Louisiana Department of Health and Hospitals-Office for Citizen's with Developmental Disabilities
Plan of Care (POC) for Children's Choice Waiver

POC TYPE: ☐ INITIAL ☐ ANNUAL

INDIVIDUAL'S NAME (LAST NAME, FIRST NAME)			DOB	LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER				RELATIONSHIP	
MEDICAID ID #				Is this a Legal Relationship as identified in Legal Status below?	
PHYSICAL ADDRESS				MAILING ADDRESS (if different)	
CITY/STATE/ZIP	PARISH		REGION	CITY/STATE/ZIP	
DAYTIME PHONE	NIGHTTIME PHONE			DAYTIME PHONE	NIGHTTIME PHONE
SUPPORT COORDINATION AGENCY				PROVIDER NUMBER	
ADDRESS OF SUPPORT COORDINATION AGENCY				SUPPORT COORDINATOR (SC)	SC SUPERVISOR
CITY/STATE/ZIP				TELEPHONE NUMBER	

SEX: ☐ MALE ☐ FEMALE **RACE:** ☐ BLACK ☐ WHITE ☐ HISPANIC ☐ ASIAN ☐ OTHER: _______________
EDUCATION: ☐ ATTENDS SCHOOL ☐ HOMEBOUND ☐ 9 MONTHS ☐10 MONTHS ☐N/A
LEGAL STATUS: ☐ MINOR ☐ INTERDICTED ☐ POWER OF ATTORNEY ☐ COMPETENT MAJOR ☐ OTHER: _________
DD: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER: ____
PRIMARY DIAGNOSIS CODE:__________________ **SECONDARY DIAGNOSIS CODE:**_______________________
ADAPTIVE FUNCTIONING: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER: _______________
90L: PHYSICIAN DATE:_____________ SC REC'D_________________ **AMBULATION:** ☐ YES ☐ NO _______________
SELF-EVACUATE HOME: ☐ YES ☐ NO **IF NO, INDIVIDUALIZED EVACUATION PLAN IS ATTACHED:** ☐ YES ☐ NO
EMERGENCY RESPONSE LEVEL: ☐ LEVEL 1Total Assistance with Life Sustaining equipment ☐ LEVEL 2 Total Assistance ☐ LEVEL 3 Can respond/Needs transportation ☐ LEVEL 4 Can respond independently

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ☐ YES ☐ NO IF YES, WHERE?_______________________
PROPOSED LIVING ADDRESS:____
ARE THERE MULTIPLE INDIVIDUALS WITH WAIVERS IN THE HOME? ☐ YES ☐ NO IF YES, HOW MANY?___________
ARE THERE MULTIPLE INDIVIDUALS WITH DD (not participants) IN THE HOME? ☐ YES ☐ NO IF YES, HOW MANY?_____
DOES THE POC INCLUDE PLANS FOR RESTRAINTS? ☐ YES ☐ NO
ARE PAID CAREGIVERS RELATED TO INDIVIDUAL? ☐ YES ☐NO IF YES, RELATION & SERVICE __________________
____
DO PAID CAREGIVERS LIVE WITH INDIVIDUAL? ☐ YES ☐ NO IF YES, NAME & SERVICE__________________________
____

PRESENT HOUSING ARRANGEMENT:
☐ ICF/DD ☐ NURSING FACILITY ☐ Permanent Supportive Housing Unit:__________
☐ OWN HOME (Parent/Guardian): ☐ OTHER'S HOME:
IF ELIGIBLE, DID THE PARTICIPANT RECEIVE AN OFFER TO CHANGE DIRECT SERVICE PROVIDERS? ☐ YES ☐ NO
WAS A CHANGE IN DIRECT SERVICE PROVIDER REQUESTED? ☐ YES ☐ NO
WAS A FREEDOM OF CHOICE OFFERED? ☐ YES ☐ NO

FOR LGE USE ONLY: HIGH RISK PARTICIPANT: ☐ YES ☐ NO (If Yes, OCDD will add to High Risk Tracking)
Final Packet Receipt Date:

POC Begin Date: **POC End Date:**

SECTION I: EMERGENCY INFORMATION (Note: Individualized Emergency Evacuation/Response Plan must be attached.)

