

ADULT DAY HEALTH CARE
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

NOTE: Definitions of all key words in this IPC can be found in the Medi-Cal Inpatient/Outpatient Provider Manual.

(1)a. Check circle that applies to this IPC: Initial TAR Reauthorization TAR Change TAR
b. (#) _____ Planned Days/Week **c.** TB Clearance Date (initial TAR only): _____
d. A complete *History and Physical* form accompanies this IPC and documents the request for ADHC services (initial TARs only). Yes No NA
e. A complete *History and Physical Update* form accompanies this IPC and documents the request for ADHC services (reauthorization TARs only). Yes No NA

(2) DIAGNOSES AND ICD CODES

Condition(s)	Yes/No	Numbered Criteria that Must be Documented as Met	
Diagnosis(es) other than those listed below	<input type="radio"/> Yes <input type="radio"/> No	Eligibility: 1, 2a, 3a, 4, 5 and 6 Medical Necessity: 1, 2a, 3, 4, 5 and R1	
Resident of an ICF/DD-H	<input type="radio"/> Yes <input type="radio"/> No	Eligibility: 1, 2b, 3b, 4, 5, and 7 Medical Necessity: 1, 2b, 4, 5, 6 and R2	
Chronic mental illness	<input type="radio"/> Yes <input type="radio"/> No	Eligibility: 1, 2b, 3b, 4, 5 and 8 Medical Necessity: 1, 2b, 3, 4, 5 and R1 Note: Box 7 must also reflect this diagnosis	
Moderate to severe Alzheimer's disease or other cognitive impairments	<input type="radio"/> Yes <input type="radio"/> No	Eligibility: 1, 2b, 3b, 4, 5 and 8 Medical Necessity: 1, 2b, 3, 4, 5 and R1	
Diagnoses	ICD Code	Diagnoses	ICD Code
Include diagnoses as provided or confirmed by the personal health care provider(s)		Include diagnoses as provided or confirmed by the personal health care provider(s)	
1		6	
2		7	
3		8	
4		9	
5		10	

(3) MEDICATIONS (frequency and dosage not required) No Medications or Supplements <input type="radio"/>	Active Prescriptions	11
	1	12
	2	13
	3	14
	4	15
	5	Over-The-Counter Medications &/or Supplements
	6	1
	7	2
	8	3
	9	4
10	5	

Note: for med management problems, please provide detailed plans in Box 27

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(4) Active Personal Medical/Mental Health Care Provider(s) (if known)	Name	Address	Phone

Criteria Verification

- Yes/No/NA must be checked for all criteria.
- All circles checked must be supported by appropriate documentation in the participant's health record.

(5) ELIGIBILITY CRITERIA

Criterion Met				The person is <u>18 years of age or older</u> and has <u>one or more</u> chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, <u>requested ADHC services</u> for the person.
#	Yes	No	NA	
1	<input type="radio"/>	<input type="radio"/>		
2	<input type="radio"/>	<input type="radio"/>		The person has <u>two or more</u> functional impairments involving ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, and hygiene. SEE MEDICAL NECESSITY CRITERION #2.
3	<input type="radio"/>	<input type="radio"/>		a. Except for persons in the designated groups, the person requires <u>substantial human assistance</u> in performing the activities listed in #2 above. b. The persons in the designated groups <u>only require assistance</u> in performing these activities. SEE MEDICAL NECESSITY CRITERION # 2a and 2b.
4	<input type="radio"/>	<input type="radio"/>		The person requires <u>ongoing or intermittent</u> protective supervision, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive or mental health condition.
5	<input type="radio"/>	<input type="radio"/>		The person requires ADHC services, as defined in W&I Code, Section 14550, that are <u>individualized and planned</u> , including, when necessary, the coordination of formal and informal services outside of the ADHC program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Except for persons in the designated groups, the person meets the <u>intermediate (NF-A) level of care</u> set forth in Section 51120 of Title 22 of the California Code of Regulations (CCR). This criteria includes all of the following; please check as applicable to this participant: <ul style="list-style-type: none"> <input type="radio"/> Requires protective and supportive care, because of mental or physical conditions or both, above the level of board and care. <input type="radio"/> Does not require continuous supervision of care by an RN or LVN except for brief spells of illness. <input type="radio"/> Does not have an illness, injury, or disability for which hospital or SNF services are required.
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A <u>resident of an ICF/DD-H facility</u> meets all of the above criteria, except as specified, AND has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through ADHC, placement to a more costly institutional level of care would be likely to occur (#1, 2b, 3b, 4 & 5). SEE MEDICAL NECESSITY CRITERION #6.
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A person <u>having chronic mental illness or moderate to severe Alzheimer's disease or other cognitive impairments</u> meets all of the above criteria, except as specified (#1, 2b, 3b, 4 & 5).

