



FAMILY-CENTERED ACTION PLAN (F-CAP)

Patient Name _____	CCS # _____	CIN _____
DOB _____	Date of FCAP _____	Initial <input type="checkbox"/> 60 day assessment <input type="checkbox"/> 6 month full review <input type="checkbox"/> Interim <input type="checkbox"/>

Care Coordinator Name _____ Agency _____ Phone _____

Care Coordinator Name _____ Agency _____ Phone _____

CCS Nurse Liaison (CCSNL) Name _____ County _____ Phone _____

Patient's PFC Enrollment Date _____ Date CCSNL forwarded patient information to Agency _____

SECTION 1-A. PATIENT/FAMILY INFORMATION - DEMOGRAPHIC

Patient Name _____		Preferred Name _____	
DOB _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Other	
Race <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> B <input type="checkbox"/> A		<input type="checkbox"/> Other	
Email _____		Cell _____	
Primary Language _____	Need for Interpreter <input type="checkbox"/> Y <input type="checkbox"/> N	Use of Language Line <input type="checkbox"/> Y <input type="checkbox"/> N	
Other Language spoken in home _____	School/Day Care _____	Grade _____	
Mother Name _____		DOB _____	
Address _____		Patient Resides Here FT <input type="checkbox"/> PT <input type="checkbox"/>	
Email _____		Phone _____	Cell _____
Father Name _____		DOB _____	
Address _____		Patient Resides Here FT <input type="checkbox"/> PT <input type="checkbox"/>	
Email _____		Phone _____	Cell _____
Other family member caring for patient _____		Relationship _____	
Name _____		DOB _____	
Address _____		Patient Resides Here FT <input type="checkbox"/> PT <input type="checkbox"/>	
Email _____		Phone _____	Cell _____
Legal Guardian _____		Relationship _____	
Name _____		DOB _____	
Address _____		Patient Resides Here FT <input type="checkbox"/> PT <input type="checkbox"/>	
Email _____		Phone _____	Cell _____
Foster Care <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, Case Worker Name _____		Phone _____
Emergency Contact Name: _____		Relationship _____	
Address _____		Phone _____	Cell _____
Comments/Notes:			

Civil Code Section 1798.17 provides that the individual will be notified of the intended purpose and use of personal information being collected. Information on this document will be used exclusively by the Department of Health Care Services and affiliates of the Partners for Children program for the purposes of monitoring and providing quality services to PFC participants.



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SECTION 1-B. PATIENT/FAMILY INFORMATION - SOCIAL

Primary Caregiver Name _____		
Relationship to patient _____		Age _____

List Each Child Living in the Home		
Name	Relationship to Patient	Age

List Each Adult Living in the Home		
Name	Relationship to Patient	Age

List Other Circle of Support Individuals		
Name	Relationship to Patient	Age

Spiritual beliefs / Religious affiliations
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Traditional Health belief system

Contextual and cultural Issues (those that influence waiver services ordered)

Family Coping

Comments/Notes:
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SECTION 2-A. MEDICAL INFORMATION - DIAGNOSIS/PROVIDERS

Diagnosis		
Waiver Diagnosis	ICD-9	
Other Diagnosis	ICD-9	
Other Diagnosis	ICD-9	
Other Diagnosis	ICD-9	
Other Diagnosis	ICD-9	
Health Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Commercial HMO <input type="checkbox"/> PPO		
Insurance Plan Name _____		
Policy Number _____	Group _____	
Health Care Providers		
Medical Home	Phone _____	
Primary Managing Physician	Phone _____	
Special Care Center (SCC)	Phone _____	
SCC Physician/Specialty	Phone _____	
SCC Nurse Specialist	Phone _____	
SCC Social Worker	Phone _____	
Other (RD, PT, OT)	Phone _____	
Special Care Center (SCC)	Phone _____	
SCC Physician/Specialty	Phone _____	
SCC Nurse Specialist	Phone _____	
SCC Social Worker	Phone _____	
Other (RD, PT, OT)	Phone _____	
Palliative Care Team/ Service in Hospital	Phone _____	
Contact Name	Phone _____	
Intermittent Home Health Agency Provider	Phone _____	
HHA Contact Name	Phone _____	
Shift/Private Duty Nursing Agency	Phone _____	
Nursing Contact Name	Phone _____	
Therapist (OT, PT, Speech)	Name _____	Phone _____
Therapist (OT, PT, Speech)	Name _____	Phone _____
MTU	Phone _____	
MTU Contact Name	Phone _____	
Mental Health Professional Involved with the Participant/Family	Type _____	Phone _____
Name _____		Phone _____
Upcoming Appointments:		



