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Independent Assessor (Required for Adul	t Medicaid 19	15i recipients):		
Name:				
Agency (if applicable):		MIS#		
Address:		City:		
Parish:	State:	Zip:		
Phone:	Cell:	Fax:	Email:	
Medical Care:				
Primary Care Physician:		MIS # (if applicable):		
Address:		City:		
Parish:	State:	Zip:		
Phone:	Cell:	Fax:	Email:	
Primary Medical Issues or Health Concerns:				
Member Name:				



#### Section II

Vision/Mission/Strengths
Member's Vision (Hopes and dreams for the future – In the Member's own words)
Family/Support Vision (Hopes and dreams for the future – In their own words)
Family/Support Team Goal:
Strengths:
Primary Treatment Diagnosis:
Member Name:
**POC is dependent upon eligibility and does not constitute a request for care until eligibility is determined.  Adult Initial Plan of Care (6/2014)

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Identified Needs (Mental Health, Substance Abuse, and Medical N	leeds Requiring Treatment)		
	Addressed via this POC	Yes	No
1.			
2.			
<del></del>			
3.			
4.			
5.			
Member Name:			
**POC is dependent upon eligibility and does not constitute a request for care	e until eligibility is determined.		
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In the section below, each identified need (listed above) being addressed in this POC is required to have a completed Plan for Identified Needs (PIN).

Plan for Identified Needs 1			
Objective/ Goal Statement:			Start Date:
Outcome Statement:			
Discharge Criteria:			D/C Date:
Strategies/ Assigned Tasks	Frequency:	Duration:	Responsible Party/Agency/Contact info:
1.			
2.			
3.			
4.			
Member Name:			110 110 110
**POC is dependent upon eligibility and Adult Initial Plan of Care (6/2014)	does not constitute a requ	uest for care until eli	gibility is determined.

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### **Adult Initial Plan of Care**

Barriers	SI				
1.					
2.					
3.					
4.					
Life Dom	ain Area of Ne	eed:			
	Family [ ]	Residence [ ]	Social [ ]	Education/Vocational [ ]	Medical [ ]
			Psychological/em	notional/behavioral [ ]	Safety [ ]
Clinical	Summary:				
M 1 M					
Member Na		eligibility and does no	 of constitute a request f	For care until eligibility is detern	nined
	al Plan of Care (		or constitute a request r	of care and englothing is determ	iniog.

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Plan for Identified Needs 2			
Objective/ Goal Statement:			Start Date:
Outcome Statement:			
Discharge Criteria:			D/C Date:
Strategies/ Assigned Tasks	Frequency:	Duration:	Responsible Party/Agency/Contact info:
1.			
2.			
3.			
4.			
Member Name:		4.6 (1.1)	

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### **Adult Initial Plan of Care**

Barriers					
1.					
2.					
3.					
4.					
Life Doma	ain Area of Ne	ed:			
	Family [ ]	Residence [ ]	Social [ ]	Education/Vocational [ ]	Medical [ ]
			Psychological/em	otional/behavioral [ ]	Safety [ ]
Clinical	Summary:				
Member Na	ame:				
**POC is d	lependent upon	eligibility and does	not constitute a request fe	or care until eligibility is determ	nined.



Plan for Identified Needs 3			
Objective/ Goal Statement:			Start Date:
Outcome Statement:			
Discharge Criteria:			D/C Date:
Strategies/ Assigned Tasks	Frequency:	<b>Duration:</b>	Responsible Party/Agency/Contact info:
1.			
2.			
3.			
4.			
Member Name:  **POC is dependent upon eligibility or	ad do ag mot constitute a mod	wast for some watil ali	aibility is determined



Barriers:				
1.				
2.				
3.				
4.				
Life Domain Area of N	leed:			
Family [ ]	Residence [ ]	Social [ ]	Education/Vocational [ ]	Medical [ ]
Co	mmunity [ ]	Psychological/em	otional/behavioral [ ]	Safety [ ]
Clinical Summary:				
Member Name:			or agra until gligibility is datarr	



Plan for Identified Needs 4			
Objective/ Goal Statement:			Start Date:
Outcome Statement:			
Discharge Criteria:			D/C Date:
Strategies/ Assigned Tasks	Frequency:	Duration:	Responsible Party/Agency/Contact:
1.			
2.			
3.			
4.			
Member Name:**POC is dependent upon eligibility at	nd does not constitute a rec	nuest for care until eligib	bility is determined.

