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Long Term Care Person-Centered Care Plan

Enrollee Personal Profile							
Medicaid ID #		POC Eff. Date		Enrollee Effective Date			
First Name		Last Name		MI		Date of Birth	
Location		Facility Name		Enrollee Phone #			
Primary Lang.		Adv. Care Planning		Details			

Family & Social History	
Do you have family or friends nearby?	
If yes, how often do you see them?	
What was your profession and/or jobs you worked?	
Do you volunteer or participate in any social groups?	

What is important to the Enrollee?	
Likes & Dislikes (i.e activities, hobbies, foods, etc.)	
What are your special family / cultural traditions?	
Personal Care or Support Preferences	

What do we need to know about the Enrollee?	
Rituals / Routines that are important to the enrollee	
List any communication limitations	
What method of communication do you prefer?	

What are the enrollee's strengths, preferences and self-care capabilities?

Member modification of HCBS setting:	
Were there any modifications made to the member's HCBS setting since the member's last assessment?	*If yes, detail:*
Provide the specific assessed need for the modification of HCBS setting?	
Does the member's current living arrangement differ from their desired living arrangement?	*If yes, detail:*
What is the member's goal in achieving the desired living environment?	
What are the barriers to the member's choice of living environment?	

List the people chosen (if any) by the enrollee to participate in their Plan of Care development & reviews:		
Name	Relationship and Contact Phone Number	

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Frequency and Details

Enrollee Name:		Medicaid ID#	

Caregiver/Informal Support Supplemental Assessment

Who does the enrollee live with?			Other:
Can the enrollee be safely left alone?		If yes, what amount of time can the enrollee be left alone?	Notes:
Are there Caregiver/Informal support available to assist with the enrollee's needs and care?		Notes:	

**Caregiver/Informal Support includes supports that are provided to the enrollee. This can include the enrollee's spouse, family members, neighbors, friends, significant others and church or community volunteer organizations that are willing to support enrollee as part of their Person Centererd Plan.

Supplemental Assessment: List of Caregiver/Informal Support

Name of Individual/Organization:

1)

Relationship:

If Other:

Role & Support Provided			
Services	Frequency, Hours and Details	Services	Frequency, Hours and Details
☐ Bathing		☐ Heavy Chores	
☐ Dressing		☐ Light Housekeeping	
☐ Eating		☐ Using Telephone	
☐ Using Bathroom		☐ Managing Money	
☐ Transferring		☐ Preparing Meals	
☐ Mobility		☐ Shopping	
☐ Respite		☐ Managing Meds	
☐ Companion		☐ Transportation	
☐ Other			Details
Stress level			
Limitations			
Willingness to Assist			
Addtl. Responsibilities			

Name of Individual/Organization:

2)

Relationship:

If Other:

Role & Support Provided			
Services	Frequency, Hours and Details	Services	Frequency, Hours and Details
☐ Bathing		☐ Heavy Chores	
☐ Dressing		☐ Light Housekeeping	
☐ Eating		☐ Using Telephone	
☐ Using Bathroom		☐ Managing Money	
☐ Transferring		☐ Preparing Meals	
☐ Mobility		☐ Shopping	
☐ Respite		☐ Managing Meds	
☐ Companion		☐ Transportation	
☐ Other			Details
Stress level			
Limitations			
Willingness to Assist			
Addtl. Responsibilities			

Additional Narrative/Notes	

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Enrollee Name		Medicaid ID#	

Community Integration: Personal Goal Planning

A goal should address issues that are identified in the care plan to ensure enrollee is integrated into the community. A goal should be built on strengths and includes steps that the enrollee will take to achieve the goal. Goals are reviewed at each visit to include progress of the goal, potential barriers to progress, any changes needed and if the goal has been met. If enrollee refuses to create a goal the reason must be documented.