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SECTION 2-B. MEDICAL INFORMATION - PROVIDERS/SUPPLIERS

Durable Medical Equipment (DME)	
DME Supplier	Phone
Equipment Supplied	
Contact Name (if applicable)	Phone
DME Supplier	Phone
Equipment Supplied	
Contact Name (if applicable)	Phone
DME Supplier	Phone
Equipment Supplied	
Contact Name (if applicable)	Phone
DME Supplier	Phone
Equipment Supplied	
Contact Name (if applicable)	Phone
Pharmacy	Phone
Contact Name (if applicable)	Phone
Pharmacy	Phone
Contact Name (if applicable)	Phone
Pharmacy	Phone
Contact Name (if applicable)	Phone
Dietician (SCC)	Phone
Contact Name (if applicable)	Phone
ER Aware of Patient	Phone
Contact Name (if applicable)	Phone
Other Provider	Phone
Contact Name (if applicable)	Phone
Other Provider	Phone
Contact Name (if applicable)	Phone

Comments/Notes:



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SECTION 3-A. HEALTH & SYMPTOM ASSESSMENTS - PHYSICAL EXAM Completed by an RN

TEMP: <input type="checkbox"/> PO <input type="checkbox"/> AX <input type="checkbox"/> Other	HEART RATE:	RESP:	B/P: (L) (R)
HEIGHT: CM IN	WEIGHT: KG LB	HEAD CIR: CM	ABD: CM

Physical Assessment: Brief summary of general physical assessment (including IV access peripheral and central; tracheostomy, gastric tube, shunt).

HEENT:	
NECK:	
CARDIOVASCULAR:	
LUNGS:	
ABDOMEN:	
EXTREMITIES:	
NEUROLOGICAL:	
HEME/LYMPH:	
OTHER:	

Comments/Notes:



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SECTION 3-B. HEALTH & SYMPTOM ASSESSMENTS - REVIEW OF SYSTEMS

Completed by an RN

EYES/EARS/NOSE/THROAT (Check all that apply)

<input type="checkbox"/> VISION IMPAIRMENT	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> DENTAL CRIES
<input type="checkbox"/> HEARING IMPAIRMENT	<input type="checkbox"/> NOSEBLEEDS	

Comments:

RESPIRATORY (Check all that apply)

<input type="checkbox"/> DYSPNEA	<input type="checkbox"/> APNEA	<input type="checkbox"/> COUGH
<input type="checkbox"/> WHEEZING	<input type="checkbox"/> TACHYPNEA	<input type="checkbox"/> TRACHEOSTOMY
<input type="checkbox"/> VENTILATION		

Comments:

CARDIAC (Check all that apply)

<input type="checkbox"/> CYANOSIS	<input type="checkbox"/> MOTTLING	
<input type="checkbox"/> SWEATS WITH FEEDS	<input type="checkbox"/> PALPITATIONS	

Comments:

NEUROLOGIC (Check all that apply)

<input type="checkbox"/> VP SHUNT	<input type="checkbox"/> SPASTICITY	<input type="checkbox"/> MACROCEPHALY
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> CONTRACTURES	<input type="checkbox"/> MICROCEPHALY
<input type="checkbox"/> DEVELOPMENTAL DELAY	<input type="checkbox"/> HYPERTONIC	<input type="checkbox"/> HEADACHES
<input type="checkbox"/> MOTOR DELAY	<input type="checkbox"/> HYPOTONIC	<input type="checkbox"/> IRRITABILITY

