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| **New Jersey Department of Human Services**  **Division of Aging Services** | **PLAN OF CARE** |

| **1. Participant Name** *(print)* | | | | **2. Plan of Care Date** *(mm/dd/yyyy)* | | | | | **2A. Closed Date**  *(mm/dd/yyyy)* | | | | **3. ID No. (JACC, SAMS, or Other)** | | | | | |
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| **4. Case Manager Name** *(print)* | | | | **5. Plan of Care Renewal/ Reassessment Due** *(mm/dd/yyyy)* | | | | | | | | | **6. Program:**  JACC  Area Plan Contract  Other | | | | | |
| **7. Residential Setting**   Group Home  Room Rental  Apt.  Boarding Home Class  A, B or C  Shelter  House  Sr. Apt. | | | | **7A. Alone**  **With Others** | | | | | | | | | **7B. Date of Birth:**  *(mm/dd/yyyy)* | | | | | |
| **8** | **9** | **10** | **Services** | | | | | **Costs** | | | **Providers** | | | **Monitoring**  **Updates \*** | | | **Updates\*** | |
| **11** | | **12** | **13** | **14** | **15** | | **16** | **17** | **18** | | **19** | **20** | **21** | **22** | **23** |
| **Date** | **Problem Statement\*:**  **Identify Assessed Needs,**  **Risk Factors and Personal Goals** | **Need**  **Codes \*** | **Service(s)**  **Needed** | | **Desired Outcome \*** | **Units Per Visit** | **Frequency \*** | **Unit**  **Cost**  **(JACC Only)** | | **Payment Source\*** | **Provider Type \*** | **Provider** | | **Monitoring Method \*** | **Monitoring Frequency \*** | **Unmet Need Code \***  **(if applicable)** | **Initials**  **(CM, Clients)** | **Date** |
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*\* See Code List on page 2.*

**PLAN OF CARE (Continued)**

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| **1. Participant Name** *(print)* | **2. Plan of Care Date** *(mm/dd/yyyy)* | | | **3. ID No. (JACC, SAMS, or Other)** | |
| **25. 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** |
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| **Back-up Plan:** | | | | | |
| **Safety / Emergency / Community-Wide Disaster:** | | | | | |

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| **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 and responsibilities as a participant of this program (as contained in**  **the Participant Agreement).**  **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: |  |
| Other: | |  | | | Date: |  |
| Other: |  | | | | Date: |  |
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\*\* 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 (as applicable).

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| \* **Code List** | | | | | | |
| **Problem Statement:**  **(Column #9)**  Briefly describe the client’s individual circumstances which serve as the basis for each assessed need.  **Need Codes: (Column #10)**  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 # 12)**  1. Maintenance  2. Independence  3. Rehabilitation  4. Prevention  5. Caregiver Relief  6. Other (specify) | **Frequency: (Column # 14)**  D- Daily (specify # of days per week)  W- Weekly  B- Bi-weekly  M- Monthly  Q- Quarterly  A- Annually O- Other (specify) **Payment Source: (Column #16)**  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. APC Funded  10. Other (specify) | **Provider Type: (Column #17)**  J- JACC Agency  M- Medicare  PEP- Participant-Employed Provider  P- Private Provider  F- Facility  I- Informal Support  **Monitoring Method:**  **(Column #19)**  C- Participant Record / Chart  R- Receipts  S- On-Site Review  D- Documentation (specify)  T- Time Sheets  P- Phone Contact With  O- Other (specify) | **Monitoring** **Frequency**: (Column #20) D- Daily  W- Weekly  B- Bi-weekly  M- Monthly  Q- Quarterly  A- Annually R- RandomO- Other (specify)U- Upon reported completion | **Unmet** **Need** **Codes** (Column # 21) 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 # 22 and 23)**  Completed only as necessary if changes are made throughout the duration of the Plan of Care. |