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### **Adult Initial Plan of Care**

Barriers:					
1.					
2.					
3.					
4.					
Life Domain Area of N	eed:				
Family [ ]	Residence [ ]	Social [ ]	Education/Vocational [ ]	Medical [ ]	
Cor	mmunity [ ]	Psychological/em	otional/behavioral [ ]	Safety [ ]	
Clinical Summary:					



Plan for Identified Needs 5			
Objective/ Goal Statement:			Start Date:
Outcome Statement:			
Discharge Criteria:			D/C Date:
Strategies/ Assigned Tasks	Frequency:	Duration:	Responsible Party/Agency/Contact:
1.			
2.			
3.			
4.			
Member Name:  **POC is dependent upon eligibility an	d doos not constitute a rea	west for ears until aligib	sility is datarminad

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### **Adult Initial Plan of Care**

Barriers:				
1.				
2.				
3.				
4.				
Life Domain Area of No	eed:			
Family [ ]	Residence [ ]	Social [ ]	Education/Vocational [ ]	Medical [ ]
Cor	mmunity [ ]	Psychological/em	otional/behavioral [ ]	Safety [ ]
Clinical Summary:				
Member Name:	n aliaihility and dass so	t aanstituta a rasusst	for care until eligibility is determ	inad



Projected Cours	e of Treatment: (ic	dentify Services projected to	be needed over the	ne next up to 12 mo	onths)
Service Type:	Frequency	Intensity (units/week)	Projected Start Date:	Projected End Date:	Provider
1.					
2.					
3.					
4.					
5.					
Member Name:					
**POC is dependent	upon eligibility and o	does not constitute a request for ca	are until eligibility is	determined.	

Adult Initial Plan of Care (6/2014)





Section 4
Natural/Community/Informal Supports (include frequency of contact)
1.
2.
3.
4.
5.
Discharge Information:
Discharge Criteria (what needs to be accomplished for this POC to be discharged – be specific)
Member Name:
**DOC is dependent upon aligibility and does not constitute a request for earn until aligibility is determined



Section 5	
Crisis Plan	
Name:	Date:
Behavioral/Mental Health Diagnosis:	
Current Medications:	
Brief History:	
Triggers:	
Potential Crisis:	
Preferred De-escalation Techniques Identified by Member (be specific):	
Member Name:**POC is dependent upon eligibility and does not constitute a request for care until eligibility is do	etermined.

Adult Initial Plan of Care (6/2014)





Action Steps/Assigned Tasks	Person Responsible	Party/Agency/Contact info:
1.		
2.		
3.		
4.		
5.		
Member Name:		
**POC is dependent upon eligibility and does	 not constitute a request for care until elic	oihility is determined



Action Steps/Assigned Tasks	Person Responsible	Party/Agency/Contact info:
Backup plan		
1.		
2.		
3.		
4.		
5.		
Member Name:		



### Section 6

Team Members (Family	, Supports and Others, and Agei	ncies involved in plan development):	
Team Member	Relationship/Role/Vocation	Agency	Contact Information
Member Name:**POC is dependent upon el	igibility and does not constitute a requ	nest for care until eligibility is determined.	

Adult Initial Plan of Care (6/2014)



#### **Section 7**

Signature indicates understanding of the POC and agreement to participate in the POC.

Plan of Care Signatures:	Date:
Member:	
Parent/Guardian:	
Independent Assessor:	
Team Member:	
Agency Representative:	Agency:

Member Name:

<sup>\*\*</sup>POC is dependent upon eligibility and does not constitute a request for care until eligibility is determined. Adult Initial Plan of Care (6/2014)



Section 8
90 Day Review
Date:
Completion and signature of this section indicates that the Provider and the member have reviewed the Initial Plan of
Care (POC) and agree with the established POC Plan for Identified Needs (PINs) relevant to this provider/agency. If
significant changes are needed, please contact the Community-Based Care Manager to complete a Plan of Care Update
Form.
90 Day Review Clinical Summary:
Member:
Parent/Guardian:
Aganay Danragantativa:
Agency Representative: Agency:
Agency Representative: Agency:
Member Name:
**POC is dependent upon eligibility and does not constitute a request for care until eligibility is determined.  Adult Initial Plan of Care (6/2014)

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