Comments:

MUSCULOSKELETAL (Check all that apply)

<input type="checkbox"/> AMBULATORY	<input type="checkbox"/> TRANSFERS WITH ASSIST	<input type="checkbox"/> AMPUTATION
<input type="checkbox"/> NONAMBULATORY	<input type="checkbox"/> TOTAL ASSIST	<input type="checkbox"/> PROSTHESIS
<input type="checkbox"/> WHEELCHAIR USE	<input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> LIMB DEFORMITY

Comments:

SKIN (Check all that apply)

<input type="checkbox"/> TURGOR	<input type="checkbox"/> PRURITIS	<input type="checkbox"/> RASH
<input type="checkbox"/> ECCHYMOSIS	<input type="checkbox"/> PETECHIAE	<input type="checkbox"/> WOUND/LESION
<input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> CENTRAL LINE	<input type="checkbox"/> PERIPHERAL LINE
<input type="checkbox"/> JAUNDICE	<input type="checkbox"/> SKIN BREAKDOWN	

Comments:



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SECTION 3-C. HEALTH & SYMPTOM ASSESSMENTS - REVIEW OF SYSTEMS/NUTRITION STATUS Completed by an RN

GASTROINTESTINAL (Check all that apply)		
<input type="checkbox"/> NAUSEA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> REFLUX
<input type="checkbox"/> VOMITING	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> OSTOMY
<input type="checkbox"/> GASTROINTESTINAL TUBE	<input type="checkbox"/> NISSEN FUNDOPLICATION	<input type="checkbox"/> ASPIRATION RISK
Comments:		

URINARY (Check all that apply)		
<input type="checkbox"/> INCONTINENT	<input type="checkbox"/> UTIs	<input type="checkbox"/> FOLEY
Comments:		

PSYCHIATRIC (Check all that apply)		
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> INSOMNIA
<input type="checkbox"/> HALLUCINATIONS	<input type="checkbox"/> CONFUSION	<input type="checkbox"/> DIFFICULTY SLEEPING
Comments:		

DIET (Check all that apply)		
<input type="checkbox"/> PO/ORAL	<input type="checkbox"/> ENTERAL TUBE	<input type="checkbox"/> TPN
<input type="checkbox"/> PO DIET/ AMOUNT/ FREQUENCY		
<input type="checkbox"/> ENTERAL TUBE	TYPE	SIZE
<input type="checkbox"/> LAST CHANGED	<input type="checkbox"/> PLACEMENT CHECKED	<input type="checkbox"/> GRAVITY <input type="checkbox"/> PUMP
<input type="checkbox"/> ENTERAL FORMULA	AMOUNT/FREQUENCY	
<input type="checkbox"/> TPN ORDERS	ACCESS	

NUTRITIONAL STATUS			
	LOW RISK	MODERATE RISK	HIGH RISK
WEIGHT	<input type="checkbox"/> STABLE AT THIS TIME	<input type="checkbox"/> UNDERWT/OBESE	<input type="checkbox"/> FTT <input type="checkbox"/> LOSING WEIGHT
APPETITE	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
HYDRATION	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
SUCK/ SWALLOW/ BREATHING	<input type="checkbox"/> WNL	<input type="checkbox"/> IMPAIRED AND WEAK	<input type="checkbox"/> UNABLE - ASPIRATION RISK
ABILITY TO CHEW/ SWALLOW	<input type="checkbox"/> WNL	<input type="checkbox"/> REQUIRES MODIFIED TEXTURE	<input type="checkbox"/> CHOKING WITH ASPIRATION RISK
ABILITY TO ORALLY FEED	<input type="checkbox"/> FEEDS SELF/INFANT	<input type="checkbox"/> REQUIRES HELP	<input type="checkbox"/> UNABLE DUE TO DIAGNOSIS

Describe any impairment with suck, swallow, breathing or the ability to chew or swallow and the effect on nutritional status.

