3. Medicaid/JACC No.
4. Case Manager Name *(print)*	5. Plan of Care Renewal Due *(mm/yyyy)*	6. Program: ☐ GO ☐ JACC
7. Residential Setting ☐Private Residence ☐AFC ☐ALR ☐CPCH ☐ALP ☐Class B Boarding Home	Facility Name *(if applicable)*	8. Health Plan Provider Agency:

			Services				Costs		Providers		Monitoring				Updates *	
9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Date	Problem Statement*: Identify Assessed Needs, Risk Factors and Personal Goals	Need Codes *	Service(s) Needed	Desired Outcome *	Units Per Visit	Frequency *	Unit Cost	Payment Source*	Provider Type *	Provider	Monitoring Method *	Monitoring Frequency *	Back-up Plan* (If applicable)	Unmet Need Code * (if applicable)	Initials (CM, Clients)	Date

PLAN OF CARE (Continued)

1. Participant Name *(print)*	2. Plan of Care Date *(mm/dd/yyyy)*	3. Medicaid/JACC No.

26. Special Instructions/Comments: [Include all of the following which apply – (1) Incorporate Client Preferences or Concerns; (2) Expound on Unmet Needs; and (3) Describe Back-up Plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns (including who is responsible with emergency contact information)] ☐ **N/A upon completion of initial POC**

Comment	Date	Comment	Date

Yes	No	
☐	☐	**I agree with this Plan of Care.**
☐	☐	**I had the freedom to choose the services in this Plan of Care.**
☐	☐	**I had the freedom to choose the providers of my services based on available providers.**
☐	☐	**I helped develop this Plan of Care.**
☐	☐	**I am aware of my rights & responsibilities as a participant of this program.**
☐	☐	**I am aware that the services outlined in this Plan of Care are not guaranteed.**
☐	☐	**I have been advised of the potential risk factors outlined in this Plan of Care.**
☐	☐	**I understand and accept these potential risk factors.**

Signature_____ ____/____/____

☐ Participant** / ☐ Representative** Date

Signatures:

Care Manager (CM): _____ Date: _____

CM Supervisor: _____ Date: _____

Facility: _____ Date: _____

Other: _____ Date: _____

Other: _____ Date: _____

** Note: All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program.

* Code List

Problem Statement: (Column #10)
Briefly describe the client's individual circumstances which serve as the basis for each assessed need.

Need Codes: (Column #11)
Identify the Code by which each assessed need is best categorized.
Client Unable to:
1. Perform ADL (specify letter)
   a. Bathing
   b. Dressing
   c. Toilet Use
   d. Transferring
   e. Locomotion
   f. Bed Mobility
   g. Eating

Need Codes, Continued
2. Perform IADL (specify letter)
   a. Meal Preparation
   b. Housework
   c. Managing Finances
   d. Medication Management
   e. Phone Use
   f. Shopping
   g. Transportation
   h. Accessing Resources
   i. Laundry
   j. Personal Hygiene
3. Personal Goal
4. Communication Needs
5. Social Isolation
6. Caregiver Relief
7. Mental Health
8. Other (specify) _____

Need Codes, Continued
9. Risk Factors
   a. Personal Safety Risk
   b. Health Condition Risk
   c. Behavioral Risk
   d. Environmental Risk
   e. Medication Risk
   f. Other Risk (specify) _____

Desired Outcome Code: (Column # 13)
1. Maintenance
2. Independence
3. Rehabilitation
4. Prevention
5. Other (specify) _____

Frequency: (Column # 15)
D- Daily (specify # of days per week)
W- Weekly
B- Bi-weekly
M- Monthly
Q- Quarterly
A- Annually
O- Other (specify) _____

Payment Source: (Column #17)
1. Medicaid
2. Medicare
3. Other Third Party Liability (TPL)
4. Local Community-Based Organization
5. County Funded Program
6. State Funded Program
7. Informal Support
8. Private Pay
9. Other _____

Provider Type: (Column #18)
T- Traditional (Medicaid Enrolled)
M- Medicare
N- Non-Traditional Provider
PEP- Participant-Employed Provider
P- Private Provider
F- Facility
I - Informal Support

Monitoring Method: (Column #20)
C- Participant Record/Chart
R- Receipts
S- On-Site Review
D- Documentation (specify) _____
P- Tele Contact with _____
O- Other (specify) _____

Monitoring Frequency: (Column #21)
D- Daily
W- Weekly
B- Bi-weekly
M- Monthly
Q- Quarterly
A- Annually
R- Random
O- Other _____
U- Upon reported completion

Back-Up Plan: (Column # 22)
Y – Yes
If a Back-Up Plan is necessary for the delivery of a service that is critical to participant well-being, indicate here and then explain Plan in Column #26.