Individual's Name:	**Age:**

Address:

Directions to home:

Persons responsible for evacuating, if necessary, or bring supplies to recipient's home:

Name:	**Relationship:**
Address:	
Home Phone:	**Work/Other Phone:**

Family members/others to contact in case of emergency:

Name:	**Relationship:**
Address:	
Home Phone:	**Work/Other Phone:**
Name:	**Relationship:**
Address:	
Home Phone:	**Work/Other Phone:**

Emergency equipment in home:(fire extinguishers, smoke detectors, first aid kits, home evacuation plan, specialized medical equipment)

Special Consideration: (assistive technology supporting independence, ventilator dependent, medications, etc.)

Agencies involved with the individual: (Service Providers, OCS, APS, LRS, churches, etc.)	
Agency:	Phone:
Contact Person:	
Agency:	Phone:
Contact Person:	
Agency:	Phone:
Contact Person:	

Individual's Doctor(s):

Doctor's Name	Specialty	Phone

SECTION II: CURRENT STATUS OF THE INDIVIDUAL'S PERSONAL OUTCOMES AND SUPPORTS

1. IDENTITY: People choose personal goals; People choose where & with whom they live; People choose where they work; People have intimate relationships; People are satisfied with services; People are satisfied with their personal situations.

Current Status:

Supports:

2. AUTONOMY: People choose their routine; People have time, space & opportunity for privacy; People decide when to share personal information; People use their environment.

Current status:

Supports:

3. AFFILIATION: People live in integrated environments; People participate in the life of the community; People interact with other members of the community; People perform different social roles; People have friends; People are respected.

Current status:

Supports:

4. ATTAINMENT: People choose services; People realize personal goals.

Current Status:

Supports:

SECTION II: CURRENT STATUS OF THE INDIVIDUAL'S PERSONAL OUTCOMES AND SUPPORTS (CONTINUED)

5. SAFEGUARDS: People are connected to natural support networks; People are safe.
Current Status:
Supports:

6. RIGHTS: People exercise rights; People are treated fairly.
Current Status:
Supports:

7. HEALTH AND WELLNESS: People have the best possible health; People are free from abuse and neglect; People experience continuity and security.
Current Status:
Supports:

SECTION III: HEALTH PROFILE

A. HEALTH STATUS

1. PHYSICAL:

2. MEDICAL DIAGNOSES/CONCERNS/SIGNIFICANT MEDICAL HISTORY:

3. PSYCHIATRIC/BEHAVIORAL CONCERNS:

4. BEHAVIOR PLAN (if needed) (Attach copy to POC): ☐ YES ☐ NO

5. INCIDENT REPORTS (for past 6 months):
A. Incidents #______________________
B. Non-critical Incidents #____________
C. Hospital Admissions #_____________
D. Emergency Visits #_________________
E. Psych Hospital Admissions #_________
F. Other:____________

6. SUMMARY:
____
____
____
____
____

B. LIST OF TREATMENTS: (Examples: catheterization, tube feeding, dressing changes, splints, braces, suction, etc.)

C. ALLERGIES:

Medications: _________________________ Food: _______________________ Airborne: _______________
What does the reaction look like, or what occurs with the reaction? **(BE SPECIFIC)**

SECTION III: HEALTH PROFILE - CONTINUED

D. MEDICATIONS/ MEDICAL PROCEDURES	DOSAGE	WHAT IS IT FOR?	HOW IS IT TAKEN? ROUTE	WHEN IS IT TAKEN? FREQUENCY	TO BE ADMINISTERED BY: (self, family, staff, CMA, CNA, etc.)

