

New Jersey Department of Human Services
Division of Aging Services

INSTRUCTIONS FOR COMPLETING THE
PLAN OF CARE (WPA-2) FORM

Plan of Care Document Instructions: Top of Page 1

1. **Participant Name** Print the participant's full (first and last) name.
2. **Plan of Care Date** Enter the full date (Month, Day, Year) the Plan of Care is developed. This is the first date the Plan contents are discussed with the participant. This is not necessarily the same date that the participant signs the Plan of Care once it is completed.
- 2A. **Closed Date** Enter date this Plan of Care was closed.
3. **Identification No.** Enter the participant's or JACC (SAMS or Other) identification number.
4. **Care Manager Name** Print the Care Manager's full (first and last) name.
5. **Plan of Care Renewal Due** Enter the estimated date (Month and Year) that the Plan of Care renewal is due for completion. Plans of Care are to be updated annually and revised as necessary when warranted by changes in the program participant's needs. For example, the annual Plan of Care is due one year (12 months) from the initial Plan of Care Date (indicated in #2).

JACC Only: The Long Term Care Re-Evaluation (level of care assessment) form (WPA-1), is to be completed prior to the annual Plan of Care renewal date. Separate instructions cover this document.
6. **Program** Indicate the Program in which the participant is currently enrolled.
7. **Residential Setting** Indicate the type of location where the participant is currently residing.
- 7 A. **Occupancy** Select if the participant resides alone or with others, i.e., family, friends, roommate.

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8. **Date** Enter the full date (Month, Day, Year) that each of the assessed needs (Problem Statements) is identified and written into the Plan of Care.
9. **Problem Statement** The Problem Statement is to illustrate the **reason(s)** for the assessed need. It should briefly describe the participant's health condition, personal goals, risk factors, and/or individual circumstances that serve as the basis for each assessed need and the way in which these impact the participant's functioning.

For example, a Column #9 entry should NOT state 'Locomotion' as the Problem Statement. Rather, it would *describe the condition* of the participant and his or her circumstances that have resulted in his or her limited mobility. Furthermore, the participant's diagnosis alone is not a sufficient summary of a Problem Statement justifying the assessed need. Rather, the *impact of the diagnosis* on the participant's day-to-day functioning should be indicated.
10. **Need Code(s)** Enter the Need Code(s) by which each assessed need is best categorized. For example, if the Problem Statement reads "Participant experienced a stroke and as a result has a poor hand grip, minimal use of her right arm, and is easily fatigued," the Need Code may be '2d' if the participant, as a result of this condition, needs assistance with '**Medication Management.**' When 'Option 8 – Other' is used, the assessor shall specify the Need in the blank provided.

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For all Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), use the **alphanumeric combination** indicated in the Code List. Also, it is possible for the assessor to enter more than one Need Code for each Problem Statement.

If the Problem Statement is best described as a Personal Goal of the participant (Option 3), please be sure that the participant's preference is clearly described and a Desired Outcome goal is also indicated in Column #12. Some examples of a participant's goal or preference are a) to be able to stay at home as long as possible rather than relocate to a nursing facility, b) to remain as independent as possible with the help of a home health aide, c) to obtain a personal computer to work out of his or her home, or d) to be able to go outside regularly or find transportation for preferred outings.

If the Problem Statement is best described as a Risk Factor (something that is likely to increase the chances that a particular event will occur), please describe these concerns on the last page of the Plan in Column #25. For example, a condition or behavior that increases the participant's chances for injury or the possibility of disease, such as the fact that smoking could lead to heart disease, lung cancer, eviction, or a serious fire hazard.

Assigned codes are used to identify the ADLs or IADLs with which the participant needs assistance or is unable to perform.

1. **ADLs** identify the specific Activity of Daily Living with which the participant needs assistance or is unable to perform.
 - a. **Bathing:** Bathing includes how the participant takes a full-body bath/shower or sponge bath. Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, and perineal area.
 - b. **Dressing:** Upper Body Dressing includes how participant dresses / undresses (street clothes and underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc. Lower Body Dressing includes how the participant dresses/undresses (street clothes and underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, socks, and fasteners.
 - c. **Toilet Use:** Including using the toilet or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing special devices required (ostomy or catheter), and adjusting clothes.
 - d. **Transferring:** Including moving to and between surfaces – to/from bed, chair, wheelchair, standing position.
 - e. **Locomotion:** Including inside and outside of home. Note: If a wheelchair is used, regard self-sufficiency once in wheelchair.
 - f. **Bed Mobility:** Including moving to and from lying position, turning side-to-side, and positioning body while in bed.
 - g. **Eating:** Including taking in food by any method, including tube feedings.
2. **IADLs** identify the specific Instrumental Activity of Daily Living (IADL) with which the participant needs assistance or is unable to perform.
 - a. **Meal Preparation:** The ability to obtain and prepare routine meals. This includes the ability to open containers and use kitchen appliances, and how meals are prepared (e.g. planning meals, cooking, assembling ingredients, setting out food, utensils), with assistive devices, if used. If person is fed via tube feedings or intravenously, treat preparation for the tube feeding as meal preparation and indicate level of help needed.
 - b. **Housework:** The ability to maintain cleanliness of the living environment and how ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up).

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- c. **Managing Finances:** The ability to handle money, plan budget, write checks or money orders, exchange currency, handle coins and paper, do financial management for basic household necessities (food, clothing, shelter), pay bills and balance a checkbook.
- d. **Medication Management:** How medications are managed and ability to follow prescribed medication regime (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).
- e. **Phone Use:** How telephone calls are made or received (with assistive devices such as large numbers or telephone amplification).
- f. **Shopping:** The ability to run errands and shop, physically acquire, transport and put away groceries. How shopping is performed for food and household items (e.g. selecting appropriate items, getting around in a store).
- g. **Transportation:** The ability to drive and/or access transportation services in the community. How participant travels by vehicle (e.g. gets to places beyond walking distance).
- h. **Accessing Resources:** The ability to identify needs and locate appropriate resources; the ability to complete phone calls, set up and follow through with appointments, and complete paperwork necessary to acquire services or participate in activities offered by the resources.
- i. **Laundry:** The ability to maintain cleanliness of personal clothing and linens.
- j. **Personal Hygiene:** Personal hygiene may include ability to perform grooming such as combing hair, brushing teeth, shaving, nail care, applying makeup, and washing/drying face and hands.

Assigned codes are used to identify other areas in which the participant requires assistance. The phrases in parentheses serve only as limited examples. Many more instances could be used to illustrate examples of each Need Code.

- 3. **Personal Goal:** Something that is a personal aspiration or objective stated by the participant (e.g. accessing transportation to attend social events, enrolling at a local community college, obtaining a personal computer, regularly attending religious services or functions, writing a book, or remaining in his or her own home for as long as possible rather than moving into a nursing facility).
- 4. **Communication Needs**
(e.g. communication disorders, hearing or speaking impairments)
- 5. **Social Isolation**
(e.g. lives alone, home in an area inaccessible to visitors)
- 6. **Caregiver Relief**
(e.g. at risk for reduction of informal supports, caregiver burnout)
- 7. **Mental Health**
(e.g. cognitive impairment, low self-esteem, depression, hopelessness, rage, emotional instability)
- 8. **Other (specify)**
- 9. **Risk Factors**
 - a. **Personal Safety Risk**
(e.g. supervision needed for personal safety; participant is self-neglecting, abusive of alcohol or other substance)
 - b. **Health Condition Risk**
(e.g. needs medical attention; visual impairments, obese, sedentary lifestyle, chronic illness, poor nutrition, sleep disturbance, poor health/hygiene, lack of oral/dental care, skin condition/bed sores, improper foot care, at risk of falls, at risk of long term institutional care in nursing facility)
 - c. **Behavioral Risk**
(e.g. risky or inappropriate behaviors or lifestyle habits)

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(Continued)**

d. Environmental Risk

(e.g. home environment, living conditions are insecure or hazardous; neighborhood is unsafe)

e. Medication Risk

(e.g. unable to appropriately manage medications; multiple medications and/or prescribing physicians)

f. Other Risk (specify)

SERVICES

11. Service(s) Needed

Service(s) Needed is used to identify distinct services. Enter the type of Service(s) that is required to address each of the assessed needs (e.g., Home Health, Transportation, Meals on Wheels).

12. Desired Outcome Codes

Desired Outcome Code identifies the general objective of the service in terms of participant functioning in the need area.

Enter the appropriate Desired Outcome from the Code List. Indicate the meaning of "Option 5 - Other" if used, in the space provided.

The Code answers the following types of questions regarding the participant's functioning:

1. **Maintenance:** Does the participant want his current level of functioning maintained?
2. **Independence:** Does the participant want to gain independent functioning in the area?
3. **Rehabilitation:** Does the participant want to restore functional ability?
4. **Prevention:** Does the participant want to prevent the problem from recurring?
5. **Caregiver Relief:** Does the services provide respite to the caregivers?
6. **Other (specify):** Does the participant want to resolve the issue, e.g. the installation of a ramp resolves the lack of access in and out of the home?

13. Units Per Visit

Units refer to the number of units of service authorized/arranged for during an occurrence/visit.

For APC: Use current unit of service as specified in the taxonomy.

For JACC Only: Enter the units of service per visit/occurrence. (See JCN 407 form.)

14. Frequency

Frequency codes are used to distinguish the number of times a service should occur. Indicate the frequency, from the list below, which best describes how often the support is provided/required.

D– Daily, specifying the number of days per week (e.g. 3x). If the participant wants services on the weekends or specific weekdays that preference can be indicated in the Problem Statement.

W– Weekly: Once every week

B– Bi-Weekly: Once every two weeks

M– Monthly: Every month (once within 30/31 days)

Q– Quarterly: Once every three months

A– Annually: Every year (once within 12 months)

O– Other (specify)

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COSTS

15. Unit Cost

For JACC Only: Enter the **Rate per Unit** of service. (See JCN 407 form) Rates, where applicable, may not exceed those established. Specify the authorized cost for each service.

16. Payment Source

Payment source codes are used to identify the source of funding for a service. Enter code, from the list below, for service payment source.

1. **Medicaid:** Medicaid is medical assistance (health insurance) provided to certain persons with low incomes and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act. Can include both traditional State Plan Medicaid services provided through a Managed Health Plan as well as non-medical services when provided under special Medicaid Waiver programs as authorized under section 1915(c) of the Social Security Act.

2. **Medicare:** Health Insurance generally for individuals over 65 and/or disabled.

Part A-Hospital Insurance: Helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care) and also helps cover hospice care and some home health care.

Part B-Medical Insurance: When medically necessary, helps cover doctors' services and outpatient care, often requiring a premium. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part D-Prescription Drug Coverage: Insurance which may help lower prescription drug costs. Private companies provide the coverage and beneficiaries choose the drug plan and may pay a monthly premium. NJ Medicaid Waiver participants do not have a premium.

3. **Other Third-Party Liability (TPL):** Private Health Insurance.

4. **Local, Community-Based Organization:** A church organization may be involved, or a local township or city community action program may be used.

5. **County Funded Program:** The county health department or a county human services office may use funds to maintain programs for seniors and persons with disabilities.

6. **State Funded Program:** Can include programs such as the Jersey Assistance for Community Caregiving (JACC) program, the Congregate Housing Services Program (CHSP), the Alzheimer's Adult Day Health Services Program (AADHS), or some other state-funded program.

7. **Informal Support:** Any free or uncompensated support given by a relative or immediate family member, friend, neighbor or other informal companion.

8. **Private Pay:** Any payment made directly by the participant out of his or her own income, resources or personal needs allowance.

9. **APC Funded:** Any service supported by funds from the County Office on Aging (AAA/ADRC) under the area plan contract.

10. **Other (specify)**

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PROVIDERS

17. Provider Type

Provider Type codes are used to identify persons who assist a participant in the areas of need. Provider / Worker is defined as an individual or entity that demonstrates competence to qualify as a provider of services.

Enter code, from the list below, to describe each type of provider.

J – JACC Agency

A provider that has applied, been authorized and enrolled by the Division of Aging Services as a JACC provider agency and as such can submit claims for JACC covered services and supplies.

M – Medicare

A provider that has applied, been authorized and enrolled by the Centers for Medicare and Medicaid Services (CMS) as a Medicare provider and as such can submit claims for Medicare covered services and supplies.

PEP– Participant-Employed Provider (PEP)

A Participant-Employed Provider refers to an individual worker who has been approved to provide authorized services as a hired employee of the participant.

P – Private Provider

A provider that is rendering goods or services based on payment made directly by the participant out of his or her own income, resources or payment made on behalf of the participant by a relative or immediate family member, friend, neighbor or other informal companion.

F – Facility (JACC only)

A Hospital, Nursing Facility, or Assisted Living Facility that would typically be used for facility-based respite stays or for residents in an Assisted Living Facility.

I – Informal Support

A relative or immediate family member, caregiver, friend, neighbor or other informal companion who provides services to the participant.

18. Provider

Enter the specific name of the Provider Agency or the name of the Participant-Employed Provider responsible for rendering each service.

MONITORING

19. Monitoring Method

Monitoring Method codes are used to identify how service provision will be verified. Both State and Federal governments seek proof that services are delivered in accordance with the Plan of Care.

Enter the appropriate Code(s), from the following, to describe how service delivery will be confirmed: Select all that Apply

C– Participant Record/Chart: e.g., case file, facility chart.

T– Time Sheets:

S– On-site Review: e.g., face to face visit with participant while service occurring, observing participant and environment.

R– Receipts: e.g., review proof of payment, vouchers, or invoices of services delivered.

D– Documentation: e.g., review of assignment sheets, service delivery logs, medication or treatment administration records.

P– Phone Contact: e.g., telephone conversations with participant, caregiver, service provider, or billing agent.

O– Other (specify)

20. Monitoring Frequency

Monitoring frequency codes indicate how often service verification is to be performed.

Enter the minimum monitoring frequency, from the codes below, required for each service.

D– Daily

M– Monthly

R– Random

W– Weekly

Q– Quarterly

U– Upon reported completion

B– Bi-Weekly

A– Annually

O– Other (specify)

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21. Unmet Need Code

Unmet Need codes convey those participant needs that have been identified but have no arranged services in place, as an obstacle/barrier limits the need from being met or resolved. Enter the code to indicate why this assessed need remains unmet.

In addition, in Column #25 on the last page of the Plan of Care, describe the impact the unmet need has on the individual's health, safety and well-being, which is likely to require the continued attention of the Care Manager.

Enter code, from the list below, for unmet need.

1. **Not available**
2. **Not affordable**
3. **Waiting list**
4. **Frequency not adequate**
5. **Refused** (service offered but participant declines)
6. **Other (specify) – expound on reason if necessary in Column #26**

JACC Only: Note: Any unmet needs described in this section must also be a component of the Long-Term Care Re-evaluation and must be acknowledged at the reassessment.

UPDATES

22. Initials

Plan of Care Updates or Changes: Throughout the Plan of Care please indicate any changes that occur during the year, prior to the annual POC renewal date.

As per the Plan of Care Policy:

- Any change to a POC requires that the **Care Manager (CM)** make the change on the POC, initial and date it, and enter an explanation for the change in the Monitoring Record.
- Changes that reflect an increase, addition, decrease, or termination of an existing service must also be initialed and dated by the **Participant**, or his or her representative no later than the date of the next scheduled visit.

23. Date

Enter the date(s), (mm/dd/yy), that the update or change to the Plan of Care was initialed by the Care Manager and by the participant if necessary.

24. Special Instructions/Comments

If upon the initial completion of the POC, there are no comments to be added to this section, please check the **N/A** box.

Enter any additional comments including the date and initial each entry.

When utilized, this section should include but not be limited to:

Participant Preferences or Concerns: Please indicate any comments or preferences from the participant. (e.g., only services after 9 a.m.)

Unmet Needs: Expound on any needs that are identified as unmet in Column #22.

Back-up Plans: Please indicate assessed needs/behaviors/situations/conditions considered to be at-risk concern(s) for the safety and/or well-being of the participant. List the interventions that will be put into place to respond to these safety concerns if service delivery fails to occur as proposed (including description of the intervention, who is involved, emergency contact information, and responsibilities).

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SIGNATURES

All Plans of Care (POC) are to include at least three signatures (Participant, Care Manager and Care Management Supervisor), and any others as applicable. All original signatures are to be secured within 30 days of receiving the case, upon completion of the POC. Copies are to be made available for all parties.

Participant's Signature: The participant's signature may be the mark of an **X** as performed by the participant. If the participant has a representative, that person may sign for the participant upon the participant's request.

Above the Participant's (or his or her Representative's) signature, the signer should attest to whether he or she Agrees (Yes) or Disagrees (No) with the following statements:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I agree with this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I had the freedom to choose the services in this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I had the freedom to choose the providers of my services based on available providers. |
| <input type="checkbox"/> | <input type="checkbox"/> | I helped develop this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am aware of my rights and responsibilities as a participant of this program (as contained in the Participant Agreement). |
| <input type="checkbox"/> | <input type="checkbox"/> | I am aware that the services outlined in this Plan of Care are not guaranteed. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have been advised of the potential risk factors outlined in this Plan of Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | I understand and accept these potential risk factors. |

If the participant marks 'No' to any of the above-mentioned queries, an explanation of the participant's concerns is to be provided in Column #25 prior to acquiring his or her signature.

The Care Manager shall explain to the program participant the special note described below the participant's signature:

'All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program.'

The Care Manager should explain, and periodically remind the participant, what specific clinical and financial criteria are required to participate in this program and who is responsible for re-determining his or her continued eligibility for both.

Care Manager (CM) Signature: The Care Manager shall sign the Plan of Care as indication that (1) the Plan of Care addresses all of the participant's assessed needs (including health and safety risk factors, and any unmet needs) and personal goals either by the provision of services or through other means; and (2) the Plan of Care has been developed in accordance with appropriate Plan of Care Policies and Procedures.

CM Supervisor Signature: The Care Management Supervisor shall sign the Plan of Care as indication that he or she has reviewed it in its entirety and agrees that the Plan of Care has been developed in accordance with appropriate Plan of Care Policies and Procedures. (If the Care Management Supervisor or Care Coordinator has a caseload and has prepared the Plan of Care, a designated qualified staff person may sign the Plan of Care as the reviewer.)

Other(s): Other involved parties, such as a family member, appointed guardian, legal representative, or other involved party, by the request of the participant, shall sign the Plan of Care as indication that he or she is aware of the assessed needs and authorized services that have been outlined in the Plan of Care.