Unmet Need Codes (Column # 23)
1. Not available
2. Not affordable
3. Waiting List
4. Frequency not adequate
5. Refused
6. Other (specify) - expound on reason if necessary in Column #26

Updates Columns # 24 and 25)
Completed only as necessary if changes are made throughout the duration of the Plan of Care.

New Jersey Department of Health and Senior Services
Division of Aging and Community Services

INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM

Plan of Care Document Instructions: Top of Page 1

1.	**Participant Name**	Print the participant's full (first and last) name.
2.	**Plan of Care Date**	Enter the full date (Month, Day, Year) the Plan of Care is developed. This is the first date the Plan contents are discussed with the participant. This is not necessarily the same date that the participant signs the Plan of Care once it is completed.
3.	**Medicaid/JACC No.**	Enter the participant's Medicaid number or JACC identification number (12 digits).
4.	**Care Manager Name**	Print the Care Manager's full (first and last) name.
5.	**Plan of Care Renewal Due**	Enter the estimated date (Month and Year) that the Plan of Care renewal is due for completion. Plans of Care are to be updated annually and revised as necessary when warranted by changes in the Waiver participant's needs. For example, the annual Plan of Care is due one year (12 months) from the initial Plan of Care Date (indicated in #2). Also, the Long Term Care Re-Evaluation (level of care assessment) form (WPA-1), is to be completed prior to the annual Plan of Care renewal date. Separate instructions cover this document.
6.	**Program**	Indicate the Program in which the participant is currently enrolled.
7.	**Residential Setting**	Indicate the type of location where the participant is currently residing and indicate the name of the facility, if applicable. • Private Residence – the private home of the participant and/or a relative, etc. • AFC – Adult Family Care Home • ALR – Assisted Living Residence • CPCH – Comprehensive Personal Care Home • ALP – Assisted Living Program in Subsidized Housing • Class B Boarding Home
8.	**Health Plan Provider Agency**	Indicate the name of the Health Maintenance Organization (HMO)/Health Plan of which the GO participant is currently a member.

Plan of Care Document Instructions: Body of Page 1

9.	**Date**	Enter the full date (Month, Day, Year) that each of the assessed needs (Problem Statements) is identified and written into the Plan of Care.
10.	**Problem Statement**	The Problem Statement is to illustrate the ***reason(s)*** for the assessed need. It should briefly describe the participant's health condition, personal goals, risk factors, and/or individual circumstances that serve as the basis for each assessed need and the way in which these impact the participant's functioning. For example, a Column #10 entry should NOT state 'Locomotion' as the Problem Statement. Rather, it would *describe the condition* of the participant and his or her circumstances that have resulted in his or her limited mobility. Furthermore, the participant's diagnosis alone is not a sufficient summary of a Problem Statement justifying the assessed need. Rather, the *impact of the diagnosis* on the participant's day-to-day functioning should be indicated.

11. **Need Code(s)**

Enter the Need Code(s) by which each assessed need is best categorized. For example, if the Problem Statement reads "Participant experienced a stroke and as a result has a poor hand grip, minimal use of her right arm, and is easily fatigued," the Need Code may be '**2d**' if the participant, as a result of this condition, needs assistance with **'Medication Management.'** When 'Option 8 – Other' is used, the assessor shall specify the Need in the blank provided.

For all Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), use the **alphanumeric combination** indicated in the Code List. Also, it is possible for the assessor to enter more than one Need Code for each Problem Statement.

If the Problem Statement is best described as a Personal Goal of the participant (Option 3), please be sure that the participant's preference is clearly described and a Desired Outcome goal is also indicated in Column #13. Some examples of a participant's goal or preference are a) to be able to stay at home as long as possible rather than relocate to a nursing facility, b) to remain as independent as possible with the help of a home health aide, c) to obtain a personal computer to work out of his or her home, or d) to be able to go outside regularly or find transportation for preferred outings.

If the Problem Statement is best described as a Risk Factor (something that is likely to increase the chances that a particular event will occur), please describe these concerns on the last page of the Plan in Column #26. For example, a condition or behavior that increases the participant's chances for injury or the possibility of disease, such as the fact that smoking could lead to heart disease, lung cancer, eviction, or a serious fire hazard.

