

**ADULT CARE HOME  
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN**

Assessment Date ___/___/___ Reassessment Date ___/___/___ <input type="checkbox"/> Significant Change ___/___/___
---

**RESIDENT INFORMATION**

(Please Print or Type)

RESIDENT \_\_\_\_\_ SEX (M/F) \_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ MEDICAID ID NO. \_\_\_\_\_

FACILITY \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ PROVIDER NUMBER \_\_\_\_\_

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN \_\_\_/\_\_\_/\_\_\_

**ASSESSMENT**

1. MEDICATIONS - Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	Dose	Frequency	Route	( <input checked="" type="checkbox"/> ) If Self-Administered
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

<input type="checkbox"/> Wandering <input type="checkbox"/> Verbally Abusive <input type="checkbox"/> Physically Abusive <input type="checkbox"/> Resists care <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Disruptive Behavior/ Socially Inappropriate	<input type="checkbox"/> Injurious to: <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Property  Is the resident currently receiving medication(s) for mental illness/behavior? <input type="checkbox"/> YES <input type="checkbox"/> NO  Is there a history of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Developmental Disabilities (DD) <input type="checkbox"/> Mental Illness	Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? <input type="checkbox"/> YES <input type="checkbox"/> NO  Has a referral been made? <input type="checkbox"/> YES <input type="checkbox"/> NO  <u>If YES:</u>  Date of Referral _____ Name of Contact Person _____ Agency _____
---	--	--

**Social/Mental Health History:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Resident \_\_\_\_\_

3. **AMBULATION/LOCOMOTION:**  No Problems  Limited Ability  Ambulatory w/ Aide or Device(s)  Non-Ambulatory  
Device(s) Needed \_\_\_\_\_  
Has device(s):  Does not use  Needs repair or replacement
4. **UPPER EXTREMITIES:**  No Problems  Limited Range of Motion  Limited Strength  Limited Eye-Hand Coordination  
Specify affected joint(s) \_\_\_\_\_  Right  Left  Bilateral  
 Other impairment, specify \_\_\_\_\_  
Device(s) Needed \_\_\_\_\_ Has device(s):  Does not use  Needs repair or replacement
5. **NUTRITION:**  Oral  Tube (Type) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Dietary Restrictions: \_\_\_\_\_  
Device(s) Needed \_\_\_\_\_  
Has device(s):  Does not use  Needs repair or replacement
6. **RESPIRATION:**  Normal  Well Established Tracheostomy  Oxygen  Shortness of Breath  
Device(s) Needed \_\_\_\_\_ Has device(s):  Does not use  Needs repair or replacement
7. **SKIN:**  Normal  Pressure Areas  Decubiti  Other \_\_\_\_\_  
Skin Care Needs \_\_\_\_\_
8. **BOWEL:**  Normal  Occasional Incontinence (less than daily)  Daily Incontinence  
 Ostomy: Type \_\_\_\_\_ Self-care:  YES  NO
9. **BLADDER:**  Normal  Occasional Incontinence (less than daily)  Daily Incontinence  
Catheter: Type \_\_\_\_\_ Self-care:  YES  NO
10. **ORIENTATION:**  Oriented  Sometimes Disoriented  Always Disoriented
11. **MEMORY:**  Adequate  Forgetful - Needs Reminders  Significant Loss - Must Be Directed
12. **VISION:**  Adequate for Daily Activities  Limited (Sees Large Objects)  Very Limited (Blind); Explain \_\_\_\_\_  
Uses:  Glasses  Contact Lens  Needs repair or replacement  
Comments \_\_\_\_\_
13. **HEARING:**  Adequate for Daily Activities  Hears Loud Sounds/Voices  Very Limited (Deaf); Explain \_\_\_\_\_  
 Uses Hearing Aid(s)  Needs repair or replacement  
Comments \_\_\_\_\_
14. **SPEECH/COMMUNICATION METHOD:**  Normal  Slurred  Weak  Other Impediment  No Speech  
 Gestures  Sign Language  Writing  Foreign Language Only \_\_\_\_\_  Other  None  
 Assistive Device(s) (Type \_\_\_\_\_) Has device(s):  Does not use  Needs repair or replacement

Resident \_\_\_\_\_

## CARE PLAN

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: 0 - INDEPENDENT, 1 - SUPERVISION, 2 - LIMITED ASSISTANCE, 3 - EXTENSIVE ASSISTANCE, 4 - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

<u>ACTIVITIES OF DAILY LIVING (ADL)</u>	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	PERFORMANCE CODE
<i>DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:</i>								
EATING								
TOILETING								
AMBULATION/LOCOMOTION								
BATHING								
DRESSING								
GROOMING/PERSONAL HYGIENE								
TRANSFERRING								

OTHER: (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)


### ASSESSOR CERTIFICATION

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

- Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### PHYSICIAN AUTHORIZATION

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

- The resident may take therapeutic leave as needed.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)**

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

**RESIDENT INFORMATION:** In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

**DATE OF MOST RECENT EXAMINATION:** Includes a yearly physical by the resident's attending physician.

**ASSESSMENT:**

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.
  
2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.
  - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.
  
  - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

**TOP OF SECOND PAGE: RESIDENT \_\_\_\_\_:** Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.
  
4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.
  
5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.
  
6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.
  
7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.
  
8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.
10. **ORIENTATION:** Check appropriate box.
11. **MEMORY:** Check appropriate box.
12. **VISION:** Check appropriate box. Expand on concerns in comments area.
13. **HEARING:** Check appropriate box. Expand on concerns in comments area.
14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

**TOP OF THIRD PAGE: RESIDENT** \_\_\_\_\_ : Place name as on Medicaid ID card in this blank.

**CARE PLAN:**

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

**ACTIVITIES OF DAILY LIVING:** Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

**ASSESSOR CERTIFICATION:** Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

**PHYSICIAN AUTHORIZATION:** The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.