Comments/Notes:



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SECTION 3-D. HEALTH & SYMPTOM ASSESSMENTS - PAIN ASSESSMENT TOOL

<input type="checkbox"/> PAIN <input type="checkbox"/> NO PAIN					
INTENSITY: <input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-8	<input type="checkbox"/> 9-10
					

UNABLE TO RATE (explain) _____

SUBJECTIVE ASSESSMENT OF PAIN

OBJECTIVE DESCRIPTION OF PAIN

LOCATION	_____
RADIATION	_____
DURATION	_____
FREQUENCY	_____

PRECIPITATING FACTORS _____

ALLEVIATING FACTORS _____

INTENSITY AFTER ALLEVIATING TREATMENT:					
<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-8	<input type="checkbox"/> 9-10
					

UNABLE TO RATE (explain) _____

PROBLEMS

Comments/Notes:



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SECTION 3-E. HEALTH & SYMPTOM ASSESSMENTS - SYMPTOM ASSESSMENT TOOL

- Nausea
 Dyspnea
 Constipation
 Anxiety
 Other: _____

Current intensity:

<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-8	<input type="checkbox"/> 9-10
					

QUALITY	
DURATION	
FREQUENCY	
PRECIPITATING FACTORS	
ALLEVIATING FACTORS	

INTENSITY AFTER ALLEVIATING TREATMENT:

<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-8	<input type="checkbox"/> 9-10
					

UNABLE TO RATE (explain)

Comments/Notes:



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SECTION 4-A. HEALTH AND SAFETY ASSESSMENTS - RISKS/HOME ENVIRONMENT (Part 1)

The purpose of the Home Environment Assessment is to ensure a safe environment that meets the needs of the patient and family.

HEALTH AND SAFETY RISK FACTORS

<input type="checkbox"/> None identified	
<input type="checkbox"/> Family violence	<input type="checkbox"/> Drugs / Alcohol
<input type="checkbox"/> Psychiatric history	<input type="checkbox"/> Suicide attempts
<input type="checkbox"/> Access to weapons	<input type="checkbox"/> History of chemical / physical restraints
<input type="checkbox"/> Gang involvement	<input type="checkbox"/> Smoking

Restraining order current and in place Yes No

Issued to whom _____	Relationship of restrained to patient _____
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Comments

HEALTH & WELFARE

For each F-CAP (initial, 6 month, and interim): Describe Care Coordinator's current efforts/activities to educate the family on risk of abuse, neglect and exploitation.

Comments/Notes:

HOME ENVIRONMENT ASSESSMENT (Part 1)

The purpose of the Home Environment Assessment is to ensure a safe environment that meets the needs of the patient and family.

Home Environment/Neighborhood

Condition	<input type="checkbox"/> Neat / Orderly / Clean	<input type="checkbox"/> Disorderly / Clean	<input type="checkbox"/> Unsanitary <input type="checkbox"/> Smoky
	<input type="checkbox"/> Damp <input type="checkbox"/> Mold	<input type="checkbox"/> Warm <input type="checkbox"/> Cold	
Primary and back-up utilities	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate	
Heating / cooling	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate	
Electrical including grounded electrical outlets	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate	
Refrigeration	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate	
Water / plumbing	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate	
Pests / Rodents present	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Telephone available	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Safety Devices installed and in working order			
Fire alarm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Carbon monoxide monitor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Fire Extinguisher	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Comments/Notes:



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SECTION 4-B. HEALTH AND SAFETY ASSESSMENTS - HOME ENVIRONMENT (Part 2)

HOME ENVIRONMENT ASSESSMENT (Part 2)

The purpose of the Home Environment Assessment is to ensure a safe environment that meets the needs of the patient and family.

Home Environment/Neighborhood (cont.)

Home is in multi-unit dwelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What floor is home located on?		
Stairs present	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wheelchair accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ramps portable/ installed available	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home well maintained	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Local emergency responders aware of child	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Public utilities aware	<input type="checkbox"/> Yes <input type="checkbox"/> No	

DME

Medical equipment in working order <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family knowledgeable in use of medical equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family aware of any potential hazards related to certain DME (e.g. oxygen tank)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home can safely accommodate all medical devices, equipment storage and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	

OTHER

Pets or other animals	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type (name)	Number	Contained in yard or crate/cage?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Internet Access	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Rural / outlying area transportation issues

Comments/Notes:



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SECTION 5-A. PERCEPTION OF ILLNESS/HEALTH CARE GOALS - PATIENT

Perception of Illness/health (for infants, toddler or patient unable to respond refer to parental comments). Check all that apply.