Note: Attach additional page if more space is needed.

NURSE DELEGATION NEEDED: ☐ YES (attach to POC if needed) ☐ NO

DSW PARTICIPANT SPECIFIC TRAINING ☐ YES (attach to POC if needed) ☐ NO

NAME:____

SECTION IV: PARTICIPANT PROFILE

A. PERTINENT HISTORICAL INFORMATION: Date, age at time of onset and cause of disability. If not known, enter "unknown." Placement history; recurring situations that impact care; response to interventions in the past; summary of events leading to request for service at this time.)

B. CURRENT LIVING SITUATION: (Describe current family situation; level of education attainment; identify family's understanding of individual's situation/condition, knowledge of disability and consequences of non-compliance with POC; economic status; relevant social environment and health factors that impact individual (i.e., health of care givers, home in rural/urban area, accessibly to resources); own home/rental/living with relatives/extended family or single family dwelling. Is the home environmentally safe? Does the home environment adequately meet the needs of individual or will environmental modifications be required?)

C. NATURAL SUPPORTS: (List family members, names and ages; how they are involved/not involved; Who is the primary care giver (PCG)? Is the PCG employed? Are any of the care givers paid for supports? If there are no natural supports, has guardianship been considered? Description of complete social support network-list friends and other community resources involved in supporting the individual on a daily basis.)

D. COMMUNITY SUPPORTS/OTHER AGENCY INVOLVEMENT: (Individual's significant life events, which may include family issues and issues with social/law enforcement agencies. Does individual have social services caseworker or Probation Officer assigned? Will you have to interact with that agency/individual?)

E. DAILY LIVING SKILLS: (Describe activities of daily living that must be completed by others. What skills can individual complete independently? With assistance? Require total assistance?)

Information included on this page is relevant to the individual's life today and provides a means of sharing social/family history not addressed in the content of the POC. Include information that the person and/or his/her family feels is important to share and relevant to supporting and achieving the outcomes determined by the person/family.

SECTION V: PERSONAL PREFERENCES

A. GIFTS AND TALENTS:	B. THINGS THAT WORK: LIKES/NEGOTIABLE	C. THINGS THAT DON'T WORK: DISLIKES/NON-NEGOTIABLE

SECTION VI: POC SERVICES, NEEDS AND SUPPORTS

Utilize this form to complete the support coordination and provider plan of care. Reference each Service Area. This form may be duplicated as necessary.

SERVICES:

SUPPORT COORDINATION
FAMILY SUPPORT
FAMILY SUPPORT / 2 CHILDREN
FAMILY TRAINING
ACTIVITIES (ex. Games, crafts, reading)

CRISIS SUPPORT
CRISIS SUPPORT / 2 CHILDREN
CRISIS SUPPORT/ CENTER BASED
CENTER BASED RESPITE

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS
PSH-HOUSING STABILIZATION
PSH-HOUSING STABILIZATION TRANSITION

APPLIED BEHAVIORAL ANALYSIS
AQUATIC THERAPY
ART THERAPY
MUSIC THERAPY
SENSORY INTEGRATION

HIPPOTHERAPY
THERAPEUTIC HORSEBACK RIDING
FAMILY /VOLUNTEER
NON-MEDICAID RESOURCES
OTHER RESOURCES (SPECIFY)

PERSONAL OUTCOMES "What" the individual wants for his/her self	**SUPPORT STRATEGY NEEDED** "What" is needed to achieve the Personal Outcome? "How" will the support be delivered? "Who" will deliver the support? (paid/unpaid support) "Where" will the support be provided? "Will" assistive devices be required? Be specific	**HOW OFTEN FOR SUPPORTS AND SERVICES** List the service/support and "How often" they will be provided?	**REVIEW / ACCOMPLISHMENT DATE** "When" will the support be reviewed/the Personal Outcome be achieved?
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	4.
4.	4.	4.	5.

