

Procedure for Completing the HCBS Waiver Plan of Treatment (POT)

The HCBS POT is a Word-based document that can be filled out either electronically or manually. A copy of the In-Home Operations (IHO) POT is available at: <http://www.dhcs.ca.gov/formsandpubs/publications/Documents/IHO-HCBS%20POTdoc-5A.pdf> IHO has enclosed a manual version of the POT in this WPCS Request Packet. **(Enclosure 5A)**

This POT can be used for Medi-Cal participants receiving services through one of the HCBS Waivers administered by IHO and/or Private Duty Nursing (PDN) services through the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefit. Below are general directions for completing each section of the form.

The **Comments** Section may be used throughout the document to provide explanatory information as necessary. The completed POT must contain original signatures from the participant and/or the legal representative, Primary Care Physician, and for HCBS Waiver participants, each HCBS Waiver service provider, i.e., primary caregiver, home health agency (HHA), or Individual Nurse Provider (INP), or for EPSDT participants, each INP. Once all signatures have been obtained, keep the original and return a signed copy of the POT to the appropriate IHO Regional Office.

Step 1: (For the Electronic POT only)

(Note: For the manual version go to Step 2)

1. **Unlock** the document;
2. Go to the **V**iew menu;
3. Click on **T**oolbars;
4. Click on **F**orms;
(A ✓ should appear next to **Forms**. The Forms toolbar will appear with the **LOCK** button turned on. In the “Locked” mode, the button will have a light gray background.)
5. Click on the **LOCK** button. In the “Unlocked” mode the button will have a medium gray background; and,
6. Complete the header at the top of Page 2 by entering the “Participant’s Name” and the Treatment Period “From” and “To” dates.

How to access the header (2 methods):

Method A: Go to Page 2. Using your mouse, double-click on the header and enter the information. To exit this function using your mouse, double-click on any area outside of the header. This information will then auto-fill on the subsequent pages.

or

Method B: Go to the **V**iew menu, click on **H**header and **F**ooter and scroll down to Page 2. Enter the information in the Header. To exit this function, go back to the menu bar, click on **V**iew, and click on the ✓ next to **H**header and **F**ooter.

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To **Lock** the document, click on the **LOCK** button. The button background will change to light gray.

Complete the POT as instructed below in Step 3.

Helpful hints for using the electronic version.

- This document has been developed with check boxes, drop-down menus, and locked fields.
- **Do not use the ENTER/RETURN key, as it will alter the formatting and disrupt the spacing throughout the document.**
- Check boxes. The check box can be marked with an “X” by placing the cursor over the box and using the mouse to single-click on it.
- Drop-down menus. The drop-down menu can be accessed by:
 - placing the cursor over the box;
 - single-clicking it with the mouse; and,
 - selecting the appropriate response.

The only drop-down menus present on the POT are found in Section 7, entitled “**Waiver-Specific Services**”.

Locked fields. The locked fields appear as gray-shaded areas and are preset so the user can tab through the document from one field to the next. You can also use your mouse to maneuver around the document.

Be sure that the **Lock** button is turned “**ON**”. If the **Lock** button is turned off prior to completion, the form will not work properly.

Spell Check. In order to spell check the document, the POT must be entirely completed and the **Lock** button must be turned “**Off**”. Go to the **Tools** drop-down menu and click on **Spelling and Grammar**. Once the spell check is complete, you can save the document by going to the **File** drop-down menu and clicking on **Save As**.

IMPORTANT: If the **Lock** button is turned back “**ON**” after any information has been entered on the POT, it will delete **all** of the information you have entered on the POT.

Step 2: (For the Manual POT only)

On Pages 2 through 14, complete the header by entering the “Participant’s Name” and the Treatment Period “From” and “To” dates. Then complete the POT as instructed below in Step 3.

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Step 3: Completing the HCBS POT (for both the Electronic and Manual POTs)

Section 1: Participant Information

Please complete as indicated. The **medical record number** of the participant is optional and is used for the provider's filing purposes. The **primary language** may include the primary caregiver's primary language, if different from that of the participant.

Section 2: HCBS Provider Information

Please complete as indicated. The "**Provider Name**" should be the name of the HHA or individual who is primarily responsible for the services described on the POT. This would include the HHA, Case Manager (CM), Professional Corporation (PC), or the lead Individual Nurse Provider (INP) L.V.N. for participants receiving EPSDT Private Duty Nursing (PDN) services without R.N. Case Management. The "**Treatment Period**" may vary depending upon the licensure and/or certification requirements of the provider.

Section 3: Primary Care Physician

Please complete as indicated. The **Primary Care Physician** should be the physician signing the POT.

Section 4: Medical Information

Please complete as indicated. Include all **ICD-9 codes** or diagnosis codes where appropriate. The "**Other**" section may be used, if there are other diagnoses pertaining to the participant. You may contact the M.D. (Primary Care Physician) to obtain the diagnosis and ICD-9 codes. For the **prognosis**, please check only one of the boxes provided for you, i.e., excellent, good, fair, or poor.

Section 5: Medi-Cal Home- and Community-Based Services Program

Please check all of the appropriate programs for which services are being requested. You may contact your assigned IHO Nurse Case Manager for the appropriate program information.