<input type="checkbox"/> Unable to assess	Reason		
<input type="checkbox"/> Understands prognosis	<input type="checkbox"/> Accepts prognosis	<input type="checkbox"/> Hoping for a miracle	<input type="checkbox"/> Worried about self
<input type="checkbox"/> Worried about others	<input type="checkbox"/> Who		
<input type="checkbox"/> Angry	<input type="checkbox"/> Disengaged from daily activities	<input type="checkbox"/> Prefers not to discuss condition	<input type="checkbox"/> Tearful
<input type="checkbox"/> Friendly	<input type="checkbox"/> Engaged in daily activities	<input type="checkbox"/> Open	
<input type="checkbox"/> Gains strength from			

Impact of spirituality /religious beliefs on perception of health and treatment options.

Health Care Goals

<input type="checkbox"/> Cure at all costs	<input type="checkbox"/> Quality of life is most important
<input type="checkbox"/> No life prolonging interventions	<input type="checkbox"/> Length of life is most important

Explain: Consider asking, "What is most important to you now?" or "What are you hoping for?"

Goals regarding pain/symptom control:

Social/Academic goals:

Information preference if bad news

<input type="checkbox"/> Detailed account of the situation	<input type="checkbox"/> Big picture, details not necessary
<input type="checkbox"/> Tell someone else, so they can tell the patient	Who?
<input type="checkbox"/> Patient would like someone present with him/her	Who?
<input type="checkbox"/> Other, comments	

Important factors in health care decision making

<input type="checkbox"/> What the family thinks	<input type="checkbox"/> What religion says	<input type="checkbox"/> Being in control	<input type="checkbox"/> Cost
---	---	---	-------------------------------

Response to "How do you and your family make decisions about your health?"

If illness terminal, talking about end of life:

<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable but willing	<input type="checkbox"/> Does not want to discuss
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Other Impressions/Observations

Comments/Notes:



FAMILY-CENTERED ACTION PLAN (F-CAP)

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SECTION 5-B. PERCEPTION OF ILLNESS/HEALTH CARE GOALS - PATIENT DESIRES

Describe the Patient’s desires: Include medical indications, patient preferences, quality of life, contextual issues, emotions, economic concerns, discussion and plan for each goal, as applicable. If patient not able to engage, move to Section 5-D.

Desires for management of pain:

Plan

Desires for management of physical symptoms:

Plan

Desires for counseling:

Plan

Desires for expressing feelings:

Plan

Desires for expressing spiritual matters:

Plan

Desired place of residence:

Plan

Desires for accomplishing academic goal(s):

Plan

Desires for accomplishing social goal(s)/ Legacy:

Plan

Desires for End of Life Goals, if appropriate:

Desired place for end of life:

Specific requests:

Comments/Notes:



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SECTION 5-C. PERCEPTION OF ILLNESS/HEALTH CARE GOALS - FAMILY

Perception of Illness/health by (check all that apply)

<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other/Circle of Support
<input type="checkbox"/> Unable to assess		Reason _____			
<input type="checkbox"/> Understands prognosis	<input type="checkbox"/> Accepts prognosis	<input type="checkbox"/> Hoping for a miracle	<input type="checkbox"/> Worried about self		
<input type="checkbox"/> Angry	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Prefers not to discuss condition		
<input type="checkbox"/> Friendly	<input type="checkbox"/> Open	<input type="checkbox"/> Tearful	<input type="checkbox"/> Gains strength from _____		
<input type="checkbox"/> Worried about others/Who? _____					

Explain differences in perception if multiple people are being assessed here.

Impact of spirituality/religious beliefs on perception of child's illness and treatment options.