Assigned codes are used to identify the ADLs or IADLs with which the participant needs assistance or is unable to perform.

1. **ADLs** identify the specific Activity of Daily Living with which the participant needs assistance or is unable to perform.
   a. **Bathing**: Bathing includes how the participant takes a full-body bath/shower or sponge bath. Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, and perineal area.
   b. **Dressing**: Upper Body Dressing includes how participant dresses / undresses (street clothes and underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc. Lower Body Dressing includes how the participant dresses/undresses (street clothes and underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, socks, and fasteners.
   c. **Toilet Use**: Including using the toilet or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing special devices required (ostomy or catheter), and adjusting clothes.
   d. **Transferring**: Including moving to and between surfaces – to/from bed, chair, wheelchair, standing position.
   e. **Locomotion:** Including inside and outside of home. Note: If a wheelchair is used, regard self-sufficiency once in wheelchair.
   f. **Bed Mobility**: Including moving to and from lying position, turning side-to-side, and positioning body while in bed.
   g. **Eating**: Including taking in food by any method, including tube feedings.

2. **IADLs** identify the specific Instrumental Activity of Daily Living (IADL) with which the participant needs assistance or is unable to perform.
   a. **Meal Preparation**: The ability to obtain and prepare routine meals. This includes the ability to open containers and use kitchen appliances, and how meals are prepared (e.g. planning meals, cooking, assembling ingredients,

setting out food, utensils), with assistive devices, if used. If person is fed via tube feedings or intravenously, treat preparation for the tube feeding as meal preparation and indicate level of help needed.

b. **Housework:** The ability to maintain cleanliness of the living environment and how ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up).
c. **Managing Finances:** The ability to handle money, plan budget, write checks or money orders, exchange currency, handle coins and paper, do financial management for basic household necessities (food, clothing, shelter), pay bills and balance a checkbook.
d. **Medication Management:** How medications are managed and ability to follow prescribed medication regime (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).
e. **Phone Use:** How telephone calls are made or received (with assistive devices such as large numbers or telephone amplification).
f. **Shopping:** The ability to run errands and shop, physically acquire, transport and put away groceries. How shopping is performed for food and household items (e.g. selecting appropriate items, getting around in a store).
g. **Transportation:** The ability to drive and/or access transportation services in the community. How participant travels by vehicle (e.g. gets to places beyond walking distance).
h. **Accessing Resources:** The ability to identify needs and locate appropriate resources; the ability to complete phone calls, set up and follow through with appointments, and complete paperwork necessary to acquire services or participate in activities offered by the resources.
i. **Laundry:** The ability to maintain cleanliness of personal clothing and linens.
j. **Personal Hygiene:** Personal hygiene may include ability to perform grooming such as combing hair, brushing teeth, shaving, nail care, applying makeup, and washing/drying face and hands.

Assigned codes are used to identify other areas in which the participant requires assistance. The phrases in parentheses serve only as limited examples. Many more instances could be used to illustrate examples of each Need Code.

3. **Personal Goal:** Something that is a personal aspiration or objective stated by the participant (e.g. accessing transportation to attend social events, enrolling at a local community college, obtaining a personal computer, regularly attending religious services or functions, writing a book, or remaining in his or her own home for as long as possible rather than moving into a nursing facility).

4. **Communication Needs**
(e.g. communication disorders, hearing or speaking impairments)

5. **Social Isolation**
(e.g. lives alone, home in an area inaccessible to visitors)

6. **Caregiver Relief**
(e.g. at risk for reduction of informal supports, caregiver burnout)

7. **Mental Health**
(e.g. cognitive impairment, low self esteem, depression, hopelessness, rage, emotional instability)

8. **Other (specify)** _____

9. **Risk Factors**
   a. **Personal Safety Risk**
   (e.g. supervision needed for personal safety; participant is self-neglecting, abusive of alcohol or other substance)

b. **Health Condition Risk**
(e.g. needs medical attention; visual impairments, obese, sedentary lifestyle, chronic illness, poor nutrition, sleep disturbance, poor health/hygiene, lack of oral/dental care, skin condition/bed sores, improper foot care, at risk of falls, at risk of long term institutional care in nursing facility)

c. **Behavioral Risk**
(e.g. risky or inappropriate behaviors or lifestyle habits)

d. **Environmental Risk**
(e.g. home environment, living conditions are insecure or hazardous; neighborhood is unsafe)

e. **Medication Risk**
(e.g. unable to appropriately manage medications; multiple medications and/or prescribing physicians)

f. **Other Risk (Specify: _____)**

SERVICES

12. **Service(s) Needed**

Service(s) Needed is used to identify distinct services. Enter the type of Service(s) that is required to address each of the assessed needs (e.g., Home Health, Transportation, Meals on Wheels).

