

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

NOTE: Definitions of all key words in this IPC can be found in the Medi-Cal Inpatient/Outpatient Provider Manual.

(1) Check box that applies to this IPC: Initial TAR Reauthorization TAR Change TAR
 (#) _____ Planned Days/Week TB Clearance Date (initial TAR only): _____
 The signature page of the *History and Physical* form accompanies this IPC and documents the request for CBAS services (initial TARs only). Yes No NA

(2) DIAGNOSES AND ICD CODES			
<u>Primary Diagnoses</u> Include diagnoses as provided or confirmed by the personal health care provider(s)	ICD Code	<u>Secondary Diagnoses</u> Include diagnoses as provided or confirmed by the personal health care provider(s)	ICD Code
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	

(3) MEDICATIONS (frequency and dosage not required) No Medications or Supplements <input type="radio"/>	Active Prescriptions	12	
	1		13
	2		14
	3		15
	4		16
	5		Over-The-Counter Medications &/or Supplements
	6		1
	7		2
	8		3
	9		4
	10		5
	11		6

(4) Active Personal Medical/Mental Health Care Provider(s)	Name	Address	Phone

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(6) CATEGORY B: For individuals who have an organic, acquired or traumatic brain injury and/or chronic mental illness:	
Participant Does <u>NOT</u> Fall Within Category B <input type="radio"/>	<ul style="list-style-type: none"> ➤ Check circle if the participant does NOT fall within Category B. ➤ Check the circles next to the criteria indicating the participant meets the stated criteria.
<input type="radio"/>	1. Has been diagnosed by a physician as having an organic, acquired or traumatic brain injury, and/or has a chronic mental illness; AND
<input type="radio"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2; AND
<input type="radio"/>	3. The individual must demonstrate a need for assistance or supervision with at least:
<input type="radio"/>	a. Two of the following activities of daily living (ADLs)/instrumental activities of daily living (IADLs): bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene; OR
<input type="radio"/>	b. One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.

(7) CATEGORY C: For individuals with Alzheimer's Disease or other dementia:	
Participant Does <u>NOT</u> Fall Within Category C <input type="radio"/>	<ul style="list-style-type: none"> ➤ Check circle if the participant does NOT fall within Category C. ➤ Check the circles next to the criteria indicating the participant meets the stated criteria.
<input type="radio"/>	1. Individuals have moderate to severe Alzheimer's Disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's Disease; AND
	<ul style="list-style-type: none"> • Stage 5: Moderately severe cognitive decline. Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential. • Stage 6: Severe cognitive decline. Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities. • Stage 7: Very severe cognitive decline. This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement.
<input type="radio"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2.

(8) CATEGORY D: For individuals with mild cognitive impairment including moderate Alzheimer's Disease or other dementia:	
Participant Does <u>NOT</u> Fall Within Category D <input type="radio"/>	<ul style="list-style-type: none"> ➤ Check circle if the participant does NOT fall within Category D. ➤ Check the circles next to the criteria indicating the participant meets the stated criteria.
<input type="radio"/>	1. Individuals have mild cognitive impairment or moderate Alzheimer's disease or other dementia, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's Disease, defined as mild or early-stage Alzheimer's disease, characterized by one or more of the following; AND:
	<ul style="list-style-type: none"> • Decreased knowledge of recent events; • Impaired ability to perform challenging mental arithmetic; • Decreased capacity to perform complex tasks; • Reduced memory of personal history; • The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations.
<input type="radio"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2; AND
<input type="radio"/>	3. The individual must demonstrate a need for assistance or supervision with two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