Health Care Goals

<input type="checkbox"/> Cure at all costs	<input type="checkbox"/> Quality of life is most important
<input type="checkbox"/> No life prolonging interventions	<input type="checkbox"/> Length of life is most important

Explain: Consider asking, "What is most important to you now?" or "What hopes do you have for your child with regard to his/her illness?"

Goals regarding pain/symptom control:

Social/Academic goals:

Information of preference if bad news

<input type="checkbox"/> Detailed account of the situation	<input type="checkbox"/> Big picture, details not necessary
<input type="checkbox"/> Tell someone else, so they can tell the family/Who? _____	
<input type="checkbox"/> Would like someone present with him/her. Who? _____	
<input type="checkbox"/> Other, comments _____	

Important factors in health care decision making

<input type="checkbox"/> What the family thinks	<input type="checkbox"/> What religion says	<input type="checkbox"/> Being in control	<input type="checkbox"/> Cost
---	---	---	-------------------------------

Response to "How do you and your family make decisions about health?"

If illness terminal, talking about end of life:

<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable but willing	<input type="checkbox"/> Does not want to discuss
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Comments/Notes:



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SECTION 5-D. PERCEPTION OF ILLNESS/HEALTH CARE GOALS - FAMILY DESIRES

Perception of Illness/health by (check all that apply)

<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other/Circle of Support
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Desires to support patient's wishes and plans Yes No

Explain

Desires support in the management of patient's pain:

Plan

Service requested

Desires for management of patient's physical symptoms:

Plan

Service requested

Sibling Assessment: "How is sibling(s) coping with patient's illness?"

Desires for sibling support (community services):

Service(s) requested

Desires for spiritual support:

Service(s) requested

Desires for family training

Education on palliative care principles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Care needs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment regimen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Equipment use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Plan

Desires respite	<input type="checkbox"/> In home respite	<input type="checkbox"/> Out of home respite
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Plan

Desires for grief / bereavement services:

Plan

Desires for End of Life Goals, if appropriate:

Desired place for end of life:

Specific requests:

Other Impressions/Observations

Comments/Notes:



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SECTION 5-E. PERCEPTION OF ILLNESS/HEALTH CARE GOALS - DECISIONS

Decision for Life Sustaining/Prolonging Treatment (check all that apply)

Patient has decision-making capacity Yes No

Designated Power of Attorney (if patient does not have capacity):

Attempt resuscitation/CPR

Do not attempt resuscitation (Allow Natural Death)

Refer to POLST or equivalent (Advanced Directive, DNR) for additional information

POLST Form kept in the home in patient home chart to give to EMS
 Copy Obtained Attached

Advanced Directive Obtained Attached

No decision made

Conversation has not taken place

Notes

If applicable, Funeral Home/Mortuary

Phone

Contact Name

Phone

Comments/Notes:



FAMILY-CENTERED ACTION PLAN (F-CAP)

Patient Name _____	CCS # _____	CIN _____
DOB _____	Date of FCAP _____	Initial <input type="checkbox"/> 60 day Partial <input type="checkbox"/> 6 month Full <input type="checkbox"/> Interim <input type="checkbox"/>

SECTION 6-A. GOALS OF CARE - CARE COORDINATOR (Sec. 1-3)

The purpose of this section is to summarize issues and compile goals and plans from each of the previous sections. This Section is for the Care Coordinator to compile the goals from the previous Sections into a central place; there may be overlap. The Care Coordinator may identify goals different from the participant/family goals.

Section 1. Patient/Family and Social Information

Issue:	Goal/Plan:

Section 2. Medical Information

Issue:	Goal/Plan:

Section 3. Health & Symptom Assessments

Issue:	Goal/Plan:

Comments/Notes:



FAMILY-CENTERED ACTION PLAN (F-CAP)

Patient Name _____	CCS # _____	CIN _____	
DOB _____	Date of FCAP _____	Initial <input type="checkbox"/>	60 day Partial <input type="checkbox"/> 6 month Full <input type="checkbox"/> Interim <input type="checkbox"/>

SECTION 6-B. GOALS OF CARE - CARE COORDINATOR (Sec. 4-5, Other)

The purpose of this section is to summarize issues and compile goals and plans from each of the previous sections. This Section is for the Care Coordinator to compile the goals from the previous Sections into a central place; there may be overlap. The Care Coordinator may identify goals different from the participant/family goals.

Section 4. Health and Safety Assessments

Issue:	Goal/Plan:

Section 5. Perception of Illness/Health Care Goals

Issue:	Goal/Plan:

Other issues not identified/addressed in Sections 1-5

Issue:	Goal/Plan:

Transition Plan discussed with Family <input type="checkbox"/> Yes <input type="checkbox"/> No	Discussed with CCSNL <input type="checkbox"/> Yes <input type="checkbox"/> No
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Transition plan/goals

Comments/Notes:



FAMILY-CENTERED ACTION PLAN (F-CAP)

Patient Name _____	CCS # _____	CIN _____	
DOB _____	Date of FCAP _____	Initial <input type="checkbox"/>	60 day Partial <input type="checkbox"/> 6 month Full <input type="checkbox"/> Interim <input type="checkbox"/>

SECTION 6-D. GOALS OF CARE - FAMILY CENTERED TEAM MEETING

The Family Centered Team (FCT) Meeting occurs every 60 days in conjunction with the F-CAP reviews, in the family home or location of their choice. This meeting consists of the patient, the patient’s parent or legal guardian, the patient’s choice of additional family members/friends/caregivers (Circle of Support), the Care Coordinator, the CCSNL, and other professionals providing services to the patient. Providers who are unavailable may provide notes to the Care Coordinator to be shared in the meeting. The CCSNL may participate by phone if necessary, but should discuss new information and major changes in the care plan with the Care Coordinator prior to the meeting.

Family members, community support and providers who participated in this conference:		Date of FCT Meeting
Name	Relationship to Patient	by phone
		<input type="checkbox"/>

List the overall team goals that integrate the patient, family, and Circle of Support desires/ goals, as well as any additional goals that have not been addressed elsewhere in the F-CAP.

Identify any differences or conflicts about the goals of care that exist between the patient, the patient’s medical decision maker, family members or members of the patient’s circle of support .

Identify any conflicts that are present among the patient’s medical team.

Plan for resolution of goal differences identified above.

SUMMARY: Care coordination is anticipated to be

High complexity

High risk

Support and management

Comments/Notes:



FAMILY-CENTERED ACTION PLAN (F-CAP)

Patient Name _____	CCS # _____	CIN _____
DOB _____	Date of FCAP _____	Initial <input type="checkbox"/> 60 day Partial <input type="checkbox"/> 6 month Full <input type="checkbox"/> Interim <input type="checkbox"/>

SECTION 7-A. SERVICES - CURRENT

EPSDT Supplemental In Home Nursing Services

Currently receiving EPSDT supplemental in home nursing services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requesting EPSDT supplemental in home nursing services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Services authorized through:	<input type="checkbox"/> EPSDT-SS Unit <input type="checkbox"/> CCS
EPSDT-SS Case Manager Name _____	Phone _____
Number of hours receiving per week if known	LVN _____ RN _____
RN Supervision per month _____	
Name of HHA or Individual Nurse Provider providing the EPSDT supplemental in home nursing services _____	Phone _____
<input type="checkbox"/> Another child in the family is also receiving these services	

Current Medi-Cal State Plan Services

Service	Frequency	Duration	Provider Name	Provider Phone

Current PFC Waiver Services

Agency Name _____			Phone _____
Care Coordinator _____			Phone _____
Service	Frequency	Duration	Notes
<input type="checkbox"/> Care Coordination			
<input type="checkbox"/> Expressive Therapies			
<input type="checkbox"/> Pain & Symptom Mgt			
<input type="checkbox"/> Family Training			
<input type="checkbox"/> Family Counseling			
<input type="checkbox"/> Personal Care			
<input type="checkbox"/> In-Home Respite			
<input type="checkbox"/> Out-of-Home Respite			
CLHF Name (Contact) _____			Phone _____

Current Community Services

Service	Frequency	Duration	Provider Name



FAMILY-CENTERED ACTION PLAN (F-CAP)

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DOB _____	Date of FCAP _____	Initial <input type="checkbox"/> 60 day Partial <input type="checkbox"/> 6 month Full <input type="checkbox"/> Interim <input type="checkbox"/>

SECTION 7-B. SERVICES - REQUESTED

Partners for Children Services Requested

List PFC services requested, check the box (Ext) if requesting extension.