13. **Desired Outcome Codes**

Desired Outcome Code identifies the general objective of the service in terms of participant functioning in the need area.

Enter the appropriate Desired Outcome from the Code List. Indicate the meaning of "Option 5 - Other" if used, in the space provided.

The Code answers the following types of questions regarding the participant's functioning:

1. **Maintenance**: Does the participant want his current level of functioning maintained?
2. **Independence**: Does the participant want to gain independent functioning in the area?
3. **Rehabilitation**: Does the participant want to restore functional ability?
4. **Prevention**: Does the participant want to prevent the problem from recurring?
5. **Other (specify)**: Does the participant want to resolve the issue, e.g. the installation of a ramp resolves the lack of access in and out of the home?

14. **Units Per Visit**

Units refer to the number of units of service authorized during an occurrence/visit.

Enter the units of service per visit/occurrence. (See JCN 407 or GO 407A forms.)

15. **Frequency**

Frequency codes are used to distinguish the number of times a service should occur. Indicate the frequency, from the list below, which best describes how often the support is provided/required.

D- Daily, specifying the number of days per week (e.g. 3x). If the participant wants services on the weekends or specific weekdays that preference can be indicated in the Problem Statement.

W– Weekly: Once every week

B– Bi-Weekly: Once every two weeks

M– Monthly: Every month (once within 30/31 days)

Q– Quarterly: Once every three months

A– Annually: Every year (once within 12 months)

O– Other (specify)

COSTS

16. **Unit Cost**

Enter the **Rate per Unit** of service. (See JCN 407 or GO 407-A forms). Rates, where applicable, may not exceed those established in DHSS Medicaid Waiver programs and/or prescribed in the Individual Service Agreement (ISA). Specify the authorized cost for each service. Rates vary but are established in policy. (e.g. Monthly rate for Care Management = $95.00, Daily rate for Social Adult Day Care = $31.12).

17. **Payment Source**

Payment source codes are used to identify the source of funding for a service. Enter code, from the list below, for service payment source.

1. **Medicaid:** Medicaid is medical assistance (health insurance) provided to certain persons with low incomes and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act. Can include both traditional State Plan Medicaid services provided through a Managed Health Plan as well as non-medical services when provided under special Medicaid Waiver programs as authorized under section 1915(c) of the Social Security Act.

2. **Medicare:** Health Insurance generally for individuals over 65 and/or disabled.

   Part A-Hospital Insurance: Helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care) and also helps cover hospice care and some home health care.

   Part B-Medical Insurance: When medically necessary, helps cover doctors' services and outpatient care, often requiring a premium. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

   Part D-Prescription Drug Coverage: Insurance which may help lower prescription drug costs. Private companies provide the coverage and beneficiaries choose the drug plan and may pay a monthly premium. NJ Medicaid Waiver participants do not have a premium.

3. **Other Third-Party Liability (TPL):** Private Health Insurance.

4. **Local, Community-Based organization:** A church organization may be involved, or a local township or city community action program may be used.

5. **County Funded Program:** The county health department or a county human services office may use funds to maintain programs for seniors and persons with disabilities.

6. **State Funded Program:** Can include programs such as the Jersey Assistance for Community Caregiving (JACC) program, the Congregate Housing Services Program (CHSP), the Alzheimer's Adult Day Health Services Program (AADHS), or some other state-funded program.

7. **Informal Support:** Any free or uncompensated support given by a relative or immediate family member, friend, neighbor or other informal companion.

8. **Private Pay:** Any payment made directly by the participant out of his or her own income, resources or personal needs allowance.

9. **Other** _____

PROVIDERS

18. **Provider Type**

Provider Type codes are used to identify persons who assist a participant in the areas of need. Provider / Worker is defined as an individual or entity that demonstrates competence to qualify as a provider of services pursuant to the approved Medicaid Waiver criteria and that provides authorized services to a participant.

Enter code, from the list below, to describe each type of provider.