Note: Planning must include and reflect emergency back-up plans for services and emergencies.

SECTION VII: POC TYPICAL WEEKLY SCHEDULE (Planning Worksheet)

FOR PLANNING PURPOSES ONLY. IF MY NEEDS CHANGE, I WILL CONTACT MY SUPPORT COORDINATOR AS SOON AS POSSIBLE. I HAVE INCLUDED ALL THE PCS, STATE PLAN, HOME HEALTH, RESPITE AND OTHER SERVICES I PLAN TO USE.

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
12:00 AM							
01:00 AM							
02:00 AM							
03:00 AM							
04:00 AM							
05:00 AM							
06:00 AM							
07:00 AM							
08:00 AM							
09:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
01:00 PM							
02:00 PM							
03:00 PM							
04:00 PM							
05:00 PM							
06:00 PM							
07:00 PM							
08:00 PM							
09:00 PM							
10:00 PM							
11:00 PM							

Comments: Include proposed waiver and non-waiver services on weekly schedule. No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice Waiver services cannot be provided on the same day at the same time as any other waiver or state plan services. Services cannot be provided in a school setting.

NAME:____

SECTION VIII: POC REQUESTED WAIVER SERVICES

List the participant's requested services as described in the POC.

Name:____________________________ Program Type: Children's Choice POC Begin Date: ____________ POC End Date:_______________

1.	2.	3.	4.	5.	6.	7.	8.	9.
Provider's Full Name	**Provider #**	**Service type**	**Procedure Code**	**Total Monthly Cost**	**# of Units (Not hours)**	**Cost per Unit**	**Yearly costs[1]**	**Admin fees[2]**
		Support Coordination	**9E001**	**$125.00**	**12**		**$1500.00**	
		Self- Direction –Family Supports -Administrative Fee		**Monthly**				
		Family Support (PCA)	**S5125**					
		Housing Stabilization			**Housing Stabilization**			

Please check your math. Total cost of all combined services[1] and administrative fees[2] cannot exceed $16,410 per POC year.	**10. Grand Total**	

Support Coordinator's Signature: ____Date: ____________________Individual/Guardian: ____Date: __________

Children's Choice Provider signature of agreement to deliver above services and understanding that services cannot begin or be reimbursed until PA is issued. _____________________________________ Date: __________

LGE/WSS APPROVAL: ____LGE: _______________________________ Date: ________________Received: ____________

SECTION VIII (A): CHILDREN'S CHOICE SERVICES (ANNUAL BUDGET SHEET)

NAME: ______________________________ PROGRAM TYPE: CHILDREN'S CHOICE POC BEGIN DATE: __________ POC END DATE:__________

TYPICAL SCHEDULE – TOTAL ADDITIONAL UNITS OF SERVICE PER QUARTER

Services Type	Services Code	MTH/ DAY/ YR ______ MTH/DAY/YR______ TOTAL # OF UNITS	MTH/DAY/YR______ MTH/DAY/YR______ TOTAL # OF UNITS	MTH/DAY/YR______ MTH/DAY/YR______ TOTAL # OF UNITS	MTH/DAY/YR______ MTH/DAY/YR______ TOTAL # OF UNITS	MTH/DAY /YR______ MTH/DAY/YR______ TOTAL # OF UNITS	TOTAL COST
					Total Schedule Cost		

*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.

*Provider Name/Provider Representative Signature: ____ Date: _________________________

*Provider Name/Provider Representative Signature: ____ Date: _________________________

Support Coordinator Signature: ____ Initials: _____________ Date: _________________________

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:

RECEIPIENT/GUARDIAN SIGNATURE ____ Date_________________________

LGE/WSS Approval Signature: ____ Date: ________________________

SECTION VIII (B) : IDENTIFIED SERVICES, NEEDS, AND SUPPORTS			CONFIDENTIAL
IDENTIFIED SERVICES AND SUPPORTS THAT WILL HELP ME MAINTAIN AND/OR ACHIEVE MY PERSONAL OUTCOMES.			
Children's Choice Waiver (Super Provider)	Children's Choice Waiver(Individual Providers)	Medicaid Funded Services	Non- Waiver Supports
☐ Family Supports	☐ Applied Behavioral Analysis	☐ EPSDT/ PCS	☐ OCDD/LGE Family Supports
☐ Shared Supports	☐ Aquatic Therapy	☐ Dental	☐ DSS/OCS
☐ Center-Based Respite	☐ Art Therapy	☐ Eye Glasses	☐ Natural Supports
☐ Environmental Accessibility Adaptations	☐ Music Therapy	☐ Home Health Extended	☐ Community Supports
☐ Specialized Medical Equipment and Supplies	☐ Hippotherapy	☐ Hospice	
☐ Family Training	☐ Therapeutic Horseback Riding	☐ Medical Transportation	
	☐ Sensory Integration	☐ Mental Health	
	☐ PSH- Housing Stabilization	☐ Podiatry Services	
	☐ PSH- Housing Stabilization Transition	☐ Substance Abuse	
		☐ Prescriptions/Medication	☐ Others
		☐ Others	

Support Coordinator Signature: ____

SECTION IX: POC SIGNATURE PAGE

SIGNATURES OF ALL PLANNING MEETING PARTICIPANTS

Planning Participant/Relationship	Planning Participant/Relationship

____ _______

SUPPORT COORDINATOR SIGNATURE **Date**

	Participant/Authorized Representative Initials
I have been offered a choice between waiver and institutional services and I have chosen (check one): _____ waiver _____ institutional	
I have been informed of the available support coordination agencies and I have chosen: (Name of Agency Chosen)____	
I have been offered the choice of available direct service providers from the OCDD Provider Freedom of Choice Listing and I have chosen: (List all Chosen Providers)	
I have been informed of all state plan services.	
I have been informed of my rights and responsibilities regarding home and community based waiver services and have been given the WSS Rights and Responsibilities Form which includes information on how to report abuse, neglect, exploitation, or extortion.	
My support coordinator has provided me with the toll-free number to contact the Health Standards Section if I want to report a complaint about my support coordinator or waiver service provider(s). That number is 1-800-660-0488.	

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify my support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify my support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.
I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion with OCDD/LGE and/or a fair hearing by requesting a fair hearing/appeal within 30 days of the approved/denied decision. I will contact the LGE for an informal discussion. I understand that a DHH Appeal may be requested by contacting OCDD/LGE, by calling or writing the Division of Administrative Law-Health and Hospitals Section, P.O. Box 4189, Baton Rouge, LA 70821-4189.

_______________________________________ _______________

Participant/Guardian Signature **Date**

_______________________________________ _______________

Witness **Date**

Reviewed by Support Coordinator Supervisor - Signature/Title:________________________ Date:_____________________

Plan of care reviewed and approved by Support Coordinator Supervisor. WSS Representative has reviewed approval documentation and is in agreement as indicated by stamp date and signature.______________________________

FOR LGE-WSS USE ONLY:

PARTICIPANT NAME:____ PROGRAM TYPE: ___________
DATE COMPLETED POC RECEIVED IN LGE-WSS ______________________ LGE-WSS PRE-CERT HOME VISIT DATE _____________
THIS POC MEETS THE IDENTIFIED NEEDS OF THE INDIVIDUAL: □ APPROVED □ DENIED
WITHOUT THE SERVICES AVAILABLE THROUGH THIS WAIVER, THE PARTICIPANT WOULD QUALIFY FOR INSTITUTIONAL CARE: YES NO
APPROVED POC BEGIN DATE: ____________________
APPROVED POC END DATE : _____________________
SERVICES APPROVED:

SIGNATURE/TITLE OF LGE- WSS REPRESENTATIVE: DATE: