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

Enclosure 5A

1. APPLICANT/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 Applicant/Appli _____

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

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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.

_____ _____ Date of onset: _____
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

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

☐ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

☐ Pediatric Day Health Care (PDHC)

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

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

☐ Acute

☐ Adult Subacute

☐ NF A

☐ NF B

☐ NF B (DP)

☐ Pediatric Subacute

☐ Pediatric NF B

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Participant's Name: _____

Treatment Period: _____ _____
FROM TO

7. WAIVER-SPECIFIC SERVICES
Please check all that apply and enter the appropriate Frequency Key Code.
(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		
☐ Transitional Case Management		
☐ HCBS Nursing Facility (Congregate Living Health Facility)		

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Treatment Period: _____ _____

FROM TO

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.

9. NUTRITIONAL REQUIREMENTS

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

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Participant's Name: _____

Treatment Period: _____ _____

FROM TO

10. MEDICATION PLAN FOR HOME PROGRAM
Please add additional pages as needed.

Allergies: _____ Reaction (if known): ---

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Who gives the medications to the patient? _____

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Participant's Name: _____

Treatment Period: _____ _____

FROM TO

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.

"The waiver applicant/participant and/or AR will hire and train the IHSS & WPCS providers in the waiver applicant/participant's personal and medical care needs. The waiver applicant/participant and/or AR will direct the IHSS & WPCS providers to assist with all of the waiver applicant/participant's activities of daily living, medication management, medical care, transfers, mobility, personal needs, house keeping, shopping, laundry & home care needs. The waiver applicant/participant and/or AR will instruct the IHSS & WPCS provider to dial 911 and ensure that the waiver applicant/participant will be transported immediately should he/she become incapacitated and unable to direct his/her own care. "

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Participant's Name: _____

Treatment Period: _____ _____
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.

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Treatment Period: _____ _____
FROM TO

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.

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Participant's Name: _____

Treatment Period: _____ _____

FROM TO

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

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Treatment Period: _____ _____
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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 applicant/participant will be able to function independently and maintain himself/herself safely in the home setting.

☐ Upon completion of this treatment plan, the applicant/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:

_____
_____
_____

19. TRAINING NEEDS FOR APPLICANT/PARTICIPANT/FAMILY

☐ No training needs have been identified for the applicant/participant and/or the family during this treatment period.

☐ Yes, there are training needs for the applicant/participant and/or the family during this treatment period.

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(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 APPLICANT/PARTICIPANT STATUS DURING THIS TREATMENT PERIOD

Please use additional pages as needed.

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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.

Applicant/Participant Signature	**Date**
Primary Caregiver Signature (as applicable)	**Date**
Physician Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**
Provider Signature	**Date**