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(12) CURRENT ASSISTIVE/ADAPTIVE DEVICES (Check all that apply):					
<input type="radio"/>	None	<input type="radio"/>	AAC Device	<input type="radio"/>	Glasses or Other Vision Aid
<input type="radio"/>	Wheelchair	<input type="radio"/>	Orthosis/Prosthesis	<input type="radio"/>	Dentures
<input type="radio"/>	Walker	<input type="radio"/>	Gait Belt	<input type="radio"/>	Respiratory Equipment (specify): _____
<input type="radio"/>	Crutches	<input type="radio"/>	Hoyer Lift	<input type="radio"/>	Other (specify): _____
<input type="radio"/>	Cane	<input type="radio"/>	Hearing Device		
(13) CONTINENCE INFORMATION (Check all that apply):					
<input type="radio"/> None					
<input type="radio"/> Incontinent of bladder: <input type="radio"/> Occasionally <input type="radio"/> Frequently <input type="radio"/> Always					
<input type="radio"/> Incontinent of bowel: <input type="radio"/> Occasionally <input type="radio"/> Frequently <input type="radio"/> Always					
<input type="radio"/> External/internal catheter					
<input type="radio"/> Ostomy					
<input type="radio"/> Other (specify): _____					
(14) FEEDING INFORMATION (Check all that apply):					
<input type="radio"/> None <input type="radio"/> Overweight <input type="radio"/> Underweight <input type="radio"/> Feeding tube <input type="radio"/> Therapeutic/special diet					
<input type="radio"/> Difficulty chewing and/or swallowing <input type="radio"/> Cannot feed self					
<input type="radio"/> Other (specify): _____					
(15) NON-CBAS CENTER SUPPORT/SERVICES (if known). Check all that apply:					
SUPPORT SERVICE			DESCRIBE (how or why the support service is insufficient)		
<input type="radio"/>	Not Known		Explain: _____		
<input type="radio"/>	NONE		-----		
<input type="radio"/>	IHSS/PCSP Services		Hours authorized per week/month: _____		
<input type="radio"/>	Targeted Case Management		Frequency: _____		
<input type="radio"/>	Other Paid Caregiver(s)		Frequency: _____		
<input type="radio"/>	ICF/DD-H		Explain: _____		
<input type="radio"/>	Lives in a Community Care Licensed Facility (e.g., Residential Care Facility)		Explain: _____		
<input type="radio"/>	Participates in a HCBS Waiver		Explain: _____		
	<input type="radio"/> MSSP				
	<input type="radio"/> Assisted Living				
	<input type="radio"/> NF A/B				
	<input type="radio"/> In-Home Operations (IHO)				
	<input type="radio"/> AIDS				

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(16) NON-CBAS CENTER SUPPORT/SERVICES (if known). Check all that apply:

Within the last 6 months, the participant received the following non-institutional services:

Not Known. Explain: _____

None.

Home Health Agency Services. Explain: _____

>>>Is the participant currently receiving **Home Health Agency Services**? Yes No

Hospice Care. Explain: _____

>>>Is the participant currently receiving **Hospice Services**? Yes No

If the participant is currently receiving either home health agency or hospice services, please specify:

Service	Frequency

Urgent Care. Explain: _____

Mental Health Services. Explain: _____

Emergency Department. Explain: _____

Other. Explain: _____

(17) RISK FACTORS (check all conditions that are demonstrated at the time of IPC completion)

<input type="radio"/> Inappropriate Affect, Appearance or Behavior	<input type="radio"/> Dementia Related Behavioral Problems
<input type="radio"/> Poor Judgment	<input type="radio"/> Fall Risk
<input type="radio"/> Medication Mismanagement	<input type="radio"/> Isolation
<input type="radio"/> Self Neglect	<input type="radio"/> Frailty
<input type="radio"/> Two or More Chronic Conditions	<input type="radio"/> Other (specify): _____

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(18) AT RISK FOR ADMISSION TO ACUTE OR INSTITUTIONAL CARE (if known). Check all that apply:

Within the last 6 months, the participant was admitted to the following level(s) of acute or institutional care:

Not Known. Explain: _____

None.

Acute Care Hospital. Explain: _____

Nursing Facility. Explain: _____

ICF/DD or ICF/DD-N. Explain: _____

Other. Explain: _____

Last Known Discharge Date from an Acute or Institutional Level of Care: _____

<p>(19)</p> <p>Yes <input type="radio"/></p> <p>No <input type="radio"/></p>	<p>CBAS Core Services – all of these services are required each day of attendance: check yes/no circle in the left-handed column for each service listed:</p>
	<p>A. Professional Nursing Services</p> <p><u>One or more of the following professional nursing services</u> on each day of attendance:</p> <p>N1 Observation, assessment, and monitoring of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions upon which admission to the CBAS center was based.</p> <p>N2 Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medication, and intervention, as needed, based upon the assessment and participant's reactions to his/her medications.</p> <p>N3 Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms.</p> <p>N4 Supervision of the provision of personal care services for the participant, and assistance, as needed.</p> <p>N5 Provision of skilled nursing care and intervention, within scope of practice, to participants, as needed, based upon an assessment of the participant, his/her ability to provide self-care while at the CBAS center, and any health care provider orders.</p>