	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			
GOAL 2	OBJECTIVE		DATE DEVELOPED	
GOAL 2	GOAL		GOAL STATUS	
GOAL 2	BARRIER		TIMEFRAME	
GOAL 2	INTERVENTION			
	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			
GOAL 4	OBJECTIVE		DATE DEVELOPED	
GOAL 4	GOAL		GOAL STATUS	
GOAL 4	BARRIER		TIMEFRAME	
GOAL 4	INTERVENTION			
	OBJECTIVE		DATE DEVELOPED	
	GOAL		GOAL STATUS	
	BARRIER		TIMEFRAME	
	INTERVENTION			

Self Management Plan

The enrollee's role in managing the physical and social affects and lifestyle changes associated with their chronic condition or a functional limitation.

How are you managing your lifestyle changes due to your current condition?	

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

LTC Service Plan Details

Service or Item Type	Service or Item Details	Timeframe (m/d/yy)		Amount	Frequency	Provider	Goal
Case Management		Start Date				Sunshine Health	
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
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		Start Date					
		End Date					

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Long Term Care Person-Centered Care Plan

Enrollee Name		Medicaid ID#	

LTC Service Plan Details

Service or Item Type	Service or Item Details	Timeframe (m/d/yy)		Amount	Frequency	Provider	Goal
		Start Date					
		End Date					
		Start Date					
		End Date					
		Start Date					
		End Date					
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		Start Date					
		End Date					

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Enrollee Name		Medicaid ID#	

Other Existing Care Plans, Services and Service Providers *(i.e. PCP, Medicare, Skilled Nursing Care, Specialty Care, Inpatient Admission, Routine Medical, etc.)*

Service Type	Service Detail, Amount and Frequency	Timeframe (m/d/yy)		Payer Source	Provider
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
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		Start Date			
		End Date			

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Enrollee Name		Medicaid ID#	

Behavioral Health - CBH or Non-CBH - Cenpatico Behavioral Health

Service Type	Service Details (If Applicable)	Timeframe (m/d/yy)		Amnt / Freq	Provider
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			
		Start Date			
		End Date			

Medication Oversight Strategies (To be reviewed every 90 days)

Medication Management		Please explain enrollee's medication strategy in the description below, even if no barrier was identified.	Recommended Strategies or Intervention	
Description/Details				

Backup/Contingency Plan - If the service provider does not show the back-up plan will be as follows:

Back-up Plan	Full Name		Contact number	
☐ Contact SHP LTC plan	Sunshine Health Plan		1-877-211-1999	
☐ Contact the current provider directly	Contact Servicing Provider		Contact Servicing Provider	
☐ Contact designated responsible party:	1		1	
☐Caregiver, ☐Family, ☐Friend to provide care,	2		2	
☐Other (specify:_____)	3		3	

I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.

Reason for Plan Of Care Review (at least every 90 days)	Care Manager Signature	Date Signed
Individual and/or Entity Responsible for monitoring the Plan of Care	**Enrollee or Enrollee's Authorized Representative**	**Date Signed**

☐ Signed ☐ Unable to Sign ☐ Refused to Sign ☐ Mailed to POA

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Long Term Care Person-Centered Care Plan

Enrollee Care Plan Summary

Enrollee Name		Date of Birth		Medicaid ID#	

Below is a summary of your plan of care that includes your service providers and the services you are receiving. Your case manager has identified services that meet your needs to provide you with appropriate care services.

HCBS/Covered Services	Provider	Start Date	End Date	Amount and Frequency
Case Management	Sunshine Health			

I (enrollee or enrollee authorized rep.) agreed to each individual provider choice for each service above and each service authorization ? Yes ☐ No ☐

I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.

Reason for Plan Of Care Review (at least every 90 days)	Care Manager Signature	Date Signed

Enrollee or Enrollee's Authorized Representative	Date Signed

☐ Signed ☐ Unable to Sign ☐ Refused to Sign ☐ Mailed to POA

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