

PFC 60 Day F-CAP

CCS#		CIN#	
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Patient Information							
Patient Name		DOB		Date Review Begun		Date sent to PFC CCSNL	
<input type="checkbox"/> 60 day re-assessment (sections, 3-A, 4, 6-A, 6-B, 6-D and 7-A are REQUIRED, Section 7B and other sections are optional as changes occur and needs indicate) <input type="checkbox"/> Supplemental Assessment							
Care Coordinator Name		Agency		Phone			
Care Coordinator Name		Agency		Phone			
PFC CCS Nurse Liaison (PFC CCSNL) Name		Agency		Phone			

Reviewed/ Changed Y N	SECTION	If "YES," describe below	Follow Up Needed	County/ State Review	
				Comments, Remediation Needed, Possible Timeline	Complete Cty State
	SECTION 1. Patient/Family Information				
<input type="checkbox"/> <input type="checkbox"/>	1-A. Demographic				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	1-B. Social				<input type="checkbox"/> <input type="checkbox"/>

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Reviewed/ Changed Y N	SECTION 2. Medical Information	If “YES,” describe below	Follow Up Needed	Comments, Remediation Needed, Possible Timeline	Complete Cty State
<input type="checkbox"/> <input type="checkbox"/>	2-A. Diagnosis/Providers				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	2-B. Providers/Suppliers				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	2-C. Hospitalizations				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	2-D. Health History				<input type="checkbox"/> <input type="checkbox"/>

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<input type="checkbox"/> <input type="checkbox"/>	2-E. Medication History				<input type="checkbox"/> <input type="checkbox"/>
Reviewed/ Changed Y N	SECTION 3. Health & Symptom Assessments	If "YES," describe below	Follow Up Needed	Comments, Remediation Needed, Possible Timeline	Complete Cty State
<input type="checkbox"/> <input type="checkbox"/>	3-A. Physical Exam *pg.3				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	3-B. Review of Systems				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	3-C. Review of Systems/Nutrition				<input type="checkbox"/> <input type="checkbox"/>

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<input type="checkbox"/> <input type="checkbox"/>	3-D. Pain Assessment Tool				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	3-E. Symptom Assessment Tool				<input type="checkbox"/> <input type="checkbox"/>

Reviewed/ Changed Y N	SECTION	If "YES," describe below	Follow Up Needed	County/ State Review	
				Comments, Remediation Needed, Possible Timeline	Complete Cty State
	SECTION 4. HEALTH AND SAFETY ASSESSMENTS				
<input type="checkbox"/> <input type="checkbox"/>	4-A. Family Educated on the Risk of Abuse, Neglect and Exploitation	Date:			<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	4-B. Changes in Environment (Especially Accessibility Related)	If yes, plan to address:			<input type="checkbox"/> <input type="checkbox"/>

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<input type="checkbox"/> <input type="checkbox"/>	4-C. Changes in Health and Welfare (e.g. Restraining Order, Gang, etc.)	If yes, plan to address:			<input type="checkbox"/> <input type="checkbox"/>
	SECTION 5. PERCEPTION OF ILLNESS/HEALTH CARE GOALS	If “YES,” describe below	Follow Up Needed	Comments, Remediation Needed, Possible Timeline	Complete Cty State
<input type="checkbox"/> <input type="checkbox"/>	5-A. Patient Perception				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	5-B. Patient Desires				<input type="checkbox"/> <input type="checkbox"/>

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<input type="checkbox"/> <input type="checkbox"/>	5-C. Family Perception				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	5-D. Family Desires				<input type="checkbox"/> <input type="checkbox"/>
Reviewed/ Changed Y N	SECTION 6. GOALS OF CARE	If "YES," describe below	Follow Up Needed	Comments, Remediation Needed, Possible Timeline	Complete Cty State
<input type="checkbox"/> <input type="checkbox"/>	6-A. Care Coordinator Sec 1-3 *pg. 4				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	6-B. Care Coordinator Sec 4-5, Other *pg. 4				<input type="checkbox"/> <input type="checkbox"/>

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<input type="checkbox"/> <input type="checkbox"/>	6-C. Outcomes				<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	6-D. Family Centered Team Meeting *pg. 5 <i>Location:</i> _____ _____ <i>Start time:</i> _____ <i>End Time:</i> _____				<input type="checkbox"/> <input type="checkbox"/>
	SECTION 7. SERVICES	If "YES," describe below	Follow Up Needed	Comments, Remediation Needed, Possible Timeline	Complete Cty State
<input type="checkbox"/> <input type="checkbox"/>	7-A. Current *pg. 6	Date: _____			<input type="checkbox"/> <input type="checkbox"/>

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CARDIOVASCULAR	
LUNGS	
ABDOMEN	
EXTREMITES	
NEUROLOGICAL	
HEME/LYMPH	
HEENT	
OTHER	

SECTION 6. GOALS OF CARE

*Section 6-A. 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

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Issue:	
Goal/Plan:	
Section 3. Health & Symptom Assessments	
Issue:	
Goal/Plan:	

SECTION 6. GOALS OF CARE	
*Section 6-B. Care Coordinator (Sec. 4-5, OTHER)	
Section 4. Health and Safety Assessments	
Issue:	
Goal/Plan:	
Section 5. Perception of Illness/Health Care Goals	

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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 PFC CCSNL: <input type="checkbox"/> Yes <input type="checkbox"/> No
Transition plan/goals:	

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SECTION 6. GOALS OF CARE
***Section 6-D. 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"/>

SUMMARY: Care coordination is anticipated to be (Check one)

- High complexity
- High risk
- Support and management

Comments/Notes

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		Current and Requested PFC Waiver Services					
Agency Name					Phone		
Care Coordinator					Phone		
Service	Current	Requested	Frequency	Duration	Notes		
<input type="checkbox"/> Care Coordination	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Pain & Symptoms Mgt	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Family training	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Family counseling	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Personal Care	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> In-Home Respite	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Out-of-Home Respite	<input type="checkbox"/>	<input type="checkbox"/>					
CLHF Name (Contact)	<input type="checkbox"/>	<input type="checkbox"/>				Phone	

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Expressive Therapies			Frequency	Duration	Notes
<input type="checkbox"/> Child Life	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Art	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Music	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Massage	<input type="checkbox"/>	<input type="checkbox"/>			

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Service	Frequency	Duration	Provider Name

Comments/Notes

SIGNATURES			
Care Coordinator			
Typed Name		Signature	Date:
PFC CCSNL			
Typed Name		Signature	Date:
Patient, if applicable			
Typed Name		Signature	Date:
Parent/Legal Guardian			
Typed Name		Signature	Date:
Physician			
Typed Name		Signature	Date:
F-CAP <input type="checkbox"/> faxed <input type="checkbox"/> emailed to PFC CCSNL		Date:	
Mailed to Family		Date:	
F-CAP mailed to Health Care provider (PCP or SCC)		Date:	