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Yes <input type="radio"/>	No <input type="radio"/>	B. Personal Care Services/Social Services <u>One or both</u> of the following core <u>personal care services</u> or <u>social services</u> on each day of attendance: P1 <u>One or both</u> of the following <u>personal care services</u> : P1a Supervision of, or assistance with, ADLs or IADLs. P1b Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering. P2 <u>One or more</u> of the following <u>social services</u> provided by the CBAS center social worker or social worker assistant: P2a Observation, assessment, and monitoring of the participant's psychosocial status. P2b Group work to address psychosocial issues. P2c Care coordination.
Yes <input type="radio"/>	No <input type="radio"/>	C. Therapeutic Activities <u>One or both</u> of the following <u>therapeutic activities</u> provided by the CBAS center activity coordinator or other trained CBAS center personnel on each day of attendance: A1 Group or individual activities to enhance the social, physical, or cognitive functioning of the participant. A2 Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.
Yes <input type="radio"/>	No <input type="radio"/>	D. Meal Service M <u>At least one</u> meal offered per day.

(20) TAR FOR REAUTHORIZATION OF CBAS SERVICES			
Yes <input type="radio"/>	No <input type="radio"/>	NA <input type="radio"/>	<u>If this is a reauthorization TAR</u> , the participant's condition would likely deteriorate if the CBAS services were denied.

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(21) Participant's Individual Plan of Care (Core Services) (must be consistent with information provided in this IPC)

CBAS CORE SERVICES (Box 21)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Professional Nursing Services				

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CBAS CORE SERVICES (Box 21)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Personal Care Services				
Social Services				

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CBAS CORE SERVICES (Box 21)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Therapeutic Activities				
Physical Therapy Maintenance Program				
Occupational Therapy Maintenance Program				
Nutrition/Diet <input type="radio"/> Regular Diet <input type="radio"/> Special Diet Specify: _____ <input type="radio"/> NPO (may receive NG, GT or IV feedings at home)				

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(22) Participant's Individual Plan of Care (Additional Services) (must be consistent with information provided in this IPC)

<p>CBAS ADDITIONAL SERVICES (Box 22)</p>	<p>Participant Problem (must include a <u>measurable</u> starting point)</p>	<p>Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)</p>	<p>Frequency of Treatment/ Intervention (e.g., 2x per week)</p>	<p>Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)</p>
<p>Physical Therapy</p>				
<p>Occupational Therapy</p>				

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<p>CBAS ADDITIONAL SERVICES (Box 22)</p>	<p>Participant Problem (must include a <u>measurable</u> starting point)</p>	<p>Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)</p>	<p>Frequency of Treatment/ Intervention (e.g., 2x per week)</p>	<p>Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)</p>
<p>Speech and Language Pathology Services</p>				
<p>Registered Dietitian Services</p>				
<p>Mental Health Services</p>				
<p>Other (please specify)</p>				

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(23) Text Box for Additional Information (Optional)

**This text box is available for the CBAS Center's use in providing information not explained elsewhere in this IPC that is relevant to the authorization of this TAR.
Please do not repeat information previously explained.**

Please Reference Box Number Being Discussed.

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(24) Signatures of Multidisciplinary Team and Program Director

Signatures of the Multidisciplinary Team Pursuant to section 14529 of the Welfare and Institutions Code, signing below certifies agreement with the treatments designated in the IPC that are consistent with the signer's scope of practice		
Printed Name	Signature	Date of Signing
	RN	
	SW	
	PT	
	OT	
By signing below I certify that I have reviewed and concur with this IPC		
Printed Name	Signature of the Primary/Personal Health Care Provider or CBAS Center Physician	Date of Signing
By signing below, I certify that <u>all assessments have been completed</u> and that <u>the participant meets the CBAS eligibility and medical necessity criteria</u> as specified in this IPC, effective on this date**:_____.		
I further certify that services will be provided as scheduled on this IPC unless otherwise noted in the participant's health record.		
Printed Name	Signature	Date of Signing
	Program Director	

** The TAR will NOT be approved for CBAS services provided prior to this date.

Privacy Statement:

The information requested on this form is required by the Department of Health Care Services, for the purpose of adjudication of Treatment Authorization Requests (TARs) for Community-Based Adult Services (CBAS) services. Failure to provide this mandatory information may result in denial of the TAR for CBAS services.