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IADLs	NA	Requires Substantial Human Assistance		Requires Assistance	
		Check	Description of Functional Ability	Check	Description of Functional Ability
Hygiene	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	
Medication Management	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	

(10) CURRENT ASSISTIVE/ADAPTIVE DEVICES (Check all that apply):

<input type="radio"/>	None	<input type="radio"/>	AAC Device	<input type="radio"/>	Glasses or Other Vision Aid
<input type="radio"/>	Wheelchair	<input type="radio"/>	Orthosis/Prosthesis	<input type="radio"/>	Dentures
<input type="radio"/>	Walker	<input type="radio"/>	Gait Belt	<input type="radio"/>	Respiratory Equipment (specify): _____
<input type="radio"/>	Crutches	<input type="radio"/>	Hoyer Lift	<input type="radio"/>	Other (specify): _____
<input type="radio"/>	Cane	<input type="radio"/>	Hearing Device		

(11) CONTINENCE INFORMATION (Check all that apply):

- None Incontinent of bladder Incontinent of bowel External/internal catheter Ostomy
 Other (specify): _____

(12) SELF-FEEDING INFORMATION (Check all that apply):

- None Overweight Underweight Feeding tube Therapeutic/special diet
 Difficulty chewing and/or swallowing Other (specify): _____

(13) MEDICAL NECESSITY CRITERION #3

Criterion Met			Except for participant's residing in an ICF/DD-H, the participant's <u>network of non-ADHC center supports</u> is insufficient to maintain the individual in the community, demonstrated by <u>at least one</u> of the following (if <u>yes</u> or <u>no</u> was checked, check all that apply below):
Yes	No	NA	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> The participant lives alone and has no family or caregivers available to provide <u>sufficient and necessary care or supervision</u> . <input type="radio"/> The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide <u>sufficient and necessary care or supervision</u> to the participant. Please describe here what sufficient and necessary care or supervision is lacking: _____

(14) NON-ADHC CENTER SUPPORT/SERVICES – PART A (if known). Check all that apply:

SUPPORT SERVICE		SUPPORT SERVICE	
<input type="radio"/>	Not Known Explain: _____	<input type="radio"/>	Case Management (e.g., TCM, MSSP waiver) Type & Frequency: _____
<input type="radio"/>	NONE	<input type="radio"/>	ICF/DD-H
<input type="radio"/>	IHSS/PCSP Services Hours authorized per week/month: _____	<input type="radio"/>	Lives in a Community Care Licensed Facility (e.g., Board and Care)
<input type="radio"/>	Other Paid Caregiver(s) Frequency: _____		

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For all support services checked above, please describe here how or why the support service(s) is insufficient: _____

(15) NON-ADHC CENTER SUPPORT/SERVICES – PART B (if known). Check all that apply:

Within the last 6 months, the participant received the following non-institutional services:

Not Known. Explain: _____

None.

Home Health Agency Services. Explain: _____

>>>Is the participant currently receiving **Home Health Agency Services**? Yes No

Hospice Care. Explain: _____

>>>Is the participant currently receiving **Hospice Services**? Yes No

If the participant is currently receiving either home health agency or hospice services, please specify:

Service	Frequency

Urgent Care. Explain: _____

Mental Health Services. Explain: _____

Emergency Department. Explain: _____

Other. Explain: _____

(16) MEDICAL NECESSITY CRITERION #4

!! ALERT !! These conditions must be reflected on the Plan of Care in Box 27 and/or 28 to describe the specific intervention, frequency and goal for each condition that will be addressed by the ADHC center.

Criterion Met		A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if ADHC services are not provided.
Yes <input type="radio"/>	No <input type="radio"/>	

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(17) RISK FACTORS (check all conditions that this participant is at risk for pursuant to criterion 4, Box 16):

<input type="radio"/> Inappropriate Affect, Appearance or Behavior	<input type="radio"/> Dementia Related Behavioral Problems
<input type="radio"/> Poor Judgment	<input type="radio"/> Fall Risk
<input type="radio"/> Medication Mismanagement	<input type="radio"/> Isolation
<input type="radio"/> Self Neglect	<input type="radio"/> Frailty
<input type="radio"/> Two or More Chronic Conditions	<input type="radio"/> Other (specify): _____

(18) AT RISK FOR ADMISSION TO INSTITUTIONAL CARE (check all levels of institutionalization that this participant is at risk for pursuant to criterion 4, Box 16):

None.

