Adult Initial Plan of Care

Plan Date: _____ IA Completion Date: _____

Section I

Member Information:

Name (Last, First, MI):		DOB	
SLA #:	Medicaid:		SSN #:
Address:		City:	
Parish:	State:	Zip:	
Phone:	Cell:	Fax:	Email:
Emergency Contact:		Phone:	

If member lives in out-of-home care please indicate:

Hospital [ ] Residential SA [ ] Nursing/LTC Facility [ ] Other [ ] (please indicate):			
Name of Agency/Location:		MIS # (if applicable):	
Address:		City:	
Parish:	State:	Zip:	
Phone:	Cell:	Fax:	Email:
Emergency Contact:		Phone:	

Member Name: _____

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Adult Initial Plan of Care (6/2014)

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Independent Assessor (Required for Adult Medicaid 1915i 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: _____

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Adult Initial Plan of Care (6/2014)

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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: _____

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Identified Needs (Mental Health, Substance Abuse, and Medical Needs Requiring Treatment)

	Addressed via this POC	Yes	No
1.		☐	☐
2.		☐	☐
3.		☐	☐
4.		☐	☐
5.		☐	☐

Member Name: _____

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Adult Initial Plan of Care (6/2014)

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Section 3

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: _____

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Adult Initial Plan of Care (6/2014)

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Barriers:
1.
2.
3.
4.

Life Domain Area of Need:

Family [ ] Residence [ ] Social [ ] Education/Vocational [ ] Medical [ ]

[ ] Psychological/emotional/behavioral [ ] Safety [ ]

Clinical Summary:

Member Name: _____

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Adult Initial Plan of Care (6/2014)

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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: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

Barriers:
1.
2.
3.
4.

Life Domain Area of Need:

Family [ ] Residence [ ] Social [ ] Education/Vocational [ ] Medical [ ]

[ ] Psychological/emotional/behavioral [ ] Safety [ ]

Clinical Summary:

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

Plan for Identified Needs 3	
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: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

Barriers:
1.
2.
3.
4.

Life Domain Area of Need:

Family [ ] Residence [ ] Social [ ] Education/Vocational [ ] Medical [ ]

Community [ ] Psychological/emotional/behavioral [ ] Safety [ ]

Clinical Summary:

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

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: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

Barriers:
1.
2.
3.
4.

Life Domain Area of Need:

Family [ ] Residence [ ] Social [ ] Education/Vocational [ ] Medical [ ]

Community [ ] Psychological/emotional/behavioral [ ] Safety [ ]

Clinical Summary:

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

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: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

Barriers:
1.
2.
3.
4.

Life Domain Area of Need:

Family [ ] Residence [ ] Social [ ] Education/Vocational [ ] Medical [ ]

Community [ ] Psychological/emotional/behavioral [ ] Safety [ ]

Clinical Summary:

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

Projected Course of Treatment: (identify Services projected to be needed over the next up to 12 months)

Service Type:	Frequency	Intensity (units/week)	Projected Start Date:	Projected End Date:	Provider
1.					
2.					
3.					
4.					
5.					

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

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: _____

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Adult Initial Plan of Care (6/2014)

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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: _____

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Adult Initial Plan of Care (6/2014)

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

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

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

Member Name: _____

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Adult Initial Plan of Care (6/2014)

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Section 6

Team Members (Family, Supports and Others, and Agencies involved in plan development):

Team Member	Relationship/Role/Vocation	Agency	Contact Information

Member Name: _____

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Adult Initial Plan of Care (6/2014)

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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:	
Team Member:	
Team Member:	
Team Member:	
Agency Representative:	Agency:
Agency Representative:	Agency:
Agency Representative:	Agency:
Agency Representative:	Agency:
Agency Representative:	Agency:

Member Name: _____

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Adult Initial Plan of Care (6/2014)

Adult Initial Plan of Care

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:	
Agency Representative:	Agency:
Agency Representative:	Agency:

Member Name: _____

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