T – Traditional (Medicaid Enrolled)
A Traditional Provider refers to an individual or entity provider/worker that provides authorized services to a participant and that is enrolled as an approved Medicaid provider able to bill UNISYS directly for the authorized service.

M – Medicare
A provider that has applied, been authorized and enrolled by the Centers for Medicare and Medicaid Services (CMS) as a Medicare provider and as such can submit claims for Medicare covered services and supplies.

N – Non-Traditional Provider
A Non-Traditional Provider refers to an individual or entity that is not enrolled to bill UNISYS directly for services but demonstrates competence to qualify as a provider of services pursuant to the approved Medicaid Waiver criteria and provides authorized services to a participant. The Division of Aging and Community Services, MIS and Data Management Office approves Non-Traditional Providers via a contractual provider agreement.

PEP– Participant-Employed Provider (PEP)
Formerly Client-Employed Provider (CEP). A Participant-Employed Provider refers to an individual worker who has been approved to provide authorized services as a hired employee of the participant.

P – Private Provider
A provider that is rendering goods or services based on payment made directly by the participant out of his or her own income, resources or personal needs allowance or payment made on behalf of the participant by a relative or immediate family member, friend, neighbor or other informal companion.

F – Facility
A Hospital, Nursing Facility, or Assisted Living Facility that would typically be used for facility-based respite stays or for residents in an Assisted Living Facility. A Facility could also be a Traditional Medicaid Enrolled Provider.

I – Informal Support
A relative or immediate family member, caregiver, friend, neighbor or other informal companion who provides services to the participant.

19. **Provider**

Enter the specific name of the Provider Agency or the name of the Participant-Employed Provider responsible for rendering each service.

MONITORING

20. **Monitoring Method**

Monitoring Method codes are used to identify how service provision will be verified. Both State and Federal governments seek proof that services are delivered in accordance with the Plan of Care.
Enter the appropriate Code(s), from the following, to describe how service delivery will be confirmed:

- **C– Participant Record/Chart:** e.g., review of Assisted Living Facility participant records.
- **S– On-site Review:** e.g., face to face visit with participant while service occurring, observing participant and environment.
- **R– Receipts:** e.g., review proof of payment, vouchers, or invoices of services delivered.
- **D– Documentation:** e.g., review of assignment sheets, service delivery logs, medication or treatment administration records.
- **P– Telephone Contact:** e.g., telephone conversations with participant, caregiver, service provider, wellness nurse, or billing agent.
- **O– Other (specify)**

21. **Monitoring Frequency**

Monitoring frequency codes indicate how often service verification is to be performed.
Enter the minimum monitoring frequency, from the codes below, required for each service.

D– Daily
W– Weekly
B– Bi-Weekly
M– Monthly
Q– Quarterly
A– Annually
R– Random
U– Upon reported completion
O– Other (specify)

22. **Back-Up Plan (if applicable)**

Indicate (Y) only if a Back-Up Plan is necessary for the assessed need. Back-Up Plans are needed if the provider identified as responsible for furnishing the services fails or is unable to deliver them and it would have a critical impact on the participant's immediate well-being. Alternative arrangements for the delivery of services would therefore be imperative. *If a Back-Up Plan is necessary, there must be a correlating Risk Factor identified on the Plan of Care as well.*

The agreed upon Back–Up Plan itself is to be fully outlined, with emergency contact information, in Column #26 on the final page of the Plan of Care.

23. **Unmet Need Code**

Unmet Need codes convey those participant needs that have been identified but have no arranged services in place, as an obstacle/barrier limits the need from being met or resolved. Enter the code to indicate why this assessed need remains unmet.

In addition, in Column #26 on the last page of the Plan of Care, describe the impact the unmet need has on the individual's health, safety and well-being, which is likely to require the continued attention of the Care Manager.

Enter code, from the list below, for unmet need.

1. **Not available**
2. **Not affordable**
3. **Waiting list**
4. **Frequency not adequate**
5. **Refused** (service offered but participant declines)
6. **Other (specify) – expound on reason if necessary in Column #26**

Note: Any unmet needs described in this section must also be a component of the Long-Term Care Re-evaluation and must be acknowledged at the reassessment.

UPDATES

24. **Initials**

Plan of Care Updates or Changes: Throughout the Plan of Care please indicate any changes that occur during the year, prior to the annual POC renewal date.

As per the Plan of Care Policy:

- Any change to a POC requires that the **Care Manager** (CM) make the change on the POC, initial and date it, and enter an explanation for the change in the Monitoring Record.
- Changes that reflect an increase, addition, decrease, or termination of an existing service must also be initialed and dated by the **Participant**, or his or her representative no later than the date of the next scheduled visit.