Agency Name _____		Phone _____	NPI _____		
Care Coordinator _____		Phone _____			
Service	Ext	From/To Dates	Units	Frequency/ Duration	Notes (include contact info if Individual provider is used)
<input type="checkbox"/> Care Coordination Initial (G9001)	--	-	1		
<input type="checkbox"/> Monthly (T2022)	<input type="checkbox"/>	-			
<input type="checkbox"/> Supplemental (G9012)	<input type="checkbox"/>	-			
<input type="checkbox"/> Expressive Therapies (G0176)	<input type="checkbox"/>	-			
<input type="checkbox"/> Pain & Symptom Mgt (S9123)	<input type="checkbox"/>	-			
<input type="checkbox"/> Family Training (S5110)	<input type="checkbox"/>	-			
<input type="checkbox"/> Family Counseling (X9508)	--	-	22		
<input type="checkbox"/> Personal Care (T1019)	<input type="checkbox"/>	-			
<input type="checkbox"/> In-Home Respite (T1005)	<input type="checkbox"/>	-			
<input type="checkbox"/> Out-of-Home Respite (H0045)	<input type="checkbox"/>	-			
CLHF Name _____		Phone _____	NPI _____		

Medi-Cal State Plan Services Requested

List Medi-Cal State Plan services requested, check the box (Ext) if requesting extension.

Code	Service	Ext	From/To Dates	Frequency/ Duration	Units	Provider Name	Provider NPI Number
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				
		<input type="checkbox"/>	-				

Community Services Requested

List community services requested, check the box if requesting extension.

Date	Service Description	Ext	Frequency/ Duration	Provider Name	Phone
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

SIGNATURES

Care Coordinator		Date
Typed Name _____		Signature _____
CCSNL		Date
Typed Name _____		Signature _____
Patient, if applicable		Date
Typed Name _____		Signature _____
Parent/Legal Guardian		Date
Typed Name _____		Signature _____
Physician		Date
Typed Name _____		Signature _____

F-CAP TRACKING

Date _____	F-CAP <input type="checkbox"/> faxed <input type="checkbox"/> emailed to CCSNL
Date _____	Mailed to Family
Date _____	F-CAP mailed to Health Care provider (PCP or SCC)



FAMILY-CENTERED ACTION PLAN (F-CAP)

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DOB _____	Date of FCAP _____	Initial <input type="checkbox"/> 60 day Partial <input type="checkbox"/> 6 month Full <input type="checkbox"/> Interim <input type="checkbox"/>

SECTION 8-B. FAMILY RESOURCES - PHONE SHEET

This page of the F-CAP is for the child and family.

Our Partners for Children Staff.

Providers (Type)	Name	Phone	Schedule/Upcoming Appointments
PFC Agency			
Care Coordinator			
Art Therapist			
Massage Therapist			
Music Therapist			
Child Life Specialist			
Family Training Nurse			
Family Counselor			
Personal Care Aide			
Respite Nurse			
Out of Home Respite CLHF			
Providers (Type)	Name	Phone	Upcoming Appointments
Child's primary doctor			
Child's EPSDT shift nursing agency			
Nurse			
Other			

Other Contacts (Type)	Name	Phone	Upcoming Appointments

24/7 Phone line If you have questions or concerns, you can call your agency at _____ and ask for the Partners for Children program staff person on-call. There will be a Registered Nurse available all day every day.

Our CCS Nurse Liaison (CCSNL)	Phone
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Your CCS Nurse Liaison will contact you monthly about Partners for Children services. Your Care Coordinator and CCSNL are available to answer any questions you may have about the program.