



Medi-Cal In-Home Operations Section
Home- and Community-Based Services (HCBS)
Manual Plan of Treatment (POT)

Enclosure 5A

1. PARTICIPANT INFORMATION

Name: _____ CIN: _____ DOB: _____ M F
Last First

Address: _____ Phone #: () _____
Area code
City State Zip code

Medical Record #: _____ Primary Caregiver: _____
(Applicable for providers who use Medical Record #'s) Relationship to Participant: _____
Primary Language: _____

2. PROVIDER INFORMATION

Name: _____ Title: _____

Address: _____ Phone #: () _____
Area code
City State Zip code

Provider #: _____ FAX #: () _____
Area code

Start of Care Date: _____ *Treatment Period: _____
(May cover up to 180 days maximum) FROM TO:

3. PRIMARY CARE PHYSICIAN

Name: _____

Address: _____ Phone #: () _____
Area code
City State Zip code

FAX #: () _____
Area code

Participant's Name: _____

Treatment Period: _____
FROM TO

***Note: The treatment period may be less than the 180 days depending upon the licensure or certification requirements of the rendering provider.**

**4. MEDICAL INFORMATION – Include ICD-9 Codes where appropriate.
Please add additional pages as needed.**

Primary Diagnosis _____ ICD-9 _____ Date of onset: _____

Secondary Diagnosis _____ ICD-9 _____ Date of onset: _____

Other Diagnosis _____ ICD-9 _____ Date of onset: _____

Other Diagnosis _____ ICD-9 _____ Date of onset: _____

Prognosis: Excellent Good Fair Poor

**5. MEDI-CAL HOME- AND COMMUNITY-BASED PROGRAM
Please check all that apply.**

Nursing Facility/Acute Hospital (NF/AH) Waiver In-Home Operations (IHO) Waiver

**6. LEVEL OF CARE (LOC)
Please check only one.**

NOTE: The LOC determination will be made by the Medi-Cal In-Home Operations Section and provided to the HCBS provider once determined.

- Acute ICF/DDH NF B (DP)
- Adult Subacute ICF/DDN Pediatric Subacute, non-ventilator dependent
- ICF/DD NF A Pediatric Subacute, ventilator dependent
- NF B

**7. WAIVER-SPECIFIC SERVICES
Please check all that apply and enter the appropriate Frequency Key Code.**

Participant's Name: _____

Treatment Period: _____
FROM TO

(Only complete if enrolled in an HCBS Waiver program.)

Service

Frequency Key Code:

D=Daily	W=Weekly
Y=Yearly	M=Monthly
O=Other	

**If other,
please describe below.**

Case Management

Environmental Accessibility Adaptations

Family Training

Personal Emergency Response Systems

Private Duty/Individual/Shared Nursing Care

Certified Home Health Aide Services

Respite

Medical Equipment Operating Expense

Waiver Personal Care Services

Community Transition Services

Habilitation Services

Participant's Name: _____
Treatment Period: _____ FROM _____ TO _____

Transitional Case Management _____

8. NONWAIVER SERVICES
Include all applicable services and frequency. May include those services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services.
Examples include: Adult Day Health Care, Pediatric Day Health Care, Medical Therapy Program, Housing Referrals, Social Service Referrals, and Vocational Rehabilitation. Please add additional pages as needed.

FROM

TO

9.

MEDICATION PLAN FOR HOME PROGRAM
Space for additional medications provided on Page 6.

Allergies: _____ Reaction (if known): _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Participant's Name: _____

Treatment Period: _____

FROM

TO

9a.

ADDITIONAL MEDICATIONS

Medication: _____ Dose: _____ Route: _____ Frequency _____

Who gives the medications to the patient? _____

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10.

NUTRITIONAL REQUIREMENTS

Please include type of diet, and method, amount, and frequency of feeding.

Empty box for nutritional requirements.

11.

TREATMENT PLAN FOR HOME PROGRAM

**Include all needed services, frequency, and duration of services and provider(s) of service(s).
Space for additional orders provided on Page 8.**

Large empty box for treatment plan for home program.

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11a.

**TREATMENT PLAN FOR HOME PROGRAM – CONTINUED
ADDENDUM**

[Empty box for treatment plan content]

FROM

TO

12.

FUNCTIONAL LIMITATIONS

**Please describe functional limitations per the physician's order within each category.
Please add additional pages, as needed.**

No limitations noted.

MOTOR: May include limitations with walking and/or gross motor movement.

No limitations noted.

SELF HELP: May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

No limitations noted.

COMMUNICATION/SENSORY: May include limitations with hearing, speech, and/or sight.

Participant's Name: _____
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13. ACTIVITIES
Include permitted activities per the physician's order, such as up with assistance, complete bedrest, up as tolerated, and/or use of adaptive equipment such as wheelchair, walker, etc.

No restrictions on activities.

Safety precautions in use: Seizure precautions Universal precautions Other:
Rehabilitation Potential: Good Fair Poor

14. MENTAL STATUS
May include information related to behavior and/or cognition such as aggression, depression, agitation, confusion, and developmental disabilities.

No limitations noted – oriented to name, date, place, and time.

15. DURABLE MEDICAL EQUIPMENT
Include all types of equipment used, providers of equipment, and funding sources (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

16. MEDICAL SUPPLIES
Include all types of supplies used, providers of supplies, and funding sources (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

FROM

TO

17. THERAPIES/REFERRALS
Check all that apply. Please include the date the referral was made and the reason why.
If therapy is ongoing, please indicate the current progress/status in Section 20.

- Physical Therapy
 _____ Date _____ Referral Reason

- Occupational Therapy
 _____ Date _____ Referral Reason

- Speech Therapy
 _____ Date _____ Referral Reason

- Enterostomal Therapy
 _____ Date _____ Referral Reason

- Medical Social Worker
 _____ Date _____ Referral Reason

- Nutritionist
 _____ Date _____ Referral Reason

- Other/List
 _____ Date _____ Referral Reason

- Other/List
 _____ Date _____ Referral Reason

- Other/List
 _____ Date _____ Referral Reason

18. TREATMENT GOALS/DISCHARGE PLAN
Please check only one.

- Upon completion of this treatment plan, the participant will be able to function independently and maintain himself/herself safely in the home setting.

- Upon completion of this treatment plan, the participant will continue to need:
 minimal moderate maximum support to be maintained safely in the home setting.
 Describe specific goals and discharge plan, as related to the identified needs:

Participant's Name: _____

Treatment Period: _____
FROM TO

19. TRAINING NEEDS FOR PARTICIPANT/FAMILY

- No training needs have been identified for the participant and/or the family during this treatment period.
- Yes, there are training needs for the participant and/or the family during this treatment period.

(If the yes box is checked, please describe the training needs and name(s) of the provider(s).)

Please use additional pages as needed.

20. SUMMARY OF PARTICIPANT STATUS DURING THIS TREATMENT PERIOD

Please use additional pages as needed.

Participant's Name: _____
Treatment Period: _____ FROM _____ TO _____

21. **After completing, please obtain original signatures.
Keep the original and mail a copy to the appropriate IHO Regional Office
attention to the Medi-Cal In-Home Operations assigned Nurse Case Manager.**

Participant Signature _____

Date _____

Primary Caregiver Signature (as applicable) _____

Date _____

Physician Signature _____

Date _____

Provider Signature _____

Date _____