Section 6: Level of Care (LOC)

The **level-of-care determination will be made by the Medi-Cal In-Home Operations Branch** and given to the provider (HHA, CM, PC, or INP). Please check **only one box**—once a determination has been provided.

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Section 7: Waiver-Specific Services

Note: *Do not complete this section* for participants receiving *only EPSDT PDN services*.

Please complete as indicated. All of the “**Waiver-Specific Services**” are listed in this section. Please check all of the services the participant is utilizing. If you are using the document electronically, please click on the arrow under the **Frequency Key Code**, and double-click on the appropriate **Key Code**. If “**Other**” is used, then please describe.

Section 8: Non-Waiver Services

For participants enrolled in one of the HCBS Waivers, federal regulations require that all non-waiver services the participant is receiving be described on the POT. The description of the services should include the amount, frequency, and the provider(s) of services. **Non-waiver services** may include 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 (i.e., Adult Day Health Care (ADHC), Pediatric Day Health Care (PDHC), Social Services Referrals, Medical Therapy Program, Housing Referrals, Respite, and Vocational Rehabilitation).

Section 9: Nutritional Requirements

Please describe any nutritional requirements for the participant, as ordered by the physician. Please indicate the type of diet, method of feeding, amount, and frequency.

Section 10: Medication Plan for Home Program

Please complete as indicated. This includes prescription and nonprescription medications.

Section 11: Treatment Plan for Home Program

M.D. orders must identify all services rendered by the provider. Please list/describe all services provided, including the:

- provider(s) of service(s);
- provider type(s);
- amount and frequency of services; and,
- type(s) of service(s) provided.

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Section 12: Functional Limitations

Please describe functional limitations, per the physician's order, within each category. If "no" limitations are noted, please check the appropriate box and proceed to Section 13.

MOTOR (i.e., amputation, contracture, paralysis, ambulation, partial weight bearing, cane, crutches, wheelchair, or walker)

SELF-HELP (i.e., incontinent of bowel/bladder or independent at home)

COMMUNICATION/SENSORY (i.e., hearing, speech, legal blindness, or glasses)

Section 13: Activities

Please describe all activities performed by the participant, as per the physician's order (i.e., endurance, dyspnea with exertion, complete bed rest, bed rest with BRP, up as tolerated, or exercises prescribed). If "no" restrictions on activities are noted, please check the appropriate box and proceed to Section 14.

Section 14: Mental Status

Please summarize the mental status of the participant (i.e., comatose, forgetful, depressed, disoriented, lethargic, agitated, or developmentally delayed). If "no" limitations are noted, please check the appropriate box and proceed to Section 15.

Section 15: Durable Medical Equipment

Please list all types of equipment used, providers of equipment, and funding sources, such as Medi-Cal, private insurance, or Medicare, *if known*.

Section 16: Medical Supplies

Please list all types of supplies used, providers of supplies, and funding sources, such as Medi-Cal, private insurance, or Medicare, *if known*.

Section 17: Therapies/Referrals

Please check all types of therapy that apply, provide the date each referral was made, and the reason(s) why the referral was made. If *therapy is ongoing*, please indicate the current progress/status in Section 20. If the type of therapy is *not listed*, please use the "*Other/List*".

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Section 18: Treatment Goals/Discharge Plans

Please check the appropriate box. If you select the second box, you must describe the level of support needed, i.e., minimal, moderate, or maximum.

Describe specific goals and discharge plans as identified on the POT, i.e., participant will be able to self-direct caregivers in trach care, primary caregivers will be knowledgeable in diabetic management, or primary caregivers will be knowledgeable in pressure relief.

Section 19: Training Needs for the Participant/Family

Please check **only one** box for training needs. If you choose “**yes**”, please use the area provided to describe the training needs of the participant/family and list the name(s) of the provider(s).

Section 20: Summary of Participant’s Status During This Treatment Period

Please summarize the **status of the participant** during the treatment period for this POT. This area may also be used, as stated in Section 17, to describe the current progress/status of ongoing therapy. Each INP is to provide a summary of the care he/she provided and the overall status of the participant, including the participant’s response to the POT and any significant changes.

Signature Section

Please complete the POT Form and **obtain original signatures** from the following:

- Participant and/or the Legal Representative;
- Primary Care Physician who oversees the participant’s home program;
- Primary Caregiver (i.e., parent, spouse, or family member);
- All providers of HCBS Waiver services (i.e., the HHA, Waiver Personal Care Services Providers, INPs, Professional Corporations, and Case Managers); and,
- All INPs, for participants only receiving Medi-Cal EPSDT INP services.

Keep the original, make a copy, and **return the copy by mail**, to the address selected below:

- | | |
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| <input checked="" type="checkbox"/> Department of Health Care Services In-Home Operations Branch 1501 Capitol Avenue, MS 4502 P.O. Box 997437 Sacramento, CA 95899-7437 | <input type="checkbox"/> Department of Health Care Services In-Home Operations Branch 311 South Spring Street, Suite 313 Los Angeles, CA 90013-1211 |
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