25. **Date**

Enter the date(s), (mm/dd/yy), that the update or change to the Plan of Care was initialed by the Care Manager and by the participant if necessary.

Plan of Care Document Instructions: Page 2

SPECIAL INSTRUCTIONS/COMMENTS

26. **Special Instructions/Comments**

If upon the initial completion of the POC, there are no comments to be added to this section, please check the **N/A** box.

Enter any additional comments including the date and initial each entry.

When utilized, this section should include but not be limited to:

Participant Preferences or Concerns: Please indicate any comments or preferences from the participant. (e.g., only services after 9 a.m.)

Unmet Needs: Please expound on any needs that are identified as unmet in Column #23.

Back-up Plans: Please indicate assessed needs/behaviors/situations/conditions considered to be at-risk concern(s) for the safety and/or well-being of the participant. List the interventions that will be put into place to respond to these safety concerns if service delivery fails to occur as proposed (including description of the intervention, who is involved, emergency contact information, and responsibilities).

SIGNATURES

All Plans of Care (POC) are to include at least three signatures (Participant, Care Manager and Care Management Supervisor), and any others as applicable. All original signatures are to be secured within 30 days of receiving the case, upon completion of the POC. Copies are to be made available for all parties.

Participant's Signature: The participant's signature may be the mark of an **X** as performed by the participant. If the participant has a representative, that person may sign for the participant upon the participant's request.

Above the Participant's (or his or her Representative's) signature, the signer should attest to whether he or she Agrees (Yes) or Disagrees (No) with the following statements:

Yes	No	
☐	☐	**I agree with this Plan of Care.**
☐	☐	**I had the freedom to choose the services in this Plan of Care.**
☐	☐	**I had the freedom to choose the providers of my services based on available providers.**

☐ ☐ **I helped develop this Plan of Care.**
☐ ☐ **I am aware of my rights & responsibilities as a participant of this program.**
☐ ☐ **I am aware that the services outlined in this Plan of Care are not guaranteed.**
☐ ☐ **I have been advised of the potential risk factors outlined in this Plan of Care.**
☐ ☐ **I understand and accept these potential risk factors.**

If the participant marks 'No' to any of the above-mentioned queries, an explanation of the participant's concerns is to be provided in Column #26 prior to acquiring his or her signature.

The Care Manager shall explain to the program participant the special note described below the participant's signature:

> **'All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program.'**

The Care Manager should explain, and periodically remind the participant, what specific clinical and financial criteria are required to participate in this program and who is responsible for re-determining his or her continued eligibility for both.

Care Manager (CM) Signature: The Care Manager shall sign the Plan of Care as indication that (1) the Plan of Care addresses all of the participant's assessed needs (including health and safety risk factors, and any unmet needs) and personal goals either by the provision of services or through other means; and (2) the Plan of Care has been developed in accordance with appropriate Plan of Care Policies and Procedures.

CM Supervisor Signature: The Care Management Supervisor shall sign the Plan of Care as indication that he or she has reviewed it in its entirety and agrees that the Plan of Care has been developed in accordance with appropriate Plan of Care Policies and Procedures. (If the Care Management Supervisor or Care Coordinator has a caseload and has prepared the Plan of Care, a designated qualified staff person may sign the Plan of Care as the reviewer.)

Facility: A representative from an Assisted Living Facility, Adult Family Care Home, or Assisted Living Program shall sign as indication that he or she is aware of the assessed needs and authorized services, and as acknowledgement that the facility plays a role in the delivery of specific services outlined in the Plan of Care.

> **Note:** *According to Policy Memorandum 2011-6, VII-4, the General Service Plan (GSP) as provided by an Assisted Living (AL) facility, and as approved by the Care Manager, may serve as the Plan of Care for the GO Medicaid participant, in lieu of the WPA-2. In these instances, the AL facility shall complete the GSP, and the Care Manager may approve it by completing the Assisted Living Care Plan Approval form (AL-2) rather than executing the WPA-2. If the GSP is not acceptable, the Care Manager shall execute the WPA-2 form.*

Other(s): Other involved parties, such as a family member, appointed guardian, legal representative, or other involved party, by the request of the participant, shall sign the Plan of Care as indication that he or she is aware of the assessed needs and authorized services that have been outlined in the Plan of Care.