Acute Care Hospital (medical or psychiatric). Explain: _____

Nursing Facility. Explain: _____

ICF/DD or ICF/DD-N. Explain: _____

Other. Explain: _____

Last Known Discharge Date from an Institutional Level of Care: _____

(19) MEDICAL NECESSITY CRITERION #5
!! ALERT !! These core services must be reflected on the Plan of Care in Box 27 and/or 28 to describe the specific intervention, frequency and goal for each core service.

Criterion Met		The participant's condition or conditions require <u>all</u> of the <u>core ADHC services</u> set forth in boxes 21-24 <u>on each day</u> of attendance that are <u>individualized</u> and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.
Yes <input type="radio"/>	No <input type="radio"/>	

(20) MEDICAL NECESSITY CRITERION #6

Criterion Met			The initial authorization of a TAR for a resident of an ICF/DD-H facility shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through ADHC, placement to a more costly institutional level of care would be likely to occur.
Yes <input type="radio"/>	No <input type="radio"/>	NA <input type="radio"/>	

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REQUIRED CORE SERVICES			
!! ALERT !! These core services must be reflected on the Plan of Care in Box 27 to describe the specific intervention, frequency and goal for each core service.			
(21)	Yes	No	A. Professional Nursing Services <u>One or more of the following professional nursing services</u> on each day of attendance: N1 <u>Assessment, and monitoring</u> of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions upon which admission to the ADHC center was based. N2 <u>Monitoring and assessment</u> of the participant's medication regimen, administration and recording of the participant's prescribed medication, and intervention, as needed, based upon professional assessment of participant's reactions to his/her medications. N3 <u>Oral or written communication with the participant's personal health care provider</u> , other qualified health care or social services provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms. N4 <u>Provision of skilled nursing care and intervention</u> , within scope of practice, to participants, as needed, based upon an assessment of the participant, his/her ability to provide self-care while at the ADHC center, and any health care provider orders.
	<input type="radio"/>	<input type="radio"/>	
(22)	Yes	No	B. Personal Care Services/Social Services <u>One or both of the following core personal care services or social services</u> on each day of attendance: P1 <u>Personal care services</u> : P1a Protective group supervision and interventions to ensure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering. P2 <u>Social services</u> provided by the ADHC center social worker or social worker assistant: P2a Assessment, and monitoring of the participant's psychosocial status provided by the ADHC center's social worker or social worker assistant. P2b Group work to address psychosocial issues.
	<input type="radio"/>	<input type="radio"/>	
(23)	Yes	No	C. Therapeutic Activities <u>One or both of the following therapeutic activities</u> provided by the ADHC center activity coordinator or other trained ADHC center personnel on each day of attendance: A1 Group or individual activities to enhance the social, physical, or cognitive functioning of the participant. A2 Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.
	<input type="radio"/>	<input type="radio"/>	
(24)	Yes	No	Contra-indications <input type="radio"/> D. Meal Service M At least one meal per day of attendance unless the participant declines the meal or medical contraindications exist, as documented in the participant's health record, that prohibit the ingestion of the meal.
	<input type="radio"/>	<input type="radio"/>	
(25) MEDICAL NECESSITY CRITERION #R1			
Criterion Met			Reauthorization of an ADHC TAR (non-ICF/DD-H resident) shall be granted when the criteria specified above have been met <u>and</u> the participant's condition would likely deteriorate if the ADHC services were denied.
Yes	No	NA	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
(26) MEDICAL NECESSITY CRITERION #R2			
Criterion Met			Reauthorization of an ADHC TAR for a resident of an ICF/DD-H facility shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through ADHC, placement to a more costly institutional level of care would be likely to occur.
Yes	No	NA	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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(27) Participant's Individual Plan of Care (Core Services) [must be consistent with information provided in Boxes 1-27 and the instructions for completion of this IPC in the *Adult Day Health Care (ADHC) Centers: TAR, IPC and H&P Form Completion* section]

ADHC CORE SERVICES (Box 27)	Participant Problem (must include a <u>measurable</u> starting point or baseline)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Professional Nursing Services (please use the numbering specified in Box 21, N1-N4 to refer to the core services)				

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ADHC CORE SERVICES (Box 27)	Participant Problem (must include a <u>measurable</u> starting point or baseline)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Personal Care Services (please use the numbering specified in Box 22, P1a to refer to the core services)				
Social Services (please use the numbering specified in Box 22, P2a and P2b to refer to the core services)				

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ADHC CORE SERVICES (Box 27)	Participant Problem (must include a <u>measurable</u> starting point or baseline)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Therapeutic Activities (please use the numbering specified in Box 23, A1 and A2 to refer to the core services)				
Physical Therapy Maintenance Program				
Occupational Therapy Maintenance Program				
Nutrition/Diet <input type="radio"/> Regular Diet <input type="radio"/> Special Diet Specify: _____ <input type="radio"/> NPO (receives NG, GT or IV feedings at home)				

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(28) Participant's Individual Plan of Care (Separately Billable Services) [must be consistent with information provided in Boxes 1-27 and the instructions for completion of this IPC in the *Adult Day Health Care (ADHC) Centers: TAR, IPC and H&P Form Completion* section]

<p>ADHC SEPARATELY BILLABLE SERVICES (Box 28) (Please care plan only those ADHC services actually provided)</p>	<p>Participant Problem (must include a <u>measurable</u> starting point or baseline)</p>	<p>Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)</p>	<p>Frequency of Treatment/ Intervention (e.g., 2x per week)</p>	<p>Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)</p>
<p>Physical Therapy</p>				

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<p>ADHC SEPARATELY BILLABLE SERVICES (Box 28) (Please care plan only those ADHC services actually provided)</p>	<p>Participant Problem (must include a <u>measurable</u> starting point or baseline)</p>	<p>Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)</p>	<p>Frequency of Treatment/ Intervention (e.g., 2x per week)</p>	<p>Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)</p>
<p>Occupational Therapy</p>				

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<p>ADHC SEPARATELY BILLABLE SERVICES (Box 28) (Please care plan only those ADHC services actually provided)</p>	<p>Participant Problem (must include a <u>measurable</u> starting point or baseline)</p>	<p>Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)</p>	<p>Frequency of Treatment/ Intervention (e.g., 2x per week)</p>	<p>Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)</p>
<p>Speech and Language Pathology Services</p>				
<p>Registered Dietitian Services</p>				

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<p>ADHC SEPARATELY BILLABLE SERVICES (Box 28) (Please care plan only those ADHC services actually provided)</p>	<p>Participant Problem (must include a <u>measurable</u> starting point)</p>	<p>Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)</p>	<p>Frequency of Treatment/ Intervention (e.g., 2x per week)</p>	<p>Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)</p>
<p>Mental Health Services</p>				
<p>Other (please specify)</p>				

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(29) Text Box (Optional)

**This text box is available for the ADHC Center's use in providing information not explained elsewhere in this IPC that is relevant to the authorization of this TAR.
Please do not repeat information previously explained.**

Please Reference Box Number Being Discussed.

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(30) Signatures of Multidisciplinary Team, Participant's Personal Health Care Provider and Program Director

Signatures of the Multidisciplinary Team Pursuant to section 14529 of the Welfare and Institutions Code Signing below certifies agreement with the treatments designated in the IPC that are consistent with the signer's scope of practice (For initial TARs, the RN, SW, PT and OT MUST sign; for reauthorization TARs, the RN and SW MUST sign; all other disciplines must sign if their services are/will be provided)		
Printed Name	Signature	Date of Signing
	RN	
	SW	
	PT	
	OT	
By signing below I certify that I have reviewed and concur with this IPC and am requesting ADHC services for this person		
Printed Name	Signature of the Primary/Personal Health Care Provider or ADHC Center Physician	Date of Signing
By signing below, I certify that <u>all assessments have been completed within 30 days of the start of services</u> and that <u>the participant meets the eligibility criteria</u> as set forth in section 14525.1 of the W&I Code and the <u>medical necessity criteria</u> as set forth in section 14526.2(d) of the W&I Code and specified in this IPC, effective on this date**:_____. I further certify that services will be provided as scheduled on this IPC unless otherwise noted in the participant's health record.		
Printed Name	Signature	Date of Signing
	Program Director	

** The TAR will NOT be approved for ADHC services provided prior to this date.

Privacy Statement:

The information requested on this form is required by the Department of Health Care Services, Utilization Management Division, for the purpose of adjudication of Treatment Authorization Requests (TARs) for Adult Day Health Care (ADHC) services. Failure to provide this mandatory information may result in denial of